



GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

# **Georgia State Medicaid HIT Plan**

**July 18, 2011**

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**Document Change Control Table**

**July 18, 2011 DCH SMHP updates/response to CMS**

<b>CMS Comments Received on June 20, 2011</b>	<b>DCH Responses Submitted on July 18, 2011</b>	<b>New Section and Page</b>
<p>1. Must fix, Page 3: Pre-Payment Audits: The fourth bullet suggests that a manual review will be conducted to ensure the payment request is valid. What is the further-defined process to manually review payment validation for 4,121 providers and 77 hospitals? Does the State have the resources available to enforce such a process? (Also previously on pages 50-51)</p>	<p><b>Pre-Payment Audits</b>                      Prior to registration and attestation at the state level, DCH will require all Eligible Professionals to complete the patient volume calculator and Eligible Hospitals to complete the patient volume and incentive payment calculator. The finalized calculators must be uploaded to the provider's application during the attestation process. DCH will work closely with Eligible Professionals to answer questions and assist with completion of the calculators. For Eligible Hospitals, DCH will meet with each hospital to finalize the patient volume and incentive payment calculations prior to the state level registration and attestation. The Department believes these steps will help minimize some of the pre-payment review steps once the provider initiates the application process.</p> <p>DCH has also developed a set of tools to expedite the pre-payment review process. DCH created multiple databases, which are an accumulation of information including paid claims histories utilizing fee-for-service and managed care encounter claims, and other information, summarized in formats as needed to conduct the reviews. These databases will allow a Payment Specialist to quickly assess a provider's eligibility to participate in the Medicaid EHR incentive program after the provider's identification has been successfully matched in MAPIR.</p> <p>The databases created include, but are not limited to:</p> <ul style="list-style-type: none"> <li>- Pre-qualification list to identify potential EHs and EPs</li> <li>- Applications received to date by provider ID and participation year</li> <li>- EP - Paid Medicaid claims with CHIP encounters</li> <li>- EP - Paid Medicaid claims without CHIP encounters</li> <li>- EP - CHIP encounters</li> <li>- EP CHIP Factors</li> <li>- EP encounters by predominant county (for CHIP calculation purposes)</li> <li>- FQHC/RHC Qualification list including a list of EPs who practice predominately at that location (in development)</li> <li>- Pediatricians</li> <li>- Hospital-based providers</li> <li>- Providers associated by Medicaid payee ID, Tax ID, and/or financial relationship who may potentially decide to participate as a group practice in the Medicaid EHR incentive program.</li> </ul> <p>These databases can be queried to extract information</p>	<p>Section Page 62-63</p>

## 2010 STATE MEDICAID HIT PLAN V.1.O

CMS Comments Received on June 20, 2011	DCH Responses Submitted on July 18, 2011	New Section and Page
	<p>based on a provider's specified 90-day period, fiscal year, or calendar year. Additional databases will be created as the need arises. The purpose for creating and maintaining these databases is to quickly determine whether a provider's assertions are reasonable and consistent with paid claims history, and whether a provider may be eligible for Medicaid EHR incentive payments.</p> <p>Table 1 below describes the procedures to be performed during a pre-payment review and the acceptable variances between self-reported amounts and the various databases listed above. If a variance exceeding the acceptable range exists, DCH may suspend the incentive payment until the difference can be resolved in an acceptable manner. The tolerable variances listed in the table below are only for the purposes of determining if incentive payments should be made before additional review procedures are performed.</p> <p>Yes, the Office of Health Information Technology and Transparency has reorganized its staffing structure to adequate support the Medicaid EHR Incentives Program, including support of pre-payment audit process.</p>	
<p>2. Must fix, Page 29: All of the outreach language is in the future tense. Since the Regional Extension Center (REC) has been funded for over a year and the other States and Medicare have initiated EHR incentive payments, what outreach activities are already underway?</p>	<p>OHITT has expanded its collaborative role with GA-HITREC to include the following activities currently underway:</p> <ul style="list-style-type: none"> <li>• Co-developed a unified "message" to the provider community recognizing that the GA-HITREC can provide technical assistance, information, and support providers ready to learn more and execute adoption, implementation or upgrade of a certified EHR system within their practice.</li> <li>• Identified cost-sharing opportunities to employ professional advertising and marketing services in order to reach a wider provider audience within the state of Georgia.</li> <li>• Dedicated an OHITT resource, Tracy Sims, to act as the GA-HITREC liaison in order to improve cross-organization communications, improve collaboration efforts, and participate in numerous outreach activities. She also participates in the GA-HITREC's monthly sub-recipient meetings.</li> <li>• DCH (OHITT and Georgia Medicaid) consistently co-sponsors events with GA-HITREC. These events include speaking engagements at various medical association meetings around the state and have participated as exhibitors at several events focused on dental, medical, practice management and nurse practitioner organizations.</li> <li>• The Medicaid Incentive Program Director, Jackie Koffi is often in attendance to personally inform and encourage providers to take the necessary steps to</li> </ul>	<p>Section A Page 39-40</p>

## 2010 STATE MEDICAID HIT PLAN V.1.O

CMS Comments Received on June 20, 2011	DCH Responses Submitted on July 18, 2011	New Section and Page
	<p>participate in the incentive program.</p> <ul style="list-style-type: none"> <li>• OHITT &amp; GA-HITREC participate in weekly one-on-one marketing and outreach-based meetings.</li> <li>• The DCH and the fiscal agent updated the web presence to include the GA-HITREC information. MIP marketing materials have been updated to display GA-HITREC co-branding.</li> <li>• DCH partnered with the GA HITREC to participate in the semi-annual Georgia Medicaid Fair that targeted ALL Medicaid providers.</li> <li>• Currently developing strategies with GA-HITREC to promote the statewide Health Information Exchange to those providers who signed with the GA-HITREC and easily transition them to the Georgia HIE.</li> <li>• OHITT is also working closely with GA-HITREC technical team to develop strategies to benefit their members. For instance, GA-HITREC recently selected Halfpenny Technologies to develop a lab hub demonstration project that will enable a seamless, secure and efficient exchange of clinical data for GA-HITREC members. This action was taken in order to further support the Georgia statewide Health Information Exchange (HIE) deployment initiative. Strategic initiatives conducted with GA-HITREC, such as this one, will be leveraged and promoted to the broader Georgia provider community to encourage participation in the statewide HIE and increase utilization of its developing services.</li> </ul>	
3. Must fix, Page 46: Remove the adjusted hospital participation based on inclusion of sub provider units.	<p><b>Eligible Hospital Payment Projection</b> DCH has modified its Eligible Hospital patient volume and incentive payment calculator to exclude sub-provider units.</p>	Section C Page 58
4. Must fix, Page 48 and throughout: A hospital based eligible professional (EP) must provide <i>more than</i> 90% of professional services in a hospital, not 90% or more.	Changes made on Page 48 (new page 57) and throughout	Section C Page 57 and throughout the document.
5. Must fix, Page 49: The State should more clearly explain what the encounter method looks like. THE SMHP is not just for CMS review, but also providers may understand as well.	<p><b>Communication to Providers on Eligibility and Payments</b> In our outreach efforts such as monthly provider webinars, participation in professional association and Medicaid events and consistent collaboration with the GA-HITREC, the State explains to providers that an encounter is any service rendered to an individual patient, an inpatient discharge or in an emergency department on any one day where Medicaid, or Medicaid demonstration grant, paid for all or part of the service or all or part of the premiums, co-payments or cost-sharing. We also explain that encounters include services rendered to Medicaid managed care</p>	Section C Page 59-60

## 2010 STATE MEDICAID HIT PLAN V.1.0

CMS Comments Received on June 20, 2011	DCH Responses Submitted on July 18, 2011	New Section and Page
	<p>patients. This information is available on our website as part of the webinar series and in the Provider User Guides that will be accessible from the DCH website, MMIS web portal and from within the MAPIR application itself.</p>	
<p>6. Must fix, Page 49-50 and throughout: Is the State's program for Medicaid and Children's Health Insurance Program (CHIP) a combined or expansion program, or is it completely separate? How would hospitals be able to determine if it's Medicaid or CHIP?</p>	<p><b>Patient Volume</b>            We understand that CMS is considering a modification that would allow CHIP patient encounter data to be included in the Medicaid patient volume threshold calculations. In that event, DCH would revise this section of the SMHP. Otherwise, Georgia's Children's Health Insurance Program is separate from the Medicaid program, which creates the following challenges for both EPs and EHs:</p> <ol style="list-style-type: none"> <li>1. DCH issues one ID card for Medicaid and CHIP members regardless of whether a member is Fee-for-Service (FFS) or enrolled in managed care. It should be noted, that eligible Medicaid and CHIP members awaiting enrollment in managed care (in choice period) are considered fee-for-service members.</li> <li>2. For FFS members, providers/hospitals verifying member eligibility may be aware that a patient is actually a CHIP patient but this information may not be updated or stored in the provider's billing or payor records. As far as the provider/hospital is concerned, the patient is a Medicaid member.</li> <li>3. Georgia has over 1M members enrolled in Georgia Families, our Medicaid managed care program. We have three contracted Care Management Organizations (CMOs) and each CMO also issues its own ID card. When a CMO member presents to a provider's office or hospital, the member's CMO card is used to confirm eligibility. While the CMO does make a distinction between Medicaid and CHIP members, the provider/hospital may not update or store this information in billing or payor records. As with the example above, as far as the provider/hospital is concerned, the patient belongs to a CMO, which means Medicaid.</li> </ol> <p>Many of the larger pediatric/pediatric specialist practices do differentiate CHIP patients, especially those affiliated with pediatric hospitals. However, DCH estimates that approximately 50% of Medicaid physician and hospital providers do not distinguish CHIP patients from Medicaid.</p> <p>We know that the Medicaid incentive program and upcoming statewide copayment changes will cause providers to modify workflows and business practices so that they will begin tracking CHIP members. Until that time, DCH is concerned that providers will be attesting to incorrect patient volume information during Georgia's registration and attestation process. It is for this reason</p>	<p>Section C Page 61</p>

## 2010 STATE MEDICAID HIT PLAN V.1.0

CMS Comments Received on June 20, 2011	DCH Responses Submitted on July 18, 2011	New Section and Page
	that DCH proposes the implementation of CHIP discount factors, based on historical claims data, that providers can use to adjust Medicaid patient volume if those providers are unable to distinguish CHIP patients from Medicaid patients.	
7. Must fix, Page 51: Please clarify how the State will verify that a provider is practicing predominantly at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC). "Practices predominantly" is not the same as patient volume and so cannot be verified via claims.	<p><b>FQHC/RHC Practices Predominantly</b>            CMS is aware that most states are unable to verify that an Eligible Professional is practicing predominantly at a FQHC or RHC. In fact, the SMHP and I-APD Community of Practice have identified this subject as a key topic for upcoming meetings. Georgia is similarly challenged since the FQHCs/RHCs in Georgia bill for services rendered and DCH or the Care Management Organizations pay the FQHC/RHC directly. Georgia has an enrollment listing of all FQHCs/RHCS and the clinical staff approved to practice at each location, but the FQHC/RHC claim does not identify the physician or Physician Assistant rendering the service. It should be noted that providers are required to attest during the state level registration process that they are practicing predominantly at an FQHC or RHC.</p> <p>In conjunction with Myers and Stauffer, DCH utilized pharmacy claims associated with a FQHC/RHC office visit and tracked provider data by the provider's DEA number. Unfortunately, every FQHC/RHC office visit does not result in a prescription and our results are incomplete. DCH has have also utilized the Uniform Data System (UDS) reports that all FQHC grantees must submit annually to HRSA. Unfortunately, the UDS reports do not report providers by name or an identification number but rather by type. If there is more than one provider in a provider type category, DCH is unable to identify a specific physician or Physician Assistant.</p> <p>DCH continues to explore methods to confirm that an Eligible Professional is practicing predominantly at a FQHC or RHC. Guidance from CMS or other states participating in the CoP Community for SMHPs and IAPDs may provide DCH with a more successful approach.</p>	Section C Page 65
8. Must fix, Page 51-52: Providers will be attesting using the Office of National Coordinator for Health Information Technology (ONC) certification number associated with their certified EHR technology. They should be attesting using the CMS EHR certification number that is generated by the ONC Certified Health IT Products list (CHPL) and that corresponds to either a whole EHR or a	<p><b>Verification of Adoption, Implementation or Upgrade of Certified EHR Technology</b>            Our MAPIR application will provide an interface with CHPL directly importing the certification number associated with their certified EHR technology. Georgia requires providers to attest to the certification within the MAPIR application.</p>	Section C Page 67

## 2010 STATE MEDICAID HIT PLAN V.1.0

CMS Comments Received on June 20, 2011	DCH Responses Submitted on July 18, 2011	New Section and Page
sufficient combination of certified modules. Please revise accordingly.		
9. Must fix, Page 52: Access to certified EHR technology is not always through a contract or purchase order. Please expand the list of acceptable documentation to reflect other options, such as data use agreements, license agreements, receipts, etc.	<p><b>Verification of Adoption, Implementation or Upgrade of Certified EHR Technology</b> Eligible Professionals and Eligible Hospitals will be required, as part of the state level registration and attestation process, to verify the adoption, implementation or upgrade (AIU) of a certified EHR system by uploading documents supporting AIU. The following is a list of documentation that will be acceptable for verifying AIU:</p> <p><b>For adoption:</b></p> <ul style="list-style-type: none"> <li>· Receipts from EHR software vendors</li> <li>· sale contracts</li> <li>· license agreements</li> <li>· service performance agreements</li> <li>· data use agreements</li> </ul> <p><b>For implementation:</b></p> <ul style="list-style-type: none"> <li>· Work plans</li> <li>· Cost reports</li> </ul> <p><b>For upgrade:</b></p> <ul style="list-style-type: none"> <li>· Receipts from EHR software vendors</li> <li>· sale contracts</li> <li>· license agreements</li> <li>· service performance agreements</li> <li>· data use agreements</li> </ul> <p>Other reasonable substantiating documents may be acceptable. This documentation is considered auditable and must be maintained by the Eligible Professional or Eligible Hospital for a period of six (6) years.</p>	Section C Page 66-67
10. Must fix, Page 52: Please clarify that providers must retain all attestation documentation for a period of six years for the purpose of auditing.	<p><b>Verification of Adoption, Implementation or Upgrade of Certified EHR Technology</b> This documentation is considered auditable and must be maintained by the Eligible Professional or Eligible Hospital for a period of six (6) years.</p>	Section C Page 67
11. Must fix, Page 52: The automated interface with the ONC CHPL is already live and allows States to verify if the CMS EHRE certification number is a valid number on the CHPL. Please revise to reflect this. If the State is referring to the capacity for a reverse match to facilitate auditing, then the wording is	<p><b>Verification of Adoption, Implementation or Upgrade of Certified EHR Technology</b> Our MAPIR application will provide an interface with CHPL directly importing the certification number associated with their certified EHR technology. Georgia requires providers to attest to the certification number within the MAPIR application. Georgia will also use this function within MAPIR to facilitate reverse match auditing.</p>	Section C Page 67

## 2010 STATE MEDICAID HIT PLAN V.1.O

CMS Comments Received on June 20, 2011	DCH Responses Submitted on July 18, 2011	New Section and Page
correct as it is.		
12. Must fix, Page 52-54 and throughout: Please note that the term National Level Repository (or NLR) is used by only internally at CMS and between CMS and States. The public term is the CMS Registration and Attestation System. Please correct the SMHP accordingly.	Changes made on Page 52-54 and throughout	Section C Page 47, 66 and throughout the document.
13. Must fix, Page 59, 76-77 and throughout: Per Medicare and Medicaid Extenders Act of 2010, the net average allowable cost (NAAC) is no longer a requirement of the program. Thus, please remove strategies related to calculating, administrating and auditing NAAC from the State's SMHP.	The net average allowable cost (NAAC) and related strategies have been removed.	NA
14. Must fix, Page 59: The third bullet reflects the requirement for payment reassignment to "entities designated by the State for the promotion of EHR adoption" (limitation of 5% of payment cost, etc.). This does not apply to payment reassignment in general and should be removed. This also applies to the table (2.13.2) on Page 77.	The net average allowable cost (NAAC) and related strategies have been removed.	NA
15. Must fix, Page 60 and 64: The SMHP does not clearly define how the Medical Assistance Provider Incentive Repository (MAPIR) and State systems will interact. Comments like "Department of Community Health to build interface/MAPIR" and "many of the details regarding MAPIR have not been finalized or configured" do not clearly define the intended customization of the MAPIR core solution to account for State specific systems,	<p>The Medical Assistance Provider Incentive Repository (MAPIR) is a web-based application that supports the CMS Registration &amp; Attestation (R&amp;A) interfaces, data exchanges and state requirements for determining eligibility, attestation, and issuing eligible provider incentive payments. MAPIR has components for both the provider end user and administrative user support. The core MAPIR application was designed by a multi-state collaborative, however, OHITT identified specific customizations related to instructional content, look and feel, branding, and email communications in order to improve usability and make the application process easy to use by Georgia Medicaid providers.</p> <p>Once the Georgia Medicaid EHR Incentives Program is launched on September 5, 2011, MAPIR will be accessible</p>	Section C Page 78-79

## 2010 STATE MEDICAID HIT PLAN V.1.0

CMS Comments Received on June 20, 2011	DCH Responses Submitted on July 18, 2011	New Section and Page
requirements and processes (e.g. how files are received through the National Level Repository, error reporting, payment cycles, etc.). The SMHP is meant to be a public document that providers and stakeholders could read to understand how the State is going to implement its program.	<p>by active Georgia Medicaid providers via the MMIS Web Portal. Providers must be authenticated into the web portal in order to access links navigating them into the MAPIR application.</p> <p>MAPIR supports work flows associated with confirming eligibility for professional providers and hospitals, attestation requirements, suspending applications for additional review, pre and post-payment error reporting, updates that may be received from the R&amp;A, appeals tracking, issuance of incentive payments, and data storage. The system has been designed to interface with MMIS for provider enrollment and claim information, to create transactions for payment within the MMIS and to store payment information within MAPIR. Customer support will be available via phone and email to address any Georgia Medicaid provider questions regarding the MAPIR application and overall incentive payment program.</p>	
16. Must fix, Page 64: What is the frequency of EHR incentive payments (monthly, semi-monthly, etc.)?	<p><b>Table 3 – Payment Process EHR Incentive Payments</b></p> <p>The frequency of Georgia’s EHR Medicaid Incentive payments is <b>monthly</b>. Providers shall be paid within 30-45 days, on the last Thursday of each month.</p>	Section C Page 79

**Table 1 – Pre-Payment Audit Process**

Pre-Payment Review		
Procedures	Reference/Database	Tolerable Variance
<b>(Both EHs and EPs)</b>		
Confirm reported Medicaid utilization meets minimum requirements for the provider type	<i>CMS Final Rule; Pediatricians; EPs, including Physician Assistants, practicing predominately in an FQHC/RHC; Hospital-Based Providers</i>	Reported percentage should be at or above minimum requirements by provider type
Determine if the provider previously applied for and was denied an incentive payment	<i>Applications received to date</i>	N/A
Confirm continuous 90-day period is within acceptable year.	CMS Final Rule	None
Confirm the provider utilized the correct CHIP Factor when the provider cannot distinguish CHIP encounters	<i>EP CHIP Factor; EP encounters by predominant county</i> <b>Note: CMS guidance may change the need for a CHIP factor</b>	None
<b>Procedures (EHs)</b>		
DCH and its consultant, Myers and Stauffer, will meet with each Eligible Hospital (EH) to finalize the EH’s patient volume (if applicable) and incentive		

## 2010 STATE MEDICAID HIT PLAN V.1.0

Pre-Payment Review		
Procedures	Reference/Database	Tolerable Variance
payment calculation prior to the EH's registration and attestation at the state level.		
<b>Procedures (EPs)</b>		
Confirm eligible professional is an allowable provider type	<i>Pre-qualification list; Hospital-based Providers; EPs, including Physician Assistants, practicing predominately in an FQHC/RHC; Pediatricians; Providers associated by Medicaid payee ID</i>	Exceptions will be reviewed on a case by case basis.
Medicaid Patient Volume Numerator (locations for which the provider will adopt, implement, upgrade EHR) - Compare reported amounts to query results for:		
Fee-for-Service encounters	<i>Paid Medicaid claims with or without CHIP encounters; CHIP encounters; Dually-eligible encounters; Providers associated by Medicaid payee ID; EPs, including Physician Assistants, practicing predominately in an FQHC/RHC</i>	15%
Managed care encounters (by each Care Management Organization)		15%
CHIP encounters		15%
Dually-eligible encounters		15%
Out-of-State Medicaid volume (only if Out-of-State Medicaid volume is required to meet the threshold requirements)	<i>Out-of-State Survey Results</i>	15%
Compare % of Medicaid (or Total Needy Individual) utilization on Prequalification list (annual basis) to % of Medicaid (or Total Needy Individual) utilization reported for the 90-day period.	<i>Prequalification list</i>	15%

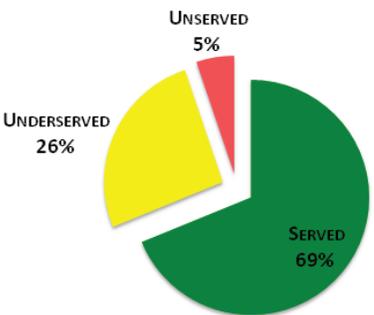
### April 7, 2011 DCH SMHP updates/response to CMS

CMS Comments Received on March 16, 2011	DCH Responses Submitted on April 7, 2011	New Section and Page
Must fix, Page 44: Please note that only state-based sanctions that prohibit receipt of federal funding must be checked. Providers could, in theory, have state-based sanctions and still participate, so long as the sanctions don't prohibit the receipt of federal funds.	<b>Licensure and Sanctions</b> Georgia Department of Community Health (DCH) will leverage available data sources to verify whether providers are sanctioned or they are properly licensed and qualified. For Federal sanctions, DCH will utilize information from the CMS registration and attestation website to identify providers with Federal sanctions as reported on the National Practitioner Data Bank, CMS Death Master File and U.S. Department of Health & Human Services, and OIG list of excluded individuals and entities. For State-based sanctions and licensure qualification issues, DCH will coordinate closely with other State agencies and partners, including licensing agencies, DCH's Medicaid Provider Enrollment program, the DCH's Program Integrity unit, DCH's Division of	Section C Page 48

## 2010 STATE MEDICAID HIT PLAN V.1.O

CMS Comments Received on March 16, 2011	DCH Responses Submitted on April 7, 2011	New Section and Page
	<p>Healthcare Facility Regulation, and the State Health Care Fraud Control Unit to determine if provider sanctions are in effect or pending. Certain, state-based sanctions would not prohibit a provider's ability to receive federal funds, such as pre-payment review or a provider placed on a corrective action plan. DCH will only verify those state-based sanctions that prohibit receipt of federal funds.</p> <p>Additionally, DCH's Medicaid Provider Enrollment program process will verify provider licensure/qualification and good standing at the time providers enroll in the Medicaid incentive program and also verify that the provider has a valid Georgia Medicaid identification number. This process will also confirm (or refute) that the provider is eligible to participate in the program based on provider type.</p>	
<p>Must fix, Page 45-46: Please provide more detail on the pre-payment audits. Is this automated? What data sources will the State use besides MMIS claims (e.g., encounter data?).</p>	<p><b>Pre-Payment Audits</b>            As stated in Section C of the SMHP, DCH conducted an analysis to pre-qualify those Eligible Professionals (EPs) and Eligible Hospitals (EHs) that potentially met the patient volume criteria. Fee for service and managed care encounter claims data will be used in the pre-qualification process. The baseline information in this qualification step will be used during the provider registration process to determine significant variances between the DCH calculation and the data submitted by the EP and EH. DCH is integrating the Medical Assistance Provider Incentive Repository (MAPIR) with the Medicaid Management Information System (MMIS) to process state-level provider registrations. The MAPIR pre-payment audit features include the following:</p> <ol style="list-style-type: none"> <li>1. MAPIR will verify provider eligibility in MMIS, sanctions and licensure, capture provider type, hospital-based status, declaration of adoption, implementation and upgrades (AIU), submission of a valid CERT number and patient volumes.</li> <li>2. MAPIR presents the user with questions regarding their practice, time frame for which they are submitting patient volumes, and identification of at least one location for utilizing certified EHR technology.</li> <li>3. At the end of the registration process, MAPIR requires providers to complete attestation with a digital signature.</li> <li>4. After MAPIR calculates the payment request, a manual review will be conducted to ensure that the payment is valid.</li> </ol>	<p>Section C            Pages 50-51</p>
<p>Page 46: How will the State determine that a provider practices predominantly in a</p>	<p><b>FQHC/RHC Practices Predominately</b>            EPs practicing at FQHCs &amp; RHCs must attest to the requirements referenced above, during the state</p>	<p>Section C            Page 51</p>

## 2010 STATE MEDICAID HIT PLAN V.1.0

CMS Comments Received on March 16, 2011	DCH Responses Submitted on April 7, 2011	New Section and Page																						
<p>specific geographical area?</p>	<p>registration and attestation process. On a pre-payment basis, DCH will determine whether the provider meets the patient volume by utilizing Medicaid and CHIP claims and encounter claims data. As part of the state's audit plan, DCH will review and audit claims and encounter claims data on a post-payment basis.</p>																							
<p>If completed, include the results of the mapping project described on page 12, being completed by GTA.</p>	<p>To date, Georgia has submitted mapping information for 149,267 road segments, 448,949 census blocks, and 8,719 community anchor institutions. In addition, 20 wireless internet service provider (WISP) coverage areas have been identified. Nearly 500 points where service providers connect to the larger internet have also been located. These connections and the network they make up are often called the Middle Mile.</p> <div style="text-align: center; margin: 20px 0;"> <p><b>Percentage of Georgia's Population Served, Unserved, and Underserved</b></p>  <table border="1" style="margin: 0 auto; border-collapse: collapse;"> <caption>Percentage of Georgia's Population Served, Unserved, and Underserved</caption> <thead> <tr> <th>Category</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>SERVED</td> <td>69%</td> </tr> <tr> <td>UNDERSERVED</td> <td>26%</td> </tr> <tr> <td>UNSERVED</td> <td>5%</td> </tr> </tbody> </table> </div> <p>Source: Georgia Broadband and Mapping Analysis Semi-Annual Report, Volume 1, January 2011</p> <p>The following outlines the 2011 planned broadband mapping activities:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="text-align: left;">Description</th> <th style="text-align: left;">Finish Date</th> </tr> </thead> <tbody> <tr> <td>Broadband Mapping Contract Renewal</td> <td>January 2011</td> </tr> <tr> <td>Georgia Broadband Mapping Website Deployed <a href="http://www.georgiabroadband.net">www.georgiabroadband.net</a></td> <td>February 2011</td> </tr> <tr> <td>Georgia Broadband Mapping and Analysis: Semi-Annual Report #1</td> <td>February 2011</td> </tr> <tr> <td>Georgia Broadband Mapping Dataset 3</td> <td>April 2011</td> </tr> <tr> <td>Georgia Broadband Mapping Dataset 4</td> <td>October 2011</td> </tr> <tr> <td>Georgia Broadband Mapping and Analysis: Semi-Annual Report #2</td> <td>November 2011</td> </tr> </tbody> </table>	Category	Percentage	SERVED	69%	UNDERSERVED	26%	UNSERVED	5%	Description	Finish Date	Broadband Mapping Contract Renewal	January 2011	Georgia Broadband Mapping Website Deployed <a href="http://www.georgiabroadband.net">www.georgiabroadband.net</a>	February 2011	Georgia Broadband Mapping and Analysis: Semi-Annual Report #1	February 2011	Georgia Broadband Mapping Dataset 3	April 2011	Georgia Broadband Mapping Dataset 4	October 2011	Georgia Broadband Mapping and Analysis: Semi-Annual Report #2	November 2011	<p>Section C Pages 16-17</p>
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## 2010 STATE MEDICAID HIT PLAN V.1.0

CMS Comments Received on March 16, 2011	DCH Responses Submitted on April 7, 2011	New Section and Page
	The Georgia Broadband Semi-Annual Reports (available at <a href="http://www.georgiabroadband.net">www.georgiabroadband.net</a> ) outline the analysis of broadband maps and sustainable adoption opportunities. The February 2011 report also describes the Georgia Technology Authority's (GTA) Domain of Excellence concept which enables Georgia to leverage the mapping data for other purposes such as education, health information technology, and public safety.	
Page 14: The State did a great job of describing current networks, but did not apply strategic impact on EHR adoption in the State. If the State is able to leverage the resources of these existing networks what percent of the estimated eligible EPs be achieved and how many will have to be reached via your outreach campaign?	The DCH outreach campaign leverages relationships with existing networks to conduct provider outreach and education regarding certified EHR technology and the Medicaid EHR Incentives Program. DCH will facilitate contact between GA-HITREC and these networks for the purpose of providing assistance and support in rural and needy markets. The DCH outreach campaign will survey these networks to determine a baseline of those providers not utilizing certified EHR technology. As a result, the survey outcomes will be used as a foundation for DCH and GA-HITREC outreach in setting projections for the Medicaid Incentives Program.	Section A Page 20
Page 38, who is OHITT and is this entity under the Medicaid umbrella? Medicaid FFP can only be used for the Medicaid program.	The Office of Health Information Technology and Transparency (OHITT) is the name of the office within DCH that is responsible for administration of the Medicaid EHR Incentives Program and the State Medicaid HIT Plan (SMHP).	Section C Page 42

### Table of Contents

**Overview of Georgia's Medicaid Program .....6**

**Section A: Georgia's "As-Is" HIT Landscape .....10**

**Section B: Georgia's "To-Be" HIT Landscape .....35**

**Section C: Activities Necessary to Administer the  
Medicaid EHR Incentive Program .....41**

**Section D: Audit Strategy .....67**

**Section E: HIT Road Map .....81**

**Appendices.....85**

### OVERVIEW OF GEORGIA'S MEDICAID PROGRAM

In order to administer and provide oversight to the Medicaid Electronic Health Record (EHR) Incentive Program, it is important to have an understanding of the existing Medicaid populations in Georgia. Similarly, facilitating, encouraging, and planning for the pursuit of initiatives to encourage the adoption of certified EHR technology in Georgia requires that same understanding. Therefore, before discussing the existing "as is" landscape of health information technology (HIT) in Georgia, an overview of Georgia Medicaid program affords insight.

The Department of Community Health (DCH) is the state agency responsible for administering the Medicaid and State Children's Health Insurance Programs (SCHIP) in Georgia. These Medicaid programs serve Georgia's most vulnerable populations. In FY 2010, the Division of Medical Assistance provided access to health care for 1.4 million Georgians at a cost of nearly \$7.0 billion in capitation and fee-for-service claims payments. The core components that constitute the Georgia Medicaid program are the following:

- **Low Income Medicaid (LIM)** -- Adults and children who meet the income standards of the Temporary Assistance for Needy Families (TANF) program may qualify to be a part of the LIM group. This program provides health care to eligible low-income families, breast and cervical cancer patients, foster children and refugees (states are federally required to cover this group, which consists of legal immigrants). The majority of LIM members are eligible for the Georgia Families care management program, which began on June 1, 2006.

Georgia Families is a partnership between DCH and private Care Management Organizations (CMOs). Georgia Families provides health care services to children enrolled in PeachCare for Kids™ and certain men, women, children, pregnant women and women with breast or cervical cancer covered by Medicaid. By providing a choice of health plans, Georgia Families enables members to select a health care plan that fits their needs. The three CMOs currently under contract with DCH are AMERIGROUP® Community Care, Peach State Health Plan™ and WellCare® of Georgia, Inc. The CMOs provide services to eligible members under full-risk capitation agreements.

Based on Georgia's six Medicaid regions, the CMOs are under contract to participate in three or more of these regions as shown in the following table:

Region	Amerigroup	Peach State	WellCare
East	X		X
North	X		X
Atlanta	X	X	X
Central		X	X
Southeast	X		X
Southwest		X	X

- **Aged, Blind and Disabled Medicaid (ABD)** -- This program provides health care for people who are aged, blind or disabled under a fee-for-service provider reimbursement model.
- **Medically Needy** -- Pregnant women, children, aged, the blind and disabled may qualify for assistance.
- **Right from the Start Medicaid (RSM Children)** -- This program focuses on children from under one to 19 years whose family incomes are at or below the appropriate percentage of the federal poverty levels for their age and family size.
- **Medicaid Long-Term Care** -- Medicaid Long-Term Care incorporate a wide range of programs including the Community Care Services Program (home and community-based services for elderly and/or functionally impaired or disabled persons); Independent Care Waiver Program (adult Medicaid members with physical disabilities including traumatic brain injuries); New Options Waiver Program/Comprehensive Supports Waiver Program (home or community-based services for people with mental retardation or developmental disabilities); Nursing Facility (for persons needing around-the-clock nursing oversight); Service Options Using Resources in a Community Environment (frail elderly and disabled persons who are eligible for Supplemental Security Income/Medicaid); Home Health Services; Hospice; and Community Mental Health Services (persons of all ages having mental illnesses or substance abuse issues).
- **Breast and Cervical Cancer Program** -- This program assists uninsured and underinsured women under age 65 who have been screened by the public health department and then diagnosed with either breast or cervical cancer.
- **Refugee Medicaid Assistance** -- Legal immigrants who are classified as refugees, asylums, Cuban/Haitian entrants, Vietnamese Americans and victims of human trafficking are eligible for Medicaid benefits during their first eight months in the United States, or after having been granted status

in one of the above. Coverage of this group is federally required and is 100 percent reimbursed by the federal government.

- **Chafee Option** -- The Foster Care Independence Act allowed states to extend Medicaid coverage to older youth (18-21) who aged out of foster care. This program was implemented on July 1, 2008.
- **Emergency Medical Assistance** -- Immigrants, including undocumented immigrants, who are eligible for Medicaid except for their immigrant status, are potentially eligible for Emergency Medical Assistance (EMA). This includes people who are aged, blind, disabled, pregnant women, children or parents of dependent children who meet eligibility criteria. Services rendered to EMA recipients are limited to emergency care only as described in the Federal Regulations (1903 (v) of the Social Security Act and the Code of Federal Regulation 42 CFR 440.255).

Over the last six years, the average monthly enrollment for Medicaid and PeachCare for Kids™ reflects significant increases. According to the latest available data the enrollment numbers are the following for these two programs:

<b>Fiscal Year</b>	<b>Medicaid</b>	<b>PeachCare for Kids™</b>
2005	1,376,730	208,185
2006	1,389,692	239,033
2007	1,278,476	274,025
2008	1,261,031	250,055
2009	1,342,049	206,355
2010	1,444,085	202,861

In state FY 2011, fiscal projections anticipate that Medicaid expenditures will exceed \$7 billion. Approximately 68% of the Medicaid and PeachCare for Kids™ members are enrolled in one of the Georgia Families CMOs. DCH will leverage the CMOs in its provider outreach and communication strategy for the adoption, implementation or upgrade of certified EHR technology. Each CMO will communicate with its large provider and hospital networks on the specifics of the Medicaid EHR incentive program.

Geographically, Georgia is the largest state east of the Mississippi River. Its 159 counties are divided into 18 public health districts. Many of these public health districts consist of communities that are largely underserved medically and that have widely dispersed populations. (See Map of Hospitals Certified for Critical Access Designation in Appendix B.) The Division of Public Health, a vital part of DCH, is responsible for serving these populations many of whom are eligible for Medicaid services.

DCH expects that the increased adoption of electronic health records for the state's Medicaid population will improve the coordination of care for the medically

underserved residents. Many of these residents live in isolated and less populated areas in Georgia. DCH believes that improved and timely medical care will reduce emergency department visits, curtail duplicative testing, reduce adverse reactions to erroneous prescriptions and thereby result in better health outcomes and cost savings, especially for the state Medicaid budget. DCH expects that health information technology can be a transformative tool capable of improving the efficiency, timeliness and safety of patient care, and better health outcomes. Based on these considerations, DCH is fully committed to the Medicaid EHR Incentive Program. DCH is convinced that an incremental approach to the initial implementation of the incentive program is appropriate, especially in light of the existing health information technology landscape in Georgia.

## **SECTION A: THE GEORGIA “AS-IS” HIT LANDSCAPE**

Question(s) Deferred for Section A

Question Number	Question
6	<i>Does the SMA have HIT/E relationships with other entities? If so, what is the nature of these activities?</i>

**Current EHR Adoption**

Georgia’s “As-Is” HIT landscape reflects a steady progression toward the increased adoption of electronic health record technology. Evaluating such a changing landscape has proven to be a challenging task. Nevertheless, the following describes what is known as of October 2010. DCH expects to provide additional or supplemental information regarding the “As-Is” HIT landscape in future submissions of the SMHP.

DCH determined the current extent of EHR adoption by physicians and hospitals generally by using the environmental scan report prepared by the Enterprise Innovation Institute at the Georgia Institute of Technology. DCH then supplemented that report by using a survey that targeted Medicaid professionals and hospitals expected to have significant Medicaid populations.. In addition, DCH engaged the professional services of an audit firm to prepare an assessment of Medicaid professionals and hospitals. The results of these three sources are discussed below.

**EHR Adoption—Physicians (Report by the Enterprise Innovation Institute)**

Using a study from SK&A, a private sector firm providing health care solutions and research, and its own research, the Enterprise Innovation Institute performed a customized analysis to estimate the adoption rates for EHRs among Georgia physicians. The results of the analysis are shown in Table 4.

Table 4 – EHR Adoption by Physicians 2010

	E.H.R. adoption		Elabs		Enotes		Eprescriptions		ALL 3 FUNCTIONS	
	Count	%	Count	%	Count	%	Count	%	Count	%
All U.S. physicians	244,877	44.38%	187,256	33.94%	190,872	34.59%	172,532	31.27%	162,567	29.46%
All GA physicians	6,727	46.97%	5,143	35.91%	5,351	37.36%	4,849	33.85%	4,573	31.93%
US primary care*	93,722	45.69%	77,272	37.67%	78,885	38.46%	77,226	37.65%	73,403	35.78%
US non-primary care	151,155	43.61%	109,984	31.73%	111,987	32.31%	95,306	27.49%	89,164	25.72%
GA primary care	2,504	46.17%	1,997	36.82%	2,065	38.07%	2,003	36.93%	1,899	35.01%
GA non-primary care	4,223	47.45%	3,146	35.35%	3,286	36.93%	2,846	31.98%	2,674	30.05%
Atlanta MSA	3,715	47.08%	2,881	36.51%	2,945	37.32%	2,692	34.11%	2,536	32.14%
GA, non-Atlanta MSA	3,012	46.83%	2,262	35.17%	2,406	37.41%	2,157	33.54%	2,037	31.67%
US by providers @ site										
1	26,604	21.44%	18,335	14.77%	19,807	15.96%	17,849	14.38%	15,955	12.86%
2	13,317	32.94%	10,038	24.83%	10,605	26.23%	9,662	23.90%	8,920	22.07%
3-5	17,827	39.80%	13,926	31.09%	14,419	32.19%	13,352	29.81%	12,401	27.69%
6-10	8,613	51.57%	6,994	41.88%	7,085	42.43%	6,442	38.57%	6,146	36.80%
11-25	4,230	61.44%	3,315	48.15%	3,288	47.76%	2,858	41.51%	2,737	39.75%
26+	1,040	63.45%	715	43.62%	696	42.46%	558	34.05%	535	32.64%
GA by providers @ site										
1	955	27.06%	700	19.84%	754	21.37%	681	19.30%	631	17.88%
2	499	39.92%	368	29.44%	402	32.16%	369	29.52%	343	27.44%
3-5	633	46.65%	492	36.26%	504	37.14%	472	34.78%	441	32.50%
6-10	279	58.13%	224	46.67%	232	48.33%	207	43.13%	195	40.63%
11-25	88	59.06%	68	45.64%	68	45.64%	62	41.61%	60	40.27%
26+	24	63.16%	16	42.11%	15	39.47%	11	28.95%	11	28.95%

Source: Enterprise Innovation Institute, Georgia Institute of Technology, August 2010.

The Enterprise Innovation Institute concluded that physician adoption rates in Georgia for three-function EHRs “were slightly higher than the national average.” It also reported that “Georgia primary care physicians had almost the same EHR adoption rate as their colleagues nationally, although the rate for non-primary care physicians was somewhat higher in Georgia than in the rest of the U. S.” The report noted, “Much larger differences are seen when considering three-function EHRs, with Georgia primary care physicians’ adoption rate a full five points higher than their non-primary care colleagues.” The report also found that adoption rates by practice size were similar to U. S. averages.

**EHR Adoption—Hospitals (Report by the Enterprise Innovation Institute)**

Using an American Hospital Association survey from 2009 and data from Georgia hospitals, the Enterprise Innovation Institute extrapolated and projected EHR adoption rates for hospitals in Georgia. The results of that analysis appear in Table 4 below.

Table 2 – EHR Adoption in Hospitals, 2009

AHA EHR Survey Items	General Hospitals Only									
	All States inc GA		All States not GA		Georgia					
					ATL MSA		Not ATL MSA		Total GA	
	#	%	#	%	#	%	#	%	#	%
<b>Total Records</b>	3,293	100%	3,210	100%	27	33%	56	67%	83	100%
<b>Hospitals with Comprehensive EHR</b>	133	4%	129	4%	3	11%	1	2%	4	5%
<b>Hospitals with Basic EHR Clinician Notes</b>	1430	43%	1382	43%	14	52%	34	61%	48	58%
<b>Hospitals with Basic EHR No Notes</b>	859	26%	845	26%	7	26%	7	13%	14	17%
<b>Total Hospitals with any EHR</b>	2422	74%	2356	73%	24	89%	42	75%	66	80%

Source: AHA, 2009 and Georgia Institute of Technology

**EHR Adoption –Medicaid Specific Information**

DCH supplemented the report by the Enterprise Innovation Institute through surveys directed specifically toward Medicaid providers. DCH obtained assistance from the following organizations: the Georgia Academy of Family Physicians, the Georgia Association for Primary Health Care, the Georgia Certified Nurse Midwives Association, the Georgia Chapter of the American Academy of Family Physicians, the Georgia Hospital Association, the Georgia Midwifery Association, the Georgia State Medical Association, and DentaQuest (a Medicaid dental network contracted with the Georgia Families CMOs).

By collaborating with key provider associations to survey their provider members across Georgia, DCH obtained information on EHR technology adoption and functionality. Most notably, the Georgia Hospital Association and the Georgia Academy of Family Physicians have been and continue to be significant supporters of EHR technology and the statewide HIE efforts.

DCH’s survey, conducted in September 2010, concentrated on providers considered potentially eligible for Medicaid incentive payments. Table 3 shows respondents’ plans to adopt certified EHRs and Table 4 shows the current extent of adoption by respondents.

**Table 3: Plans to Adopt Certified EHR**

Provider Type	Within 12 Months	Within 24 Months	More than 24 Months	Undecided
Acute Care Hospitals	54	12	1	
Children’s Hospitals	2	0	0	
Critical Access Hospitals	17	1	0	1
Dentists	12	5	1	
Nurse Practitioners	3	0	0	
Pediatric Physicians	43	10	1	
Physicians	114	13	3	

**Table 4: Current Extent of EHR Adoption by Practitioners and Hospitals**

Provider Type	Total “Yes” Responses	% Adoption of Provider Group	% Adoption of Total
Acute Care Hospitals	41	75.9%	10.4%
Children’s Hospitals	2	100.0%	0.5%
Critical Access Hospitals	11	55.0%	2.8%
Dentists	17	21.3%	4.3%
Nurse Practitioners	3	100.0%	0.8%
Pediatric Physicians	28	47.5%	7.1%
Physicians	99	61.9%	25.0%

DCH tabulated the survey responses by type of professional and type of hospital. In addition, DCH obtained estimates of eligible providers as calculated by Myers & Stauffer, an outside audit firm, who using historical claims and payment data prepared estimates of Medicaid professionals considered potentially likely to qualify for incentives. To project estimates as to 2011 Medicaid incentive payments, Myers & Stauffer also analyzed certain hospital data to calculate Medicaid incentive payments for qualifying hospitals. The results of this professional analysis are discussed later in this document in considerable detail in Section C of this Plan. That discussion includes an analysis by category type of eligible professional and eligible hospital.

With respect to adopting EHRs, as shown in Table 3 above, many of these hospitals have plans to adopt certified EHRs within 12 months. Very few hospitals remain in the undecided category. Similarly, many Medicaid physicians also displayed significant interest in adopting certified EHRs within 12 months. The exact types of EHRs that are currently being used by providers throughout Georgia who responded to the DCH survey are listed in Appendix A.

### **Broadband Access, Limitations, and Grants**

DCH recognizes that broadband connectivity is an essential prerequisite to the exchange of electronic health information. The lack of broadband connections in certain isolated areas of Georgia and the inability of some existing broadband connections to support the electronic exchange of health information represent challenges to the effective use of electronic health record technology.

As of July 2010, 20 of Georgia's 159 counties had less than 50 percent access to broadband. Broadband access is particularly problematic in some of Georgia's rural areas. In order for the electronic exchange of health information to occur, the broadband access issue must be resolved. Solutions to the broadband access problem are well underway. In 2006 the state began funding to expand wireless broadband access to rural areas. The OneGeorgia Authority, established in 2006, operates a program to assist rural communities in establishing broadband networks. The Broadband Rural Initiative to Develop Georgia's Economy (BRIDGE) is continuing to provide financial assistance including grants and loans to support the deployment of high-speed broadband in rural areas in Georgia. Eligible recipients are typically cities, counties, and multi-county authorities. BRIDGE provides low or zero interest loans to private sector entities to encourage broadband service in underserved rural areas.

Wireless Communities Georgia (WCG) is a separate program that is providing assistance to rural communities in establishing broadband networks. Under the WCG program, local governments are responsible for proposing, planning and implementing the wireless projects in their communities. The Georgia Technology Authority is responsible for managing the awards and monitoring project implementation.

In December 2009, the National Telecommunications and Information Administration awarded the Georgia Technology Authority a \$2.2 million grant for statewide broadband mapping. In February 2010, the Sanborn mapping firm was selected to perform a comprehensive mapping of broadband access throughout the state. The mapping project is scheduled to be completed in early 2011. After the mapping project is finished, DCH will be in a better position to evaluate the scope of broadband coverage and to help address deficiencies.

On August 4, 2010, Governor Perdue announced three new broadband projects for Georgia that will receive almost \$13 million in federal funding through ARRA. All three projects are designed to bring high-speed Internet access to underserved homes and businesses in rural communities. Financed in conjunction with private matching funds, the first of the three awards will extend Windstream Corporation's broadband network to 29,000 people, 750 businesses, and 50 community institutions in areas located in north Georgia. The second award will provide broadband services to 44,000 people, 2,000 businesses, and 120 community institutions in areas as geographically diverse as Canton, Dalton, Jasper, Irwinville, Manchester, Milledgeville, and Trion. Including these three

latest awards, various broadband projects in Georgia have received more than \$109 million in ARRA funding to expand broadband services throughout the state. Most of the ARRA funding for these broadband projects is designed to bring high-speed Internet access to rural communities without Internet access. Recent broadband funding has helped support, among other things, the enabled use of EHRs for patients at the Medical College of Georgia.

The expansion of broadband access, particularly in rural and isolated communities, will help enable eligible Medicaid and Medicare providers to participate in the respective incentive programs. DCH plans to leverage the expanded broadband connectivity to facilitate the adoption and implementation of electronic health record technology. Expanded broadband connectivity in rural and isolated communities will facilitate access to an operational statewide HIE.

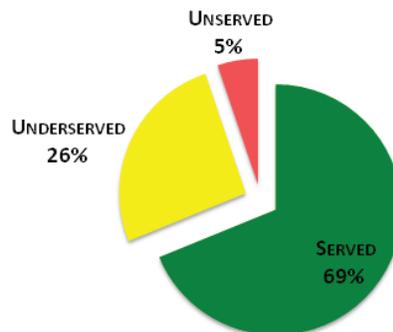
The implementation of the Medicaid EHR Incentive Program will be impacted by these broadband constraints—the extent of which is not yet fully known. The availability and affordability of broadband access is especially problematic for the 91 of 159 counties that are considered underserved counties that are located in the southeastern and southwestern parts of Georgia.

DCH plans to integrate this broadband expansion, especially in rural and isolated areas, into its long-term objective of expanding electronic health information connectivity and into its more immediate goal of encouraging the use of certified EHRs that will meet the requirements of meaningful use not only for Stage 1 but also for Stages 2 and 3.

### Broadband Update April 4, 2011

To date, Georgia has submitted mapping information for 149,267 road segments, 448,949 census blocks, and 8,719 community anchor institutions. In addition, 20 wireless internet service provider (WISP) coverage areas have been identified. Nearly 500 points where service providers connect to the larger internet have also been located. These connections and the network they make up are often called the Middle Mile.

Percentage of Georgia's Population Served, Unserved, and Underserved



Source: Georgia Broadband and Mapping Analysis Semi-Annual Report, Volume 1, January 2011

The following outlines the 2011 planned broadband mapping activities:

s

Description	Finish Date
Broadband Mapping Contract Renewal	January 2011
Georgia Broadband Mapping Website Deployed <a href="http://www.georgiabroadband.net">www.georgiabroadband.net</a>	February 2011
Georgia Broadband Mapping and Analysis: Semi-Annual Report #1	February 2011
Georgia Broadband Mapping Dataset 3	April 2011
Georgia Broadband Mapping Dataset 4	October 2011
Georgia Broadband Mapping and Analysis: Semi-Annual Report #2	November 2011

The Georgia Broadband Semi-Annual Reports (available at [www.georgiabroadband.net](http://www.georgiabroadband.net)) outline the analysis of broadband maps and sustainable adoption opportunities. The February 2011 report also describes the Georgia Technology Authority’s (GTA) Domain of Excellence concept which enables Georgia to leverage the mapping data for other purposes such as education, health information technology, and public safety.

**Federally Qualified Health Centers and Health Resources Services Administration HIT/EHR Funding**

The Georgia Association of Primary Health Care (GAPHC), the state primary care association, has received \$1.4 million in federal funds and \$1.5 million in state funds for the development and implementation of an HIT/EHR in 100 percent of Georgia’s Federally Qualified Health Centers (FQHCs). This funding from the Health Resources Services Administration has supported:

1. Current assessment;
2. Development of an overall statewide FQHC HIT/EHR plan;
3. Implementation of a centralized network hub;
4. Establishment of centralized HIT/EHR Network Operations Center; and
5. Implementation of HIT/EHR statewide in 100 percent of all FQHCs.

Currently, 100 percent of Georgia’s 27 FQHCs with 135 clinical locations have been serviced by this funding. Approximately 75 percent of the members of GAPHC have either fully implemented EHRs or are in the process of implementing EHRs. GAPHC is providing the overall coordination, training, and also installation assistance for the FQHCs.

**Veterans Administration and Indian Health Services Clinical Facilities**

Within Georgia are three major medical facilities located in Atlanta, Augusta, and Dublin for military veterans and their families. In addition to the three VA Medical Centers, the Veterans Health Administration operates many geographically dispersed facilities including clinics and centers in Athens, Decatur, Albany,

Columbus, East Point, Lawrenceville, Macon, NE Georgia/Oakwood, Newnan, Perry, Rome, Savannah, Smyrna, Stockbridge and Marietta. Facilities range from small clinics that provide outpatient care to large medical centers with significant inpatient populations and their associate specialties such as surgical care. All locations use an electronic health record system known as VistA. All of these facilities are connected to the VA's infrastructure through VistA and the Computerized Patient Record System (CPRS) to share clinical information both within VA locations in Georgia and across the nation within the VA's technical infrastructure.

A regional pilot is currently underway in Georgia with interoperability goals for the exchange of health information. The Augusta Metro Health Information Exchange is planning an HIE to include major hospitals in east central Georgia including, among other facilities, the Charlie Norwood VA Medical Center, East Central Health District (DCH) and the Eisenhower Army Medical Center. Lessons learned from this collaborative effort involving a DCH facility, a VA facility and DOD facility should provide invaluable practical information on how to facilitate an effective electronic exchange of health information among and between disparate end-users.

Georgia has no Indian Health Service clinical facilities.

### **Stakeholders' Engagement in Existing HIT/HIE Activities and the Characterization of Involvement in Such Activities**

- The Chatham County Safety Net Planning Council, Inc. (CCSNPC) launched an HIE in May 2010. Its electronic health technology system includes medical records and e-prescribing. CCSNPC primarily serves the medically indigent. This HIE links the J.C. Lewis Health Center, a FQHC, and Memorial Health University Medical Center, a major hospital in Savannah. CCSNPC is actively working to expand its HIE to provide additional network services to other providers in the Savannah area. This HIE is now known as ChathamHealthLink IT Consortium. (Actively exchanging patient data and information).
- The Georgia Regional Health Information Organization (RHIO) services most of northeast Georgia. It is a private collaboration between hospitals, clinics, and providers with governance by participants. It is based in Athens, Georgia. It is a start-up, not-for-profit organization. (Actively exchanging information.)
- State Office of Rural Health (SORH) operates the Georgia Farmworker Health Program (GFHP). GFHP provides health care services to 21 rural counties through six clinic sites located in central and south Georgia. In 2007, SORH created a technology solution to allow online access through a secure Internet browser. For over two years, this HIE has been

providing real time reports to the individual clinics and the SORH. Through this HIE, a clinic can obtain a patient's record which includes a history of visits including diagnostic codes, treatment codes, and notes concerning the patient's medical history. In addition, the HIE allows for insurance billing or billing to Georgia Medicaid. The GFHP HIE facilitates health reporting to accommodate health planning and trend monitoring. It aligns six separate clinics across a large geographical area to improve the quality and delivery of health care. GFHP provides valuable reporting for health planning and trend monitoring, and improves the quality of health care being offered to a broad range of users. (Actively exchanging patient information).

- Georgia Healthcare Systems, a Health Center Controlled Network, connects Georgia's 27 Federally Qualified Health Centers (FQHCs) electronically via a practice management system. These FQHCs deliver services at 114 sites and 82 rural health clinics. (Actively exchanging information).
- Children's Healthcare of Atlanta, an operational HIE, uses comprehensive EHRs to link its member hospitals in the system. (Actively exchanging patient data and information).
- Central Georgia Health Exchange based in Macon includes the Medical Center of Central Georgia and 450 physicians in an affiliated physician hospital organization engaged in data exchange involving approximately 130,000 patients. (Actively exchanging patient data and information across unaffiliated providers).
- Harbin Clinic, Floyd Regional Medical Center, and Redmond Regional Medical Center in Rome are exchanging data elements related to patient care. (Actively exchanging patient information).
- Georgia Partnership for TeleHealth, Inc. provides collaborative telehealth across Georgia with an emphasis on rural health care and trauma care.
- West Georgia Health in LaGrange is expanding its enterprise HIE into a service area HIE through agreements with community providers, an ambulatory EMR vendor, and a core infrastructure HIE vendor.
- The Veterans Administration operates 3 hospitals and 13 clinics in Georgia. All of these facilities are linked electronically to a national health data base through VistA, a health information exchange system. (Actively exchanging patient data and information).
- The Department of Defense operates two DOD hospitals, one Army Medical Center, and two Air Force Medical Groups in Georgia. These

facilities are linked electronically through the DOD's HIE system. (Actively exchanging patient data and information).

- The Georgia Cancer Quality Information Exchange, based in Atlanta, launched an HIE focused on quality metrics in May 2010. The Georgia Cancer Quality Information Exchange is actively partnering with the Lewis Cancer & Research Center at St. Joseph's/Candler, the Harbin Clinic, Redmond Regional Medical Center, Piedmont Hospital, and the John B. Amos Cancer Center at Columbus Regional. These facilities are exchanging health care data in real time. The Exchange has already documented improvements in cancer patient care including improved timeliness in staging for patients prior to treatment, reduced time to biopsy, and improved cancer patient pain management. The Exchange focuses on 52 measures relating to breast, colorectal, lung, prostate, and all cancers. (Actively exchanging patient data and information across unaffiliated organizations).
- All Public Health Departments located across Georgia receive immunization, syndromic surveillance, and notifiable lab results electronically. (Actively exchanging data).
- The Augusta Metro Health Information Exchange is planning an HIE to include major hospitals in east central Georgia including, among other facilities, the Charlie Norwood VA Medical Center, East Central Health District (DCH) and the Eisenhower Army Medical Center.

The DCH outreach campaign leverages relationships with existing networks to conduct provider outreach and education regarding certified EHR technology and the Medicaid EHR Incentives Program. DCH will facilitate contact between GA-HITREC and these networks for the purpose of providing assistance and support in rural and needy markets. The DCH outreach campaign will survey these networks to determine a baseline of those providers not utilizing certified EHR technology. As a result, the survey outcomes will be used as a foundation for DCH and GA-HITREC outreach in setting projections for the Medicaid Incentives Program.

**Governance Structure of Existing HIEs in Georgia, Involvement of State Medicaid, the Geographic Reach and Scope of Participation of the HIEs**

There are a number of existing HIEs in Georgia. Some of these HIEs are still in the early stages with finalizing their governance structure while others are fully functional. Therefore, the first part of this question that pertains to governance is being deferred. The geographic reach and scope of participation for these HIEs is detailed below.

- ChathamHealthLink IT Consortium, formerly known as the Chatham County Safety Net Planning Council, Inc., operates on a county-wide basis. It is a non-profit organization controlled by a county-wide planning body of key stakeholders. Its partners include: the Chatham County Health Department; two federally qualified health centers: Curtis V. Cooper Primary Health Care and the J. C. Lewis Health Center; volunteer medicine clinics: Community Health Mission and the two clinics associated with St. Joseph's/Candler Mission Services—St. Mary's Health Center and Good Samaritan. Two hospital systems, Memorial Health University Medical Center and St. Joseph's/Candler Health Systems are participating partners. Several community organizations and representatives from the City of Savannah and Chatham County are key participants on the Planning Council. The ChathamHealthLink IT Consortium is actively seeking additional partners to expand its HIE to other providers beyond the immediate Savannah area.
  - Grants from DCH and the Health Resources and Services Administration provided start-up financing to Chatham HealthLink (CHL). This funding was coordinated with federal funding to J.C. Lewis Primary Healthcare Center (FQHC) for EMR acquisition and implementation as well as significant in-kind contributions of technical assistance from Memorial Health University Medical Center. The ongoing business model is under development by the CHL IT Consortium.
  - The consortium selected Orion Health's Rhapsody Integration Engine, including the Catalyst Enterprise Master Patient Index, as the core architecture components. The Rhapsody Integration Engine provides secure patient data transmission via VPN to a central Oracle based clinical data repository (CDR). Data stored in the pilot configuration includes demographics, allergies and alerts, medications, encounter summary, medical history and lab orders and results. Authorized user access to the CDR is provided by Orion's Concerto Physicians' Portal.
  - The pilot project is transmitting patient data from J.C. Lewis' Healthport EHR and MUMC's Emergency Department's AllScripts EHR to the CDR.

- CHL defined HL7 v2.4 as its interoperability standard.
- The Georgia Regional Health Information Organization (GARHIO) serves most of northeast Georgia. It is a private collaboration between hospitals, clinics, and providers with governance by participants. It is based in Athens, Georgia, and is a start-up, not-for-profit organization.
- The State Office of Rural Health (SORH) operates the Georgia Farmworker Health Program (GFHP). The geographical scope of GFHP is primarily 21 rural counties located in central and south Georgia where the SORH operates the program through six clinic sites. GFHP is governed by a board that consists of fifty-one (51) percent consumer participation. This governance structure applies to all aspects within the organization.
- Georgia Healthcare Systems, a Health Center Controlled Network, connects Georgia's 27 Federally Qualified Health Centers (FQHCs) electronically via a practice management system. These FQHCs deliver services at 114 sites and 82 rural health clinics. The Network is self-governed and its geographical scope spans the entire state. FQHCs are primarily community governed. The FQHCs exist statewide and mainly serve communities in underserved areas. Their geographic reach is limited mostly to a single county and/or bordering counties.
- Children's Healthcare of Atlanta, an operational HIE, uses comprehensive EHRs to link its member hospitals in the system. Children's Healthcare consists of two hospital campuses and 20 satellite locations around the metro Atlanta area. It was formed through the merger of two pediatric health systems—Egleston Children's Health Care System and Scottish Rite Children's Medical Center. A Board of Trustees provides governance and the overall leadership to the organization. Children's Healthcare's HIE is a self-contained system among its participating physicians and hospitals. Children's Healthcare serves communities in Atlanta and surrounding counties. The HIE is internal to the Children's Healthcare system and the HIE is governed within the organization.
- Central Georgia Health Exchange (CGHE) is based in Macon and includes the Medical Center of Central Georgia and 450 physicians in an affiliated physician hospital organization engaged in data exchange involving approximately 130,000 patients. These physicians communicate with each other through an electronic hub (Health Exchange). The Health Exchange is financed completely by physician practices. The Health Exchange uses nationally recognized standards and the majority of the doctors' offices use eClinicalWorks™ for an electronic ambulatory medical system.

The pertinent points concerning CGHE's organizational governance structure and financing are as follows:

- a. CGHE consists of 450 physicians, faculty of Mercer University Medical School and the Medical Center of Central Georgia. They established a Technology Committee to govern design, build and deploy CGHE.
  - b. CGHE is financed through subscription fees that are included in the participating providers' and institutions' membership fees. There are two primary levels of membership: local members (members that are included in the clinical network) and regional members (members that use some of the services but are not fully integrated in the clinical network).
  - c. The Technical Committee chose eClinicalWorks Electronic Health eXchange (eEHX) as the core architecture component for CGHE. It also chose eClinicalWorks' electronic health record and practice management systems as preferred application software for members.
  - d. CGHE members that are both fully integrated into the provider network (i.e., local members) and are eClinicalWorks EHR customers have full patient data integration via eEHX. Regional members and local members that are not eClinicalWorks EHR customers (eleven practices) have basic patient data exchange via secured messaging, including patient demographics and a Continuity of Care Record summary.
  - e. e-Prescribing is offered with connection to SureScripts. Laboratory orders and results reporting are offered through connections to the Medical Center of Central Georgia and major reference labs (e.g., LabCorp).
  - f. CGHE maintains a data warehouse that extracts data from eEHX for quality analytics and reporting.
  - g. Based on the decision to use eEHX, CGHE is Continuity of Care Record standard compliant.
- Harbin Clinic, Floyd Regional Medical Center, and Redmond Regional Medical Center in Rome are exchanging data elements related to patient care. (Actively exchanging patient information).
  - Georgia Partnership for TeleHealth, Inc. provides collaborative telehealth across Georgia with an emphasis on rural health care and trauma care. Georgia Partnership for TeleHealth is a charitable nonprofit corporation formed to improve health care in rural and underserved communities throughout the state. Geographically, the Georgia Partnership for TeleHealth serves the entire state with 37 different Patient Presentation Sites, 8 Tele-Trauma Sites, and 16 Tele-Radiology Sites. It is governed by a Board of Directors most of whom are physicians.

Georgia Partnership for TeleHealth is responsible for the Open Access Network (OAN): a web of statewide access points based on strategic

- partnerships with successful telemedicine programs and the creation of new telemedicine locations. Using both live video and store and forward technologies, OAN connects 121 specialists in 176 locations. In FY 2009, OAN supported 19,000 patient encounters. In FY 2010, Georgia Partnership for TeleHealth forecasts OAN will support 40,000 patient encounters. The U.S. Commerce Department awarded GPT a \$2.5 million grant to connect institutions such as hospitals, schools and public health departments by expanding the existing telehealth network to 67 additional community anchor sites.
- West Georgia Health in LaGrange is expanding its enterprise HIE into a service area HIE through agreements with community providers, an ambulatory EMR vendor, and a core infrastructure HIE vendor. Geographically, West Georgia Health's core focus is west Georgia and east Alabama. This HIE is a private collaboration with a private governance structure. In addition, research indicates that:
    - a. The health system's board is providing the initial governance for the service area health information exchange.
    - b. A technical committee that included hospital leadership and community providers selected AllScripts EHR and Medicity's Novo Grid as the two architecture core components.
    - c. Planning is underway for the pilot functionality.
  - The Veterans Administration operates 3 hospitals and 13 clinics in Georgia. All of these facilities are linked electronically to a national health data base through VistA, a health information exchange system. The Veterans Administration's network is world-wide and is self-contained meaning that it is controlled by the U. S. Department of Veterans Affairs in Washington, D. C.
  - The Department of Defense operates two DOD hospitals, one Army Medical Center, and two Air Force Medical Groups in Georgia. These facilities are linked electronically through the DOD's HIE system. The Department of Defense network is also world-wide and is self-contained meaning that it is controlled by the U. S. Department of Defense in Washington, D. C.
  - The Georgia Cancer Quality Information Exchange, based in Atlanta, launched an HIE focused on quality metrics in May 2010. The Georgia Cancer Quality Information Exchange is actively partnering with the Lewis Cancer & Research Center at St. Joseph's/Candler, the Harbin Clinic, Redmond Regional Medical Center, Piedmont Hospital, Floyd Medical Center, and the John B. Amos Cancer Center at Columbus Regional. These facilities are exchanging health care data in real time. The Exchange has already documented improvements in cancer patient care including improved timeliness in staging for patients prior to treatment,

reduced time to biopsy, and improved cancer patient pain management. The Exchange focuses on 52 measures relating to breast, colorectal, lung, prostate, and all cancers. The geographical scope of the Exchange is statewide. Significant facts include the following:

- a. The Georgia Cancer Coalition (GCC) is providing governance to the Exchange with technical committee representation from each institution.
  - b. Start-up financing originated with State of Georgia tobacco settlement funding and other grants and in-kind contributions from the institutions.
  - c. GCC chose Medicity's Novo Grid to provide core exchange architecture components. The patient data exchanged is defined by the GCC's data model for building a community cancer care dashboard.
  - d. GCC is maintaining a data warehouse that is used to store and report quality indicators for cancer care in the city of Rome and the Floyd County catchment areas.
  - e. HL7 is the interoperability standard.
- All Public Health Departments located across Georgia receive immunization, syndromic surveillance, and notifiable lab results electronically. The Division of Public Health is a division within DCH. Geographically, Public Health includes the entire state as divided into 18 separate health districts. As for governance structure, DCH is responsible for the Division of Public Health.
  - The Augusta Metro Health Information Exchange is planning an HIE to include major hospitals in east central Georgia including, among other facilities, the Charlie Norwood VA Medical Center, East Central Health District (DCH) and the Eisenhower Army Medical Center

### **The Role of the MMIS in Georgia Medicaid's Current HIT/HIE Environment and the Coordination of the HIT Plan with the MITA Transition Plans**

The Georgia MMIS is a mainframe application with primarily batch processing for claims and file updates. The MMIS is the single source of statewide Medicaid data. The role of the MMIS is limited to fiscal agent activities that support the Medicaid program to include member eligibility and enrollment, provider enrollment and reporting, claims payment, and federal reporting. The MMIS receives unidirectional immunization registry data from GRITS and vital records data from the Division of Public Health.

MMIS is currently undergoing an update and the new system went 'live' on November 1, 2010. The Georgia MMIS System has an important role within the landscape of Health Information Technology (HIT) and Health Information Exchange (HIE). Georgia's Medicaid process, supported by the MMIS System,

will be aligned and coordinated with the HIT Plan, which includes a roadmap for HIT Activity in Georgia. Collectively, the combined focus of the systems and processes, including the MITA transition plans, provide the foundation for: 1) the modernization of the State Medicaid Management Information System; 2) data sharing capabilities through HIE; 3) more effective and efficient health care systems, processes, and operations; and 4) long-term cost effectiveness in health care.

High-level programs impacted by this successful coordination of health care systems include:

- 1) Provider Management
  - Enrolling Providers
  - Managing Provider Information
  - Managing Provider Outreach
- 2) Operations Management
  - Managing Payment Information
- 3) Program Management
  - Developing Agency Goals and Initiatives
  - Developing and Maintaining Program Policy
  - Developing and Maintaining Benefit Packages
- 4) Program Integrity
  - Fraud and Abuse

The State HIT Coordinator and the State Medicaid Director are actively collaborating to coordinate MMIS, MITA, HIE, MIP, and other HIT initiatives to build a foundation for a critical architecture of essential health care processes.

### **State Activities Currently Underway or in the Planning Phase to Facilitate HIE and EHR Adoption; Medicaid's Role; REC's Role in Assisting Medicaid Providers to Implement EHR Systems and Achieve Meaningful Use**

DCH is a collaborating partner with the National Health Museum in a pioneering effort to introduce user-friendly health-related technology to Early County in southwest Georgia. In 2004, the National Health Museum began conducting nationwide testing of customized digital communication devices or kiosks. The kiosk program was first tested in science museums and hospital environments across the nation.

The kiosk system offers an innovative tool to address health issues and gives local citizens an opportunity to use promising technology to learn about healthier lifestyle choices and conditions that proportionately impact them.

Key considerations in the selection of Early County as the first location to pilot the kiosk program were its combination of community resources and service-delivery environment. Representatives from all major segments of the

community – health care, business/commercial, education, civic and faith-based organizations – have been actively involved in the effort. Early County offers well-coordinated and comprehensive health care services in one central location. The developing Federally Qualified Health Center (FQHC) shares space with and coordinates services provided by the DCH's Public Health county health departments. This environment creates an ideal venue for pilot testing of a kiosk because residents receive primary health care and public health services in one location.

Phase 1 of the Community Kiosk Pilot Program created a successful prototype that could be scaled for statewide replication. The flexible kiosk design allows for easy replication in other counties across Georgia. By emphasizing prevention, the community obtains information on: H1N1 and immunizations (adults and children); diabetes; obesity; hypertension; and sexual and reproductive health.

The results of the kiosk project in Early County include:

- Technical and training blueprint (hardware, software and procedures) for implementing health kiosks in additional rural Georgia communities;
- A communications and outreach toolkit for providing public health education tools and information;
- Documentation of the project outcomes, lessons learned and test results;
- Recommended next steps for executing Phase 2 -- implementing health kiosks in additional rural Georgia communities; and
- Improved awareness of healthier lifestyle choices for the consumers using the FQHC and public health services.

By empowering consumers to use a health care technology tool like the kiosk, DCH anticipates that consumers are more likely to be proactive in managing their own health care decisions and ultimately to become better consumers of EHR technology.

Another entity that has been instrumental in facilitating HIE and EHR adoption is the Health Information and Technology and Transparency Advisory Board. The HITT Advisory Board has had a significant role in assisting DCH with promoting the formation of a statewide HIE and the increased adoption of EHRs. The HITT Advisory Board and its committees consist of more than 35 stakeholder organizations and interest groups representing providers, public health, payers, advocates, and consumers. The HITT Advisory Board meetings are typically conducted monthly and are open to the general public.

The HITT Advisory Board developed four workgroups specific to HIE activities: (1) Business and Clinical Operations, (2) Technical Infrastructure, (3) Governance and Finance, and (4) Legal and Privacy. These workgroups:

- Provided guidance on the business, clinical, and technical requirements of the statewide HIE, including recommending criteria to help providers meet meaningful use, improve clinical decision making and achieve interoperability;
- Assisted with the development of a financially sustainable business plan that includes a recommended governance structure for the statewide HIE; and
- Provided consultation as to legal and policy barriers to health information exchange.

In addition, the Office of Health Information Technology and Transparency is working in conjunction with the Division of Public Health to review the existing and largely legacy technology assets located at the state's 18 Public Health Districts. Funded in part by a grant from the U.S. Department of Agriculture, this joint collaboration is intended to assist in efforts to upgrade health information technology with a view toward possible future interoperability with the statewide HIE.

Another significant development is the ONC's selection in February 2010 of the National Center for Primary Care ("NCPC") at the Morehouse School of Medicine as the Regional Extension Center for Georgia. Now known as the Georgia Health Information Technology Regional Extension Center (GA-HITREC) received approximately \$19.5 million in federal funding to provide assistance to primary care providers in the adoption of certified electronic health record technology and the "meaningful use" of that electronic technology. GA-HITREC plans to provide outreach and support services to at least 1,600 primary care providers within two years. GA-HITREC is helping primary care providers to achieve "meaningful use" of electronic health record systems in their practices by offering guidance and developing initiatives that provide vendor selection and group purchasing, interoperability and health information exchange, project management and implementation, privacy and security best practices and workforce support.

Over the last several months, the Office of HITT and GA-HITREC have been working together on a regular basis in planning and strategy sessions. DCH and GA-HITREC plan to leverage their resources and achieve cross-program coordination. With those goals in mind, the Office of HITT hired a business analyst whose principal job function is to serve as the liaison between DCH and GA-HITREC on a daily basis supporting all joint projects and initiatives throughout the state. The liaison is primarily responsible for creating joint press releases, working with e-Connect, linking web addresses on both GA-HITREC and GA-HITT sites, and producing co-branding materials. The two leaders of this group are preparing to create self-promo kits, produce byline articles for distribution, posting Outreach and Education scheduled activities, marketing, and joint webinars.

Both GA-HITREC and DCH (through its Office of HITT) seek to advance the adoption, implementation and meaningful use of health information technology among Georgia's health care providers. Both share the same goals of improving the safety, quality, accessibility, availability and efficiency of health care for Georgians. According to GA-HITREC, its mission is to "use a community approach to assist Georgia's providers with the selection, successful implementation, and meaningful use of certified Electronic Health Records ("EHR") systems to improve clinical outcomes and quality of care provided to their patients." This mission complements DCH's goals. Both DCH and GA-HITREC are committed to ensuring that the state's indigent population and those who are medically underserved receive improved continuity of health care.

GA-HITREC is launching a "community-oriented" approach and is:

- Registering physicians and physician groups;
- Organizing purchasing cooperatives;
- Developing technical partnerships;
- Facilitating training sessions in the community;
- Preparing to distribute communication pieces outlining the project;
- Using its Vendor Selection Committee to negotiate group purchasing discounts;
- Participating in the OHITT Advisory Board meetings;
- Developing business partnerships within communities; and
- Co-sponsoring training and other outreach programs with DCH.

DCH has assigned a training and outreach coordinator to work with GA-HITREC. The coordinator assists the GA-HITREC with onsite visits with small groups of providers, co-hosts video conferences and webinars and creates modules that are DCH centered and informative regarding the GA-HITT MIP and HIE initiatives. As DCH continues to collaborate with the GA-HITREC, DCH will participate in individualized training sessions with practices and PCP forums.

It is anticipated that DCH and GA-HITREC will develop joint communications and training materials to encourage and facilitate the adoption of EHRs and assisting medical providers in implementing EHRs.

GA-HITREC is planning to provide outreach and technical assistance to priority primary-care providers to enable such professionals to achieve meaningful use of certified EHR technology. While its focus is on primary-care providers, GA-HITREC has committed to providing this assistance to any provider in Georgia.

This extensive outreach and assistance provided by the GA-HITREC, combined with DCH's provider outreach and education plans, are expected to increase participation in the Medicaid EHR Incentive Program. (See Appendix C for the DCH Training Plan).

### July 2011 Update for GA-HITREC/OHITT Collaboration Activities:

OHITT has expanded its collaborative role with GA-HITREC to include the following activities currently underway:

- Co-developed a unified “message” to the provider community recognizing that the GA-HITREC can provide technical assistance, information, and support providers ready to learn more and execute adoption, implementation or upgrade of a certified EHR system within their practice.
- Identified cost-sharing opportunities to employ professional advertising and marketing services in order to reach a wider provider audience within the state of Georgia.
- Dedicated an OHITT resource, Tracy Sims, to act as the GA-HITREC liaison in order to improve cross-organization communications, improve collaboration efforts, and participate in numerous outreach activities. She also participates in the GA-HITREC’s monthly sub-recipient meetings.
- DCH (OHITT and Georgia Medicaid) consistently co-sponsors events with GA-HITREC. These events include speaking engagements at various medical association meetings around the state and have participated as exhibitors at several events focused on dental, medical, practice management and nurse practitioner organizations.
- The Medicaid Incentive Program Director, Jackie Koffi is often in attendance to personally inform and encourage providers to take the necessary steps to participate in the incentive program.
- OHITT & GA-HITREC participate in weekly one-on-one marketing and outreach-based meetings.
- The DCH and the fiscal agent updated the web presence to include the GA-HITREC information. MIP marketing materials have been updated to display GA-HITREC co-branding.
- DCH partnered with the GA HITREC to participate in the semi-annual Georgia Medicaid Fair that targeted ALL Medicaid providers.
- Currently developing strategies with GA-HITREC to promote the statewide Health Information Exchange to those providers who signed with the GA-HITREC and easily transition them to the Georgia HIE.
- OHITT is also working closely with GA-HITREC technical team to develop strategies to benefit their members. For instance, GA-HITREC recently selected Halfpenny Technologies to develop a lab hub demonstration project that will enable a seamless, secure and efficient exchange of clinical data for GA-HITREC members. This action was taken in order to further support the Georgia statewide Health Information Exchange (HIE) deployment initiative. Strategic initiatives conducted with GA-HITREC, such as this one, will be leveraged and promoted to the broader Georgia provider community to

encourage participation in the statewide HIE and increase utilization of its developing services.

### **Relationship of Medicaid to the State HIT Coordinator, Joint HIE/Medicaid Activities, and the REC's Support for the EHR Incentive Program**

The Georgia Health Information Technology (HIT) Coordinator reports directly to the DCH Commissioner. Additionally, the State HIT Coordinator is charged with coordinating health information technology activities within DCH, across state government, and is a vital contact between DCH and CMS. The State HIT Coordinator works closely with the State Medicaid Director (Business Owner of the Medicaid EHR Incentive Program) and reviews Medicaid EHR Incentive Program plans with the State Medicaid Director prior to submission to CMS. The State Medicaid Director has assigned a Medicaid subject matter expert to work on the Medicaid EHR Incentive Program on a day-to-day basis.

The Georgia HIT Coordinator is coordinating HIT efforts with Medicaid, the Division of Public Health and with other federally funded state programs. The State HIT Coordinator is actively seeking to:

- Advance operationally viable strategies that accelerate the success of the EHR incentive program in meeting shared meaningful use goals;
- Ensure state program participation in planning and implementation activities including, but not limited to Medicaid, Behavioral Health, Public Health;
- Ensure that State Medicaid HIT Plans and State HIE plans are coordinated;
- Leverage various state program resources such as immunizations registries, public health surveillance systems, and CMS/Medicaid funding to ensure resources are being maximized (e.g., ARRA authorized Medicaid 90/10 match leverage to support HIE activities); and
- Identify, track and convene the various federal HIT grantees for cross-program coordination and to leverage program resources.

As discussed previously, DCH and GA-HITREC are actively collaborating to leverage their collective resources toward the shared goal of increasing participation in the Medicaid EHR Incentive Program.

### **Medicaid Activities Currently Underway Likely to Influence the Direction of the EHR Incentive Program Over the Next Five Years**

The single most significant activity underway at this time is the implementation of a new MMIS which became operational on November 1, 2010. Notwithstanding the completion of extensive testing conducted in conjunction with that vendor (HP), DCH anticipates having to make certain modifications and adjustments to this new MMIS for its Medicaid program. After the MMIS implementation and

stabilization period is complete, DCH believes that the new system will provide invaluable support for the Medicaid Incentive Program.

### **Significant Changes to State Laws or Regulations That May Affect Implementation of the EHR Incentive Program**

The OHITT legal team has assessed current state laws and regulations and has not determined the existence of any recently enacted laws likely to pose any significant impediments to the implementation of the Medicaid Incentive Program. The legal team is endeavoring to ensure that the heightened protection afforded by current state law to the medical records and medical information belonging to HIV positive patients, mental health patients, rape victims, and other protected categories of individuals is completely implemented.

### **HIT/HIE Activities that Cross State Borders and Medicaid Beneficiaries Crossing State Lines**

DCH has established collegial working relationships with other states in the southeast region, especially Georgia's five bordering states--Florida, Tennessee, Alabama, North Carolina and South Carolina. DCH is actively collaborating with other states in the region on a regular basis through the Medicaid Multi-state Collaborative and the Southeast Regional Collaboration on HIE-HIT (SERCH) meetings and telephone conference calls. SERCH encompasses eleven states and routinely has participants in telephone conference calls from Alabama, Arkansas, Florida, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia and, of course, Georgia. The regional membership in SERCH includes representatives from Medicaid, health information and technology state coordinators, regional extension center staffs, and health information exchange staff including technical coordinators. SERCH is a joint partnership that consists of regional partners from these eleven states and federal partners from CMS and ONC. SERCH seeks to facilitate the resolution of cross border issues between states as well as the exchange of ideas on how states can maximize their limited resources. The SERCH group conducts weekly conference calls that are typically organized around topics of mutual concern. DCH recognizes the value in coordinating and collaborating with other states. DCH plans to continue to engage in the exchange of ideas, plans, and information with other states with respect to advancement of EHRs.

Georgia Medicaid beneficiaries occasionally cross state lines when accessing health care services. Beneficiaries enrolled in Georgia Medicaid are allowed to receive non-emergent and emergent services in border state communities within a 50 mile radius of the Georgia border (i.e., Alabama, Florida, North Carolina, South Carolina and Tennessee). These border communities are defined by zip codes. Providers rendering non-emergent services must be enrolled in Medicaid and, for managed care members, must be contracted with a Care Management Organization.

Table 5 below details the emergency care and non-emergent services received by Medicaid members in approved border communities in CY 2009 (paid through June 2010), excluding durable medical equipment (DME), mail order pharmacy and reference lab work performed out-of-state (e.g., LabCorp). The counts are not additive as distinct members may have received both emergent and non-emergent services. Border state utilization represents approximately 2.08% of the total Medicaid membership.

**Table 5: Emergency Care and Non-emergent Services received by Medicaid members in approved border communities in CY 2009**

Border State Claims	Emergent Care		Non-Emergent Care		Total Distinct Member Count	Total Claim Cost
	Distinct Members	Claim Cost	Distinct Members	Claim Cost		
Total	14,868	\$25,581,027	37,391	\$40,002,793	41,217	\$65,583,820

Medicaid beneficiaries, including managed care members, may also receive emergent and non-emergent services outside of Georgia and the approved border communities. Such non-emergent services must be approved by DCH or Care Management Organizations for payment.

Typically, providers rendering these out-of-state services are not enrolled Georgia Medicaid providers. Table 6 represents this CY 2009 out-of-state utilization, excluding DME, mail order pharmacy and out-of state reference lab work. The out-of-state utilization represents approximately 1.55% of the total Medicaid membership.

**Table 6: CY 2009 out-of-state utilization, excluding DME, mail order pharmacy and out-of state reference lab work**

Out-of-State Claims	Emergent Care		Non-Emergent Care		Total Distinct Member Count	Total Claim Cost
	Distinct Members	Claim Cost	Distinct Members	Claim Cost		
Total	6,028	\$7,699,114	26,192	\$41,935,863	30,654	\$49,634,977

Over the next two months, DCH will work with members of SERCH to develop processes and procedures to address those eligible providers that may want to include patient volume data from multiple states in order to qualify for EHR incentive payments. The finalized approach will be included in Georgia's next SMHP submission.

**Current Interoperability Status of the State Immunization Registry and Public Health Surveillance Reporting Database(s)**

DCH's Division of Public Health is responsible for the Georgia Immunization Registry (GRITS), a system designed to collect, maintain, and disseminate complete and accurate vaccination records in order to promote effective and cost-efficient disease prevention and control. The GRITS program assists health care providers and public health officials with assessing and improving community immunization status and providing reminders when children need vaccinations or vaccination updates. The Registry enables providers across Georgia to quickly access immunization records of Georgians and helps avoid duplicative and unnecessary immunizations.

GRITS contains immunization histories entered by Georgia health care providers for persons of all ages from birth to death. The primary focus of GRITS is to ensure that individuals receive appropriate, timely immunizations to lead healthy, disease-free lives; assure access to up-to-date immunization records; meet the needs of the state immunization registry mandate; and provide a registry that is cost-effective, user friendly, and efficient. The Registry allows enrolled providers, both public and private, to input and access an individual's complete immunization record.

The Registry is also used in population-based reminders for children who are behind schedule in receiving their shots. Thus, GRITS helps to improve the health of Georgia's citizens and provides a more accurate portrayal of the immunization status of all of Georgians.

Currently, the GRITS database contains approximately 9 million patient records and over 90 million immunization records for these patients. Approximately 20,000 active users in 7,500 public and private provider organizations access GRITS through either web-based user interface, batch data exchange (via flat file) or real time data exchange (via HL7/PHINMS). DCH anticipates that the statewide HIE will incorporate GRITS into an electronic health care database.

**Descriptions of any Transformation or CHIPRA HIT Grants**

On October 4, 2007, CMS awarded DCH a \$3.9 million Medicaid Transformation Grant. DCH used the funding toward the development of Georgia's transparency website for health care consumers. This website provides information on cost, quality of care, availability of services, and disease management and wellness accessible to beneficiaries of Medicaid Care Management Organizations (CMOs), Georgia's Uninsured Plans, the State Health Benefit Plans, and all consumers of health care in Georgia. The information helps consumers make informed choices about their health care. The grant funded 79.7 percent of the

website project in federal fiscal years 2007 and 2008. Additional funding was appropriated by the state.

DCH successfully launched [www.georgiahealthinfo.gov](http://www.georgiahealthinfo.gov), the transparency website for health care consumers in December 2008. Within a month over 100,000 users had visited it. The website was developed using data from approximately 20 sources, including Medicaid claims; Public Health; Office of Regulatory Services; Georgia Hospital Association; and CMS. Another feature of [georgiahealthinfo.gov](http://georgiahealthinfo.gov) is the link to the rich data content on health, wellness, prevention and disease content from the Mayo Clinic. Feedback from visitors indicates that they find the transparency site useful and easy to navigate.

DCH commissioned an external evaluation of [georgiahealthinfo.gov](http://georgiahealthinfo.gov) to obtain the users' perspective of the website in terms of overall usability, functionality and aesthetics when accessing the website. The evaluation of [georgiahealthinfo.gov](http://georgiahealthinfo.gov) indicated the use of the website by health care consumers could improve health care quality and efficiency and have a positive impact on Medicaid beneficiaries. The evaluation concluded that:

- [georgiahealthinfo.gov](http://georgiahealthinfo.gov) easily and quickly provides users with specific and thorough information about health care;
- Participants' knowledge and perception of health care information changed after reviewing the content of [georgiahealthinfo.gov](http://georgiahealthinfo.gov);
- The website format met users' expectations, especially as it related to navigation, content and organization; and
- Participants had a positive overall perception of the website.

In June 2009, DCH launched Phase 2 of [georgiahealthinfo.gov](http://georgiahealthinfo.gov). Phase 2 included the addition of data for Long-Term Care, Federally Qualified Health Clinics (FQHCs), Public Health Clinics, Nursing Homes Quality Ratings, and Trauma and Stroke Centers. [georgiahealthinfo.gov](http://georgiahealthinfo.gov) continues to empower Georgians with an easy-to-use website featuring health care services, cost, quality and educational information to encourage healthier outcomes, result in engaged, savvy consumers who are in control of their own health. DCH plans to leverage the Medicaid Transformation Grant for the utilization of the Medicaid EHR Incentive Program as explained later in this document.

## **SECTION B: GEORGIA'S "TO-BE" LANDSCAPE**

Question(s) Deferred for Section B

Question Number	Question
2	<i>What will SMA's IT system architecture look like in five years to support achieving the SMA's long term goals and objectives?</i>
6	<i>If the state has FQHC's with HRSA HIT/EHR funding, how will those resources and experiences be leveraged by SMA to encourage EHR adoption?</i>
7	<i>How will the SMA assess and/or provide technical assistance to Medicaid providers around adoption and meaningful use of EHRs?</i>
8.	<i>How will the SMA assure that populations with unique needs, such as children, are appropriately addressed by the EHR Incentive Program?</i>

**HIT / HIE Goals and Objectives for Georgia Medicaid**

NOTE: The description below presents DCH's initial HIT/HIE goals and objectives. DCH expects that further refinement of these goals and objectives will be reflected in future iterations of the SMHP.

DCH's strategic vision for health information technology and exchange focuses on improving health outcomes for all Georgians. By encouraging the use of certified EHRs by Medicaid providers and by fostering participation in the statewide HIE, DCH expects to improve health care and health care access across Georgia.

DCH envisions that in Georgia by 2015:

- It is estimated that approximately 18.59 percent (19,813) of Medicaid physician providers currently are eligible for the Medicaid Incentive Program. DCH expects that a minimum of 18 percent of the eligible Medicaid providers will implement a certified EHR and meet meaningful criteria.

It is estimated that there are 77 Georgia hospitals eligible for payment under the Medicaid Incentive Program. DCH expects that a minimum of 50 of the eligible hospitals will implement a certified EHR and meet the appropriate meaningful use criteria.

- DCH is collaborating with private stakeholders to build a statewide HIE that will be a network of networks. The Georgia Statewide HIE is extensively discussed in other sections of this plan and in the Strategic and Operational Plan for the HIE. The expectation is that within five years HIE access would be available to a minimum of 75 percent of Georgia.

- All Public Health district clinics will have access to the HIE within the five year period
- Medicaid population information will be available through the HIE within the five year period
- Enhance provider awareness of privacy and security issues and solutions
- Increase the use of telemedicine especially in rural and physician shortage areas.

DCH is coordinating accomplishing these goals through activities supported by the HIE Cooperative Agreement and by CMS's incentives program for the adoption and meaningful use of EHRs. It is obvious that without increased adoption, implementation and upgrading of EHRs by providers in Georgia, these objectives cannot be achieved. DCH recognizes the need for provider outreach and communication activities to encourage the adoption of electronic technology in health care. For that reason, DCH has created the following provider adoption goals:

- Ensure that Medicaid providers are fully informed about the financial incentives available under the incentive program;
- Encourage Medicaid providers to become meaningful users of certified EHR technology;
- Support GA-HITREC's efforts to facilitate the adoption and use of EHRs by primary care physicians in Georgia;
- Conduct outreach activities targeted directly toward providers who are not yet using EHRs;
- Conduct educational and informational activities focused on Georgia's managed care organizations, potentially eligible Medicaid providers, and other state agencies and entities outside of DCH.

Looking forward to the next five years, Georgia's Health Information Technology goals are consistent with the goals of the ONC. Under the leadership of the Governor and the Commissioner, DCH seeks to use health information technology to help:

- Improve health care quality, access and affordability
- Improve clinical decision-making at the point of care
- Increase health care transparency among providers, patients, and payers
- Improve the public health infrastructure by making public health data readily available.

**Medicaid Provider Interface for the EHR Incentive Program**

DCH intends to provide a provider portal that will allow Medicaid providers to interface with the IT system as it relates to EHR Incentive Program registration. DCH is planning to use HP's Medical Assistance Provider Incentive Repository (MAPIR) product that is currently under development for a multi-state collaboration led by the Commonwealth of Pennsylvania. The registration process for Medicaid providers with the R&A and with DCH and the applicable procedures for attestation are discussed in considerable detail in Section C of this document.

**HIE Governance Structure to Achieve Georgia's HIT / HIE Goals**

Currently, DCH is in the process of collaborating with public and private stakeholders to form a 501(c) (3) non-profit organization to govern the building and management of the Georgia statewide HIE. The bylaws for the Georgia Statewide HIE are currently being drafted.

The plans are to use an open and integrated architecture comprised of HIE networks currently existing throughout the state. As envisioned, the statewide HIE, a public/private partnership organization will consist of a "network of networks." An important objective of the organization is to provide a vehicle for providers to meet meaningful use criteria defined in the final Meaningful Use Rule. In order to meet these goals the plan includes the following crucial elements:

- Integration of existing HIEs
- Statewide Master Patient Index
- Record Locator Service
- Access of Medicaid member demographic and claims information
- Access to immunization data via GRITS the Public Health immunization registry
- Expansion of broadband service throughout the state
- Participation by pharmacies for e-prescribing
- Clinical laboratory participation to provide for electronic ordering of labs and delivery of lab results
- Access by self-insured employers and major insurance companies to required data.

In order to achieve these goals the governance structure will establish oversight committees to create the framework, policies and procedures for each of these areas. DCH expects that these critical areas will be subdivided into workgroups to meet the needs for each area. For example: A current technical committee would likely be subdivided into workgroups for pharmacy, insurance, and laboratories. After the governance structure becomes finalized and the

workgroups submit reports that are adopted by the non-profit organization, DCH will supplement this version of the SMHP to provide additional information.

### **Georgia's Steps to Encourage EHR Adoption in 2011**

DCH is undertaking specific steps to encourage provider adoption of EHR technology. DCH plans to continue to build upon the success that the OHITT has achieved in facilitating the formation of the statewide HIE. In addition, as part of the Medicaid Incentive Program, DCH has begun implementing a comprehensive outreach plan that is designed to inform and encourage providers to move toward the adoption and use of certified EHR technology.

The Communications Division of DCH is working with the Georgia Health Information Technology Regional Extension Center (GA-HITREC) in developing a communications plan to make information available to the target audiences. This information will equip audiences with the knowledge and skills that are needed to successfully implement EHR technology in their practices. GA-HITREC is responsible for providing assistance with planning for technical training of providers. A sample audience characterization instrument is found in Appendix D.

From a communications and education perspective, DCH plans to:

- Focus on stakeholder adoption/use benchmarks and;
- Develop, implement, monitor and measure the performance of a planned communications strategy designed to build awareness, understanding and participation in the Medicaid Incentive Program.

Messaging will be segmented by stakeholder group (i.e., eligible providers such as physicians, hospitals, labs, etc.). Primarily, messaging will inform, educate and persuade eligible providers about the value of adopting, implementing and using a certified EHR system.

Message delivery channels include the following: public relations and media relations, collateral support materials, partner events and support materials. The branding and messaging surrounding the Medicaid Incentive Program and the adoption of certified EHR technology will be integrated into the state's "umbrella" branding initiatives for HIT/HIE outreach and communications.

### **Leverage of HIT-Related Grant for Implementing the EHR Incentive Program**

As discussed previously in Section A, CMS awarded a \$3.9 million Medicaid Transformation Grant to DCH and DCH used the federal funding in conjunction with state funds toward the development of Georgia's transparency website of health care consumers. This website, [www.georgiahealthinfo.gov](http://www.georgiahealthinfo.gov), contains rich

data content on health, wellness, and disease. DCH plans to leverage this website into the Medicaid EHR Incentive Program to give providers information about the program.

**Enactment of New State Laws or Changes to State Laws**

DCH does not anticipate the need for the enactment of any new state laws at this time.

**SECTION C:**

**ACTIVITIES NECESSARY TO ADMINISTER AND  
OVERSEE THE EHR INCENTIVE PAYMENT PROGRAM**

Question(s) Deferred for Section C

Question Number	Question
11	<i>How will this data collection and analysis process align with other clinical quality measures data, such as CHIPRA?</i>

**Introduction**

DCH, including the Office of Health Information and Technology (OHITT) and the Division of Medical Assistance (Medicaid), is responsible for the Medicaid EHR Incentive Program, including the development of procedures and processes to ensure the effective administration and oversight of the program. The Office of Health Information Technology and Transparency (OHITT) is the name of the office within DCH that is responsible for administration of the Medicaid EHR Incentives Program and the State Medicaid HIT Plan (SMHP).

This section of the SMHP details DCH’s plans to administer and oversee the incentive program in accordance with the HITECH Act and the Final Rule (42 CFR Parts 412, 413, 422 and 495 (Medicare and Medicaid Programs; Electronic Health Record Incentive Program). This plan describes how DCH will perform the following tasks:

- Identification of potentially eligible professionals (EPs) and eligible hospitals (EHs)
- Provider outreach efforts to maximize the meaningful use of certified electronic health record (EHR) technology
- Validation of EPs and EHs to ensure that all incentive program requirements are met
- Development of provider attestations so that providers commit in writing to complying with program requirements
- Calculation of hospital incentive payments
- Oversight and audit activities to prevent waste, fraud and abuse
- Management of a multi-level provider appeals process

The SMHP developed by DCH relied on the collaboration of OHITT, the Divisions of Medical Assistance, Public Health, Information Technology, the Office of Rural Health, the Office of the Inspector General, the MMIS Fiscal Agent and external stakeholders, such as key statewide provider associations. Further, DCH utilized the following resources to ensure a thorough and robust SMHP and an auditable framework for administering the incentive program:

- The provisions of ARRA, the HITECH Act and the applicable federal rules
- The HITECH Act Systems Interactions and Interface Control Document (ICD) Version 1.4 to understand the functional requirements
- HITECH teleconferences sponsored by CMS and ONC
- SERCH teleconferences attended by CMS representatives
- Teleconferences sponsored by the National Association of State Medicaid Directors and attended by CMS and ONC representatives, and DCH personnel.

At this time, DCH is providing specific details in this section of the SMHP for the implementation, administration and oversight of the Medicaid EHR Incentive Program. DCH anticipates that additional issues may arise in the future and where appropriate, DCH will identify issues that will be addressed in subsequent versions of the SMHP.

### **Identification of Potentially Eligible Providers**

As stated in Section A, DCH engaged Myers and Stauffer, a certified public accountant firm, to review and analyze MMIS fee-for-service claims and managed care encounter data paid in State Fiscal Year 2010 to project the number of potentially eligible professionals expected to qualify for Medicaid incentive payments. Claims were filtered by Category of Service (CoS) and Major Program code and then aggregated by claim type and procedure code. Next, a time value was applied to the aggregate data. COS included in this analysis are 430, 450, 460, 480, and 740. For purposes of this analysis, only the Medicaid Program (Major Program Code = "M") were included except for practitioners billing separately at a Federally Qualified Health Center (FQHC) and/or Rural Health Center (RHC). Myers and Stauffer relied on the CMS based Resource Based Relative Value Scale (RBRVS) to assign time values, which does not contain a time value for all procedure codes. Specifically, dental procedure codes are excluded from this database and thus no time value was available for this practitioner type.

Myers and Stauffer then calculated the eligible practitioners (EPs) by mandating a total of 600 total annual paid hours (30% of 2000 annual workable hours) for physicians, nurse midwives, and nurse practitioners. Physician Assistants were not included in the analysis since Georgia does not have any Federally Qualified Health Centers or Rural Health Centers "so led" by Physician Assistants. A separate calculation was completed for Pediatricians having 400 (20% of 2000 annual workable hours) total annual paid hours, but not exceeding the 600 hour threshold. Since RBRVS time values were not readily available for dentists, we utilized total Medicaid compensation to establish the number of eligible dentists. For purposes of this analysis, it was assumed that any dentist receiving \$75,000 or greater in total compensation from Medicaid (CHIP was excluded) would

## 2010 STATE MEDICAID HIT PLAN V.1.0

satisfy the required 30% patient threshold. To determine if any providers may be eligible by participating in a group practice, Myers and Stauffer also aggregated providers by the Payee and divided the total paid hours by the number of practitioners designating payments to that Payee. For those providers exceeding a 600 total annual paid hour average as a group, we included each provider in that group practice in the listed total eligible providers. Finally, Myers and Stauffer attempted to remove providers with a primary hospital based practice by utilizing provider type and location codes maintained in the claims data.

Provider Type	Number of Providers	Percentage Eligible	Number of Eligible Providers**
Physician*	20,291	17.74%	3,215
Nurse Midwife	189	36.51%	69
Nurse Practitioner	2860	4.34%	124
Dentist	1234	26.66%	329
Pediatrician	N/A	N/A	384
<b>Total</b>	<b>24,574</b>	<b>16.77%</b>	<b>4,121</b>

\*Total number of providers includes all Pediatricians as does the Percentage Eligible.

\*\*Includes Pediatricians exceeding 600 annual Medicaid hours.

& Assumes full participation by all eligible providers in the first year at a rate of \$21,250 payment for providers & \$14,167 for pediatricians.

# Assumes full participation by all eligible providers at a rate of \$65,750 and \$42,500 for pediatricians.

Since the analysis above incorporates a full working year to meet the minimum 30% threshold, some providers may have been erroneously excluded from the list. Eligible providers may select a 90 day period for which the Medicaid threshold may be met. Since this 90-day period may not be fully representative of the entire year, a provider might meet the 30% threshold for any given 90-day period, while not satisfying the 600 Medicaid hour standard above for the entire year. While it is not possible to accurately determine the exact number of providers meeting this 90-day standard, a review of the data described above indicates that approximately 700 additional providers are within 5 percent (25% total) of the 600 annual hour threshold established above and may qualify based on a favorable 90-day period within a given year.

As a final analysis, we assessed the number of out-of-state providers who billed for services on behalf of Georgia Medicaid members. As a threshold for analysis, we utilized 300 hours (and \$40,000 for dentists) utilizing the same

RBRVS analysis described above. As a result of this analysis, we determined that there were 19 providers and 4 dentists who may qualify using a multi-state Medicaid ratio. Should these providers qualify, they may select to participate in the Georgia program.

### **Eligible Hospital Payment Projection**

Myers and Stauffer performed an analysis of hospital cost report information to estimate the number of eligible hospitals and amount of Medicaid electronic health record (EHR) incentive payments. The cost report information was obtained from two data sources. The first data source was electronic cost report files obtained from the Department of Community Health (DCH) hospital team for cost report fiscal periods ending in calendar year 2009. The information from these cost reports consisted of Medicaid and total days, Medicaid and total discharges, Medicaid health maintenance organization (HMO) days, other uncompensated care charges, and total charges. The second data source was the electronic cost report database maintained by the Centers for Medicare and Medicaid Services (CMS) on the CMS website. This database is known as the Healthcare Cost Report Information System (HCRIS). The information from this database consisted of total discharges for a three-year period for purposes of computing an average growth rate in discharges (federal fiscal years [FFY] 2005-2007).

The number of projected eligible hospitals was calculated by determining the average length of stay and the Medicaid patient volume for each hospital. Average length of stay was computed by dividing total days by total discharges. Medicaid patient volume was computed by dividing Medicaid discharges by total discharges. Hospitals with an average length of stay greater than 25 and a Medicaid patient volume percentage less than 10 percent are not eligible for incentive payments. For purposes of this projection, hospitals have been included that have a Medicaid patient volume above 9 percent and below 10 percent, as these hospitals may be eligible based on FFY 2010 cost report information and FFY 2007-2009 discharges.

For the projected eligible hospitals, the estimated aggregate EHR incentive payment for each hospital was calculated based on the above data. The calculation followed the final rule parameters and the calculation model developed by the University of Iowa. However, Myers and Stauffer believes that the Iowa model contains two potential errors. First, the formulas in the Iowa model for calculating the discharge-related amounts result in a negative amount if a hospital has fewer discharges than the "floor" of 1,150. In this projection, these formulas have been corrected so that the discharge-related amount incorporates the actual number of discharges if the provider has fewer than 1,150 discharges. Secondly, the formula in the Iowa model for calculating the allowed discharges for the first year in the theoretical four-year period inflates the

discharges from the fiscal year prior to the first payment year by the average annual growth rate in discharges. Myers and Stauffer believes the language in the final rule (75 FR 44498) indicates that the average annual growth rate in discharges is to be applied to the 2nd through 4th year. The calculation has been updated such that the discharges for the first year of the theoretical four-year period represent discharges from the fiscal year prior to the first payment year.

The number of projected eligible hospitals and aggregate EHR incentive payments for the projected eligible hospitals are shown below.

- *Projected Eligible Hospitals – 77*
- *Projected aggregate EHR incentive payments for 77 eligible hospitals - \$152.5M*

<b>Hospital Type</b>	<b>Number of Hospitals</b>	<b>Percentage Eligible</b>	<b>Number of Eligible Hospitals</b>
Acute Care	106	58.49%	62
Critical Access	34	38.24%	13
Children’s	2	100.00%	2
Ineligible (Rehab, LTC Hosp)	7	N/A	N/A
<b>Total</b>	<b>149</b>	<b>51.68%</b>	<b>77</b>

At the request of the State, we assessed the regions associated with the hospitals previously described as potentially eligible for incentive payments. The chart below outlines the percentages of potentially-eligible hospitals, by hospital type, distributed by region.

Region	Acute Care	Critical Access	Children’s	Total
Atlanta	22%	—	3%	25%
Central	13%	4%	—	17%
East	6%	—	—	6%
North	13%	1%	—	14%
Southeast	9%	4%	—	13%
Southwest	17%	8%	—	25%

Through the Southeast Regional HIT-HIE Collaboration (SERCH) workgroup, DCH submitted an inquiry to CMS seeking guidance on this issue. CMS responded as follows:

*The regulation requires the use of inpatient bed day data and defines inpatient bed day according to Medicare’s definition of an inpatient bed day. To the extent that days or discharges for other parts of the hospitals can qualify as inpatient*

*bed days according to Medicare’s definition, they should be allowable. Otherwise they should not be included.*

Based on the above response and the Medicare definition of an inpatient bed and inpatient bed day in CMS. Pub. 15-1 and 15-2, Myers and Stauffer believes inpatient sub-provider unit data should be included in the hospital eligibility and payment calculations. For purposes of this estimate, including sub-provider information results in one hospital being eliminated from Medicaid Incentive Payment eligibility and thus there is a reduction in the projected total aggregate EHR incentive payments as shown below:

- *Projected Eligible Hospitals – 76*
- *Projected aggregate EHR incentive payment for 76 eligible hospitals - \$149.1M*

<b>Hospital Type</b>	<b>Number of Hospitals</b>	<b>Percentage Eligible</b>	<b>Number of Eligible Hospitals</b>
Acute Care	106	57.55%	61
Critical Access	34	38.24%	13
Children’s	2	100.00%	2
Ineligible (Rehab, LTC Hosp)	7	N/A	N/A
<b>Total</b>	<b>149</b>	<b>51.01%</b>	<b>76</b>

At the request of the State, we assessed the regions associated with the hospitals previously described as potentially eligible for incentive payments. Based on the inclusion of sub-provider information, the chart below outlines the percentages of potentially-eligible hospitals, by hospital type, distributed by region.

<b>Region</b>	<b>Acute Care</b>	<b>Critical Access</b>	<b>Children’s</b>	<b>Total</b>
Atlanta	22%	—	3%	25%
Central	13%	4%	—	17%
East	7%	—	—	7%
North	13%	1%	—	14%
Southeast	9%	4%	—	13%
Southwest	16%	8%	—	24%

At DCH’s request, Myers and Stauffer created a Hospital Calculation Template. (See Appendix F) If approved by CMS, DCH intends to use the calculator in Appendix F and to share the Hospital Calculator Template with hospitals in Georgia.

**Note:** Other uncompensated care charges from cost report worksheet S-10 was available for approximately two-thirds of the total projected eligible hospitals. The remaining eligible hospitals did not report other uncompensated care charges on worksheet S-10. The absence of this data element may understate the Medicaid share percentage and the projected EHR incentive payments. For purposes of this estimate, other uncompensated care charges for the hospitals that did not report this data was estimated by multiplying total charges by the average percentage of other uncompensated care charges to total charges for the hospitals reporting other uncompensated care charges.

### **July 2011 Eligible Hospital Payment Production:**

DCH has modified its Eligible Hospital patient volume and incentive payment calculator to exclude sub-provider units.

### **Licensure and Sanctions**

Georgia Department of Community Health (DCH) will leverage available data sources to verify whether providers are sanctioned or they are properly licensed and qualified. For Federal sanctions, DCH will utilize information from the CMS registration and attestation website to identify providers with Federal sanctions as reported on the National Practitioner Data Bank, CMS Death Master File and U.S. Department of Health & Human Services, and OIG list of excluded individuals and entities. For State-based sanctions and licensure qualification issues, DCH will coordinate closely with other State agencies and partners, including licensing agencies, DCH's Medicaid Provider Enrollment program, the DCH's Program Integrity unit, DCH's Division of Healthcare Facility Regulation, and the State Health Care Fraud Control Unit to determine if provider sanctions are in effect or pending. Certain, state-based sanctions would not prohibit a provider's ability to receive federal funds, such as pre-payment review or a provider placed on a corrective action plan. DCH will only verify those state-based sanctions that prohibit receipt of federal funds.

Additionally, DCH's Medicaid Provider Enrollment program process will verify provider licensure/qualification and good standing at the time providers enroll in the Medicaid incentive program and also verify that the provider has a valid Georgia Medicaid identification number. This process will also confirm (or refute) that the provider is eligible to participate in the program based on provider type.

### **Hospital-Based Providers**

Hospital-based providers are ineligible to participate in the incentive program and are defined as those professionals who provide **more than 90%** of their services in a hospital setting (inpatient and emergency room). To ensure that hospital-based providers are excluded from the program, DCH will analyze professional claim and managed care encounter data in the MMIS for the appropriate reporting period to determine the rendering provider NPI and the HIPAA standard

transaction Place of Service codes on the claim and encounter data. DCH intends to use Place of Service Codes 21-Inpatient Hospital and 23-ER as a basis for determining hospital-based services.

### **Verifying Overall Content of Provider Attestations**

DCH will utilize a state portal for providers to report attestation information. DCH staff, including members of the legal team and Audits, will closely review the attestation information provided through the portal. Utilizing DCH staff and external auditors, DCH will conduct pre-payment and post-payment audits and reviews of provider attestations. These audits and reviews will be conducted in a manner that appropriately focuses audit efforts. This may include assessments of providers or attestations that are of higher risk, or an approach based on random sampling. DCH intends to leverage existing resources by using existing Program Integrity infrastructure and resources, supplemented as necessary and appropriate by contract services.

EPs will be required to attest that they are not hospital-based. For all EPs attesting non hospital-based status and requesting incentive payments, DCH will conduct reviews of FFS and managed care encounter claims data from the MMIS to verify that the EP is not hospital-based. This review will be performed in accordance with the Final Rule's definition of a hospital-based EP. EPs with more than 90 percent of their services performed with HIPAA standard transaction Place of Service (POS) code of 21 (Inpatient) or 23 (Emergency Room) will be considered hospital-based. DCH may also review other relevant information that may be available relative to hospital-based status.

### **Communication to Providers on Eligibility and Payments**

DCH is implementing a communication approach that contains the flexibility to provide appropriate communication to providers in multiple formats. The preferred approach for routine communication will be electronic in nature, either through electronic mail or a notification for the provider to retrieve information that resides in the incentive payment portal. Formal communication with the provider, such as when payment should be expected, denials of eligibility, selection for audit, and appeal correspondence will occur via electronic correspondence and written letter where applicable.

### **July 2011 Provider Communication Update:**

In our outreach efforts such as monthly provider webinars, participation in professional association and Medicaid events and consistent collaboration with the GA-HITREC, the State explains to providers that an encounter is any service rendered to an individual patient, an inpatient discharge or in an emergency department on any one day where Medicaid, or Medicaid demonstration grant, paid for all or part of the service or all or part of the premiums, co-payments or

cost-sharing. We also explain that encounters include services rendered to Medicaid managed care patients. This information is available on our website as part of the webinar series and in the Provider User Guides that will be accessible from the DCH website, MMIS web portal and from within the MAPIR application itself.

### **Patient Volume**

DCH intends to calculate patient volume using encounters. For EPs, a Medicaid encounter is defined as all of the services rendered to an individual in a single day. In calculating Medicaid patient volume, Children's Health Insurance Plan (CHIP) encounter data is excluded for all EPs except those practicing predominantly at an FQHC or RHC where it is included as needy individual encounter data. EPs must meet the minimum patient volume thresholds based on encounter data attributable to Medicaid, and CHIP data where applicable, during the continuous 90-day period selected by the EP during the prior calendar year.

For EHs, a Medicaid encounter includes services rendered to a patient per inpatient discharge or emergency room services rendered in any single day.

DCH will utilize provider attestations for Medicaid patient volume calculations. Although provider attestations will be the initial step, DCH will also review and verify (or reject) patient volume in the following manner:

- For EPs, DCH will monitor EP attestations of Medicaid patient volume by utilizing FFS and managed care encounter claims data from the MMIS to estimate the time spent on Medicaid patients. The findings from the analysis of claims data will be compared to attestations to assess the reasonableness of the attestations. Significant discrepancies between the claim analysis and attestation information will be investigated, and additional audit procedures may be conducted to verify the accuracy of the provider's attestation. These procedures may include audits of provider documentation and records.
- For EHs, cost report information will be reviewed and compared to attestation information to assess the reasonableness of the attestation. DCH will utilize Medicaid discharges and total discharges from cost report worksheet S-3, Part I for this verification. DCH is in the process of compiling an electronic database of hospital cost reports that will be utilized for hospital eligibility verification and payment calculations. MMIS claims data may also be used to monitor and validate (or reject) Medicaid discharges from attestations and cost reports.

### July 2011 Update for Patient Volume:

We understand that CMS is considering a modification that would allow CHIP patient encounter data to be included in the Medicaid patient volume threshold calculations. In that event, DCH would revise this section of the SMHP. Otherwise, Georgia's Children's Health Insurance Program is separate from the Medicaid program, which creates the following challenges for both EPs and EHs:

1. DCH issues one ID card for Medicaid and CHIP members regardless of whether a member is Fee-for-Service (FFS) or enrolled in managed care. It should be noted, that eligible Medicaid and CHIP members awaiting enrollment in managed care (in choice period) are considered fee-for-service members.
2. For FFS members, providers/hospitals verifying member eligibility may be aware that a patient is actually a CHIP patient but this information may not be updated or stored in the provider's billing or payor records. As far as the provider/hospital is concerned, the patient is a Medicaid member.
3. Georgia has over 1M members enrolled in Georgia Families, our Medicaid managed care program. We have three contracted Care Management Organizations (CMOs) and each CMO also issues its own ID card. When a CMO member presents to a provider's office or hospital, the member's CMO card is used to confirm eligibility. While the CMO does make a distinction between Medicaid and CHIP members, the provider/hospital may not update or store this information in billing or payor records. As with the example above, as far as the provider/hospital is concerned, the patient belongs to a CMO, which means Medicaid.

Many of the larger pediatric/pediatric specialist practices do differentiate CHIP patients, especially those affiliated with pediatric hospitals. However, DCH estimates that approximately 50% of Medicaid physician and hospital providers do not distinguish CHIP patients from Medicaid.

We know that the Medicaid incentive program and upcoming statewide copayment changes will cause providers to modify workflows and business practices so that they will begin tracking CHIP members. Until that time, DCH is concerned that providers will be attesting to incorrect patient volume information during Georgia's registration and attestation process. It is for this reason that DCH proposes the implementation of CHIP discount factors, based on historical claims data, that providers can use to adjust Medicaid patient volume if those providers are unable to distinguish CHIP patients from Medicaid patients.

### **Pre-Payment Audits**

As stated in Section C of the SMHP, DCH conducted an analysis to pre-qualify those Eligible Professionals (EPs) and Eligible Hospitals (EHs) that potentially

met the patient volume criteria. Fee for service and managed care encounter claims data will be used in the pre-qualification process. The baseline information in this qualification step will be used during the provider registration process to determine significant variances between the DCH calculation and the data submitted by the EP and EH. DCH is integrating the Medical Assistance Provider Incentive Repository (MAPIR) with the Medicaid Management Information System (MMIS) to process state-level provider registrations. The MAPIR pre-payment audit features include the following:

1. MAPIR will verify provider eligibility in MMIS, sanctions and licensure, capture provider type, hospital-based status, declaration of adoption, implementation and upgrades (AIU), submission of a valid CERT number and patient volumes.
2. MAPIR presents the user with questions regarding their practice, time frame for which they are submitting patient volumes, and identification of at least one location for utilizing certified EHR technology.
3. At the end of the registration process, MAPIR requires providers to complete attestation with a digital signature.
4. After MAPIR calculates the payment request, a manual review will be conducted to ensure that the payment is valid. Details of the manual review are displayed below:

### **July 2011 Update for Pre-Payment Audits:**

Prior to registration and attestation at the state level, DCH will require all Eligible Professionals to complete the patient volume calculator and Eligible Hospitals to complete the patient volume and incentive payment calculator. The finalized calculators must be uploaded to the provider's application during the attestation process. DCH will work closely with Eligible Professionals to answer questions and assist with completion of the calculators. For Eligible Hospitals, DCH will meet with each hospital to finalize the patient volume and incentive payment calculations prior to the state level registration and attestation. The Department believes these steps will help minimize some of the pre-payment review steps once the provider initiates the application process.

DCH has also developed a set of tools to expedite the pre-payment review process. DCH created multiple databases, which are an accumulation of information including paid claims histories utilizing fee-for-service and managed care encounter claims, and other information, summarized in formats as needed to conduct the reviews. These databases will allow a Payment Specialist to quickly assess a provider's eligibility to participate in the Medicaid EHR incentive program after the provider's identification has been successfully matched in MAPIR.

The databases created include, but are not limited to:

- Pre-qualification list to identify potential EHs and EPs

- Applications received to date by provider ID and participation year
- EP - Paid Medicaid claims with CHIP encounters
- EP - Paid Medicaid claims without CHIP encounters
- EP - CHIP encounters
- EP CHIP Factors
- EP encounters by predominant county (for CHIP calculation purposes)
- FQHC/RHC Qualification list including a list of EPs who practice predominately at that location (in development)
- Pediatricians
- Hospital-based providers
- Providers associated by Medicaid payee ID, Tax ID, and/or financial relationship who may potentially decide to participate as a group practice in the Medicaid EHR incentive program.

These databases can be queried to extract information based on a provider’s specified 90-day period, fiscal year, or calendar year. Additional databases will be created as the need arises. The purpose for creating and maintaining these databases is to quickly determine whether a provider’s assertions are reasonable and consistent with paid claims history, and whether a provider may be eligible for Medicaid EHR incentive payments.

Table 1 below describes the procedures to be performed during a pre-payment review and the acceptable variances between self-reported amounts and the various databases listed above. If a variance exceeding the acceptable range exists, DCH may suspend the incentive payment until the difference can be resolved in an acceptable manner. The tolerable variances listed in the table below are only for the purposes of determining if incentive payments should be made before additional review procedures are performed.

The Office of Health Information Technology and Transparency has reorganized its staffing structure to adequately support the Medicaid EHR Incentives Program, including support of pre-payment audit process.

**Table 1 – Pre-Payment Audit Process**

Pre-Payment Review		
Procedures	Reference/ <i>Database</i>	Tolerable Variance
<b>(Both EHs and EPs)</b>		
Confirm reported Medicaid utilization meets minimum requirements for the provider type	CMS Final Rule; <i>Pediatricians; EPs, including Physician Assistants, practicing predominately in an FQHC/RHC; Hospital-Based Providers</i>	Reported percentage should be at or above minimum requirements by provider type
Determine if the provider previously applied for and was denied an incentive payment	<i>Applications received to date</i>	N/A
Confirm continuous 90-day period is	CMS Final Rule	None

## 2010 STATE MEDICAID HIT PLAN V.1.0

Pre-Payment Review		
Procedures	Reference/Database	Tolerable Variance
within acceptable year.		
Confirm the provider utilized the correct CHIP Factor when the provider cannot distinguish CHIP encounters	<i>EP CHIP Factor; EP encounters by predominant county</i> <b>Note:</b> CMS guidance may change the need for a CHIP factor	None
<b>Procedures (EHs)</b>		
DCH and its consultant, Myers and Stauffer, will meet with each Eligible Hospital (EH) to finalize the EH's patient volume (if applicable) and incentive payment calculation prior to the EH's registration and attestation at the state level.		
<b>Procedures (EPs)</b>		
Confirm eligible professional is an allowable provider type	<i>Pre-qualification list; Hospital-based Providers; EPs, including Physician Assistants, practicing predominately in an FQHC/RHC; Pediatricians; Providers associated by Medicaid payee ID</i>	Exceptions will be reviewed on a case by case basis.
Medicaid Patient Volume Numerator (locations for which the provider will adopt, implement, upgrade EHR) - Compare reported amounts to query results for:		
Fee-for-Service encounters	<i>Paid Medicaid claims with or without CHIP encounters; CHIP encounters; Dually-eligible encounters; Providers associated by Medicaid payee ID; EPs, including Physician Assistants, practicing predominately in an FQHC/RHC</i>	15%
Managed care encounters (by each Care Management Organization)		15%
CHIP encounters		15%
Dually-eligible encounters		15%
Out-of-State Medicaid volume (only if Out-of-State Medicaid volume is required to meet the threshold requirements)	<i>Out-of-State Survey Results</i>	15%
Compare % of Medicaid (or Total Needy Individual) utilization on Prequalification list (annual basis) to % of Medicaid (or Total Needy Individual) utilization reported for the 90-day period.	<i>Prequalification list</i>	15%

### FQHC / RHC Practices Predominantly

EPs at FQHCs and RHCs must meet the criteria for predominantly practicing (over 50 percent of total patient encounters occurring over a period of 6 months at an FQHC or RHC) and have at least 30 percent needy individual patient volume defined as individuals receiving care under Medicaid (Title XIX) or CHIP

(Title XXI), or provided uncompensated care by the provider or those individuals for whom care is provided at either no charge or reduced charges based on the individuals' ability to pay. EPs at FQHCs and RHCs are not subject to the hospital-based provider limitations.

EPs practicing at FQHCs & RHCs must attest to the requirements referenced above, during the state registration and attestation process. On a pre-payment basis, DCH will determine whether the provider meets the patient volume by utilizing Medicaid and CHIP claims and encounter claims data. As part of the state's audit plan, DCH will review and audit claims and encounter claims data on a post-payment basis.

### July 2011 Update for FQHC/RHC Practices:

CMS is aware that most states are unable to verify that an Eligible Professional is practicing predominantly at a FQHC or RHC. In fact, the SMHP and I-APD Community of Practice have identified this subject as a key topic for upcoming meetings. Georgia is similarly challenged since the FQHCs/RHCs in Georgia bill for services rendered and DCH or the Care Management Organizations pay the FQHC/RHC directly. Georgia has an enrollment listing of all FQHCs/RHCs and the clinical staff approved to practice at each location, but the FQHC/RHC claim does not identify the physician or Physician Assistant rendering the service. It should be noted that providers are required to attest during the state level registration process that they are practicing predominantly at an FQHC or RHC.

In conjunction with Myers and Stauffer, DCH utilized pharmacy claims associated with a FQHC/RHC office visit and tracked provider data by the provider's DEA number. Unfortunately, every FQHC/RHC office visit does not result in a prescription and our results are incomplete. DCH has also utilized the Uniform Data System (UDS) reports that all FQHC grantees must submit annually to HRSA. Unfortunately, the UDS reports do not report providers by name or an identification number but rather by type. If there is more than one provider in a provider type category, DCH is unable to identify a specific physician or Physician Assistant.

DCH continues to explore methods to confirm that an Eligible Professional is practicing predominantly at a FQHC or RHC. Guidance from CMS or other states participating in the CoP Community for SMHPs and IAPDs may provide DCH with a more successful approach.

### **Verification of Adoption, Implementation or Upgrade of Certified EHR Technology**

To qualify for a Medicaid incentive payment in the first year, eligible providers must attest that they are adopting, implementing or upgrading (AIU), or

demonstrating meaningful use. AIU activities have been defined by CMS as follows:

- **Adopt:** Acquired or purchased certified EHR technology;
- **Implement:** Installed or commenced utilization of certified EHR technology;  
or
- **Upgrade:** Expanded certified EHR functionality or upgraded to certified EHR technology.

DCH will utilize provider attestations as the initial data source for determining that the EHR technology is certified. Attestations will contain the product name and the unique ONC certification number for the certified EHR technology software or module. The certified number must match a product number on the ONC CHPL (Certified HIT Product List). DCH will require providers to provide evidence of AIU at the time of enrollment in the incentive program by requiring submission of a copy of a signed contract or purchase order with an EHR vendor for the certified EHR product at issue. DCH will inform providers that they should maintain the original documentation for audit purposes. To ensure that the provider is meeting requirements for certified EHR technology, DCH staff will verify the EHR product name and certification number with CHPL. DCH will conduct manual checks with CHPL until such time that ONC has developed and implemented the web-based interface allowing states to automate the matching process.

The provider's attestation to AIU of certified EHR technology and the supportive documentation will serve as evidence in the support the provider's attestation for meeting the AIU requirements. Both attestations and the certified EHR technology evidence will be subject to audit or review.

### July 2011 Update for Verification of Adoption, Implementation or Upgrade of Certified EHR Technology:

Eligible Professionals and Eligible Hospitals will be required, as part of the state level registration and attestation process, to verify the adoption, implementation or upgrade (AIU) of a certified EHR system by uploading documents supporting AIU. The following is a list of documentation that will be acceptable for verifying AIU:

#### **For adoption:**

- Receipts from EHR software vendors
- sale contracts
- license agreements
- service performance agreements
- data use agreements

### **For implementation:**

- Work plans
- Cost reports

### **For upgrade:**

- Receipts from EHR software vendors
- sale contracts
- license agreements
- service performance agreements
- data use agreements

Other reasonable substantiating documents may be acceptable. This documentation is considered auditable and must be maintained by the Eligible Professional or Eligible Hospital for a period of six (6) years.

Our MAPIR application will provide an interface with CHPL directly importing the certification number associated with their certified EHR technology. Georgia requires providers to attest to the certification number within the MAPIR application. Georgia will also use this function within MAPIR to facilitate reverse match auditing.

### **Meaningful Use**

After DCH completes the AIU processing and payments in 2011, DCH will modify the EHR incentive processes, as needed, for the purpose of verifying meaningful use. Although DCH will require attestations for the demonstration of meaningful use, DCH has not yet determined the method or the manner for receiving meaningful use documentation from providers (e.g., clinical data in flat files). Further, DCH has not yet defined the audit requirements for meaningful use in 2012 or made the decision to move the four public health related objectives from the menu set of meaningful use measures to the core set. At this time, DCH does not intend to propose any changes to the meaningful use definition. DCH will be able to provide updates on meaningful use documentation, and the public health related measures in the next version of the SMHP.

### **Systems Modifications and Timelines**

#### **IT System Changes Required for Incentives Program**

DCH systems, including those used by IT, Financial Management, DMAP, and Communications, will be involved in critical aspects of the Medicaid EHR Incentives Program.

- DCH IT and OHITT, including supporting contractors, will support the development and implementation of R&A interfaces, and installation of MAPIR

- DCH Financial Management, IT, and OHITT will support the R&A and MMIS interface development, as well as disbursement of incentive payments
- Communications and OHITT provider outreach staff are responsible for supporting outreach efforts and electronic communications
- Communications and OHITT staff are responsible for the development and implementation of a HIT website with all of the key incentive program information.

### **Timeframe for IT**

On November 1, 2010, DCH converted its Medicaid Management Information System (MMIS) and the new MMIS vendor is Hewlett Packard Enterprise Systems (HP). For this reason, DCH does not expect to fully utilize the MMIS in the administration of the incentive program until a later date. As stated earlier, DCH intends to utilize the web-based MAPIR product to support the Medicaid incentive program through 2011. Due to the fact that the MMIS is in transition it is not possible to determine when an MMIS I-APD will be submitted and DCH is unable to estimate a timeframe for systems modifications.

DCH is scheduled to participate in the Group 2 interface testing with the CMS Registration and Attestation System (R&A) beginning in the early months of 2011. DCH will launch its Medicaid incentive program after the completion of successful R&A and state connectivity testing, which is targeted for January-March 2011. As a result of this MMIS conversion timetable, DCH has evaluated alternatives for administering the EHR incentive program, including activities associated with the R&A interfaces, provider eligibility verification, pre-incentive payment validation, incentive payment workflows and post-payment audit functions. None of these options will adversely affect DCH's commitment to a successful MMIS transition and certification process.

CMS and multiple federal contractors are still developing the R&A in order to allow providers to register for EHR incentive payments. DCH recognizes that it must support the provider application process, verify provider eligibility and, when appropriate, make EHR incentive payments to providers. Based on the complexity of the provider application and verification processes, DCH has decided to join the multi-state collaborative led by the Commonwealth of Pennsylvania's Office of Medical Assistance Programs and HP. At the time of this SMHP, thirteen states with an HP MMIS are working together with HP to develop a core application that will interface with the R&A as well as individual states' MMIS to support the provider application process and to generate Medicaid incentive payments. The HP module is known as the Medical Assistance Provider Incentive Repository (MAPIR) and is a web-based application designed with the following functionality:

- Interface with the R&A

- Eligibility Verification and Notification
- Eligible Professional or Eligible Hospital Attestation
- Incentive Payment Calculation and Distribution
- Appeals Tracking
- User Interface for state personnel (or contractors) to be able to view, monitor and support payment applications submitted by providers
- Provider portal to view and validate R&A data and register and attest through submission of application.

On November 15, 2010 Georgia joined the multi-state MAPIR collaborative as the thirteenth state and to use MAPIR to support the EHR incentives program. Descriptions of the payment workflows are described in Section C but will be further updated in future versions of the SMHP as the MAPIR application is developed and revised, and DCH determines its customization needs. DCH will address the customization of MAPIR for Georgia's specific requirements in the Implementation Advanced Planning Document (I-APD). A critical customization will be the mechanism for making approved incentive payments. Due to the apparent success of Georgia's MMIS conversion in its first month of operation, DCH intends to leverage its MMIS to make the incentive payments once the MMIS is certified by CMS. DCH's payment workflow will then utilize MMIS for payments.

Another advantage of the multi-state collaborative and the MAPIR application is the approach for testing with the R&A prior to implementation by individual states. CMS has agreed that once the MAPIR application has performed successful R&A interface testing, all states included in the collaborative will receive approval for interface testing. CMS has indicated that R&A testing for Group 2 states will occur between January and March 2011. After the successful completion of testing MAPIR with the R&A, states within the MAPIR collaborative are then responsible for testing their own connectivity with the R&A. As MAPIR development proceeds and Georgia identifies its customization requirements and associated implementation timeline, DCH will be able to provide updates on the customization requirements in the next iteration of the SMHP.

### **Website and Assistance for Medicaid Providers**

DCH has deployed a website for use by providers at [www.dch.georgia.gov/ehr](http://www.dch.georgia.gov/ehr). This site contains the most current information on the Georgia Medicaid EHR Incentive Program. The site includes information on eligibility and registration in addition to links to other sites that provide important information on the incentive program. DCH has established an e-mail box for provider questions. The mailbox is monitored throughout the day and questions are routed to the appropriate resource. Frequently Asked Questions (FAQs) will be posted on the website. In addition, DCH plans to establish a hotline for provider questions. A complete

description of DCH's communications and outreach efforts can be found in Appendix D of this document.

### **Medicaid Provider Appeals**

DCH intends to work with Medicaid providers to alleviate the need for appeals. DCH anticipates that Medicaid providers will have questions and concerns relating to program eligibility, calculations of Medicaid patient volume thresholds, documentation that providers must submit to prove the adoption, implementation, or upgrading of certified EHRs, calculations of payment amounts, and adverse audit results. With the exception of adverse audit results, DCH expects to make available an informal review process to provide assistance to providers with respect to these issues and other related concerns.

To expedite the payment process for authorized incentives, to minimize the number of provider appeals and to enhance transparency in the administration of the program, DCH intends to approach the estimated payment calculations as follows:

#### *Eligible Professionals*

Identifications of potentially likely EPs have been completed. DCH intends to notify these professionals of possible eligibility for incentive payments and to inform them with respect to patient volume calculations, including the continuous 90-day reporting period, the attestation requirements, and the exclusion of CHIP patients where applicable. DCH believes that this outreach effort will reduce the number of appeals sought by EPs.

#### *Eligible Hospitals*

Similarly, calculations have been completed for the estimated incentive payment for each hospital in Georgia. DCH intends to share this information and the calculation template with each acute care, children's and critical access hospital regardless of whether the Medicaid eligibility threshold is met. In the interest of transparency, DCH believes that expectations regarding incentive payments, and potential issues or eligibility questions can be addressed prior to R&A registration. DCH anticipates that this approach will greatly reduce the number of hospital appeals. The State HIT Coordinator has already advised hospital leaders and hospital associations of this approach and it will be further communicated in upcoming webinars with hospital providers.

#### *Appeals Generally*

There shall be a panel of Administrative Hearing Officers appointed by the Commissioner. Appeals shall conform and be comparable to the process and procedures that apply to State Medicaid provider appeals set forth in Chapter 500 of the Manual entitled "Part 1, Policies and Procedures for Medicaid/Peachcare for Kids™" and codified by statute at O.C.G.A. § 50-13-19. The failure to comply with the requirements as set forth below shall result in the waiver of appellate rights.

### *Initial Review Process*

1. A Medicaid provider shall request initial review of the decision to deny eligibility for an incentive payment or the decision as to the amount of an incentive payment within thirty (30) days of such by submitting a written inquiry to the following address:

Georgia Department of Community Health  
DCH Medicaid Incentive Program  
2 Peachtree Street NW  
32<sup>nd</sup> Floor  
Atlanta, Georgia 30303

Attn: Medicaid Incentive Program

2. DCH will issue an initial review determination within thirty (30) days after the request for initial review. The initial review determination shall be in writing.

### *Review by an Administrative Hearing Officer*

1. A provider shall have thirty (30) days from the date of the initial review determination to request administrative review by a hearing officer of the initial review determination. Administrative review shall be completed, if not waived by the Medicaid provider, at the earliest practical date.

- A. For a Medicaid provider to obtain administrative review, a written request must be filed with DCH at the address above. The request must include all grounds for determination and must be accompanied by all supporting documentation and explanation that the provider wishes the Division to consider. Letters requesting administrative review that are not accompanied by supporting documentation will not be accepted or considered.
- B. In cases involving an audit of a provider, any documentation submitted for administrative review may, at DCH's discretion, subject the case, in whole or in part, to re-audit.
- C. Request for administrative review resulting from audits by the

Program Integrity Unit or an outside auditor, unless otherwise instructed in the initial review letter, should be forwarded to the following:

Georgia Department of Community Health  
Program Integrity Section  
2 Peachtree Street NW  
Atlanta, Georgia 30303

2. The failure to comply with the requirements of administrative review, including the failure to submit all necessary documentation within 30 days, shall constitute a waiver of any and all further appeal rights, including the right to a hearing.
3. Whenever the opportunity for administrative review is available to the Medicaid provider, the administrative review process must be completed in order for a provider to be entitled to a hearing. Issues at a hearing are limited to those issues that were brought through the administrative review process.
4. A request for hearing must be in writing and received by the Division within fifteen (15) business days after the date on which the provider received the decision of the Division that is the basis for the appeal. The request for hearing must include the following information:
  - A. A clear expression by the provider or the provider's representative that a hearing before the administrative hearing officer is being sought.
  - B. Identification of the adverse administrative review decision or other Division action being appealed and all issues that will be addressed at the hearing.
  - C. A copy of the review decision or Division action at issue.
  - D. A specific statement explaining why the provider believes the administrative review decision or other Division action is wrong.
  - E. A concise statement of the relief sought.
5. For purposes of determining the timeliness of a request for a hearing by the administrative hearing officer, the computation of any period of time shall begin with the first day following the date on which the Medicaid provider received the decision that is the basis for the appeal.

*Review by the Commissioner*

Any party may petition the Commissioner for a review of the hearing officer's decision within ten (10) days from the date of that party's receipt of the decision on appeal.

- A. If any party fails to appeal the initial decision of the hearing officer within the time authorized to do so, the party shall have waived all rights to further review or revision of that decision.
- B. If a party requests a record of the proceedings, after receipt of the initial decision by the hearing officer, that party shall have an additional five (5) days from the date of the receipt of the record in which to submit a written statement of legal or factual errors. However, a request for a record shall not in any manner lengthen the time of ten (10) days from receipt of the decision in which a petition for review must be submitted to the Commissioner.

### *Appeal of the Commissioner's Decision*

Any party adversely affected by a final decision by the Commissioner may seek review of such final decision by filing a Petition for Judicial Review in the Superior Court of Fulton County. Such appeal shall be by petition which shall be filed in the Clerk's Office of such court within thirty (30) days after service of the final decision of the Commissioner. Such appeal shall be held in accordance with O.C.G.A. § 50-13-19. Such an appeal is available **only** upon exhaustion of all applicable administrative remedies.

### **Oversight of FFP Funding**

DCH will implement the appropriate accounting processes and controls to ensure that Federal funding for incentive payments and HIT administrative activities are accounted for separately. For financial reporting and accounting purposes, separate accounts will be established to track costs and payments under the EHR incentive payment program. DCH staff who work on the HIE and incentive programs are required to track time for all activities. OHITT and Medicaid staff will require contractors working on the Medicaid Incentive Program to establish codes to accurately report activities on a project-specific basis. DCH Accounting and the OHITT financial analyst are responsible for generating reports for DCH's internal management and for submission to CMS.

### **Role of Agency Contractors**

DCH is not expecting current agency contractors to have a significant role in 2011 for the EHR Incentive Program. Beginning in 2011, DCH will contract with an outside auditing firm for the purpose of auditing all relevant processes to ensure payment accuracy and compliance with all processes.

### **Provider Registration, Verification, and Determination Process**

The Medicaid EHR Incentive Payment Process is detailed pictorially in Appendix E. Appendix E illustrates the flow of the provider registration process. The following tables provide a detailed summary of the EP and EH provider registration process. These tables answer questions on;

- Assignment of payments
- Voluntary participation by EP

**Note:** Georgia does not intend to disburse payment to providers through Medicaid managed care plans so that process is not included in this document.

Table 2 – Provider Registration Process

Action	System Modification
EP or EH successfully registers with the R&A (the R&A is able to validate all required data)	
DCH will receive daily batch file from the R&A via interface with DCH	<b>July 2011 Update:</b> DCH building interface between MAPIR and CMS R&A
Upon receipt, DCH will automatically validate the R&A file to match to DCH provider file records and to ensure provider applicant meets all eligibility requirements: <ul style="list-style-type: none"> <li>• Eligible Professional type (physician, nurse practitioner, certified nurse midwife and dentist). Physician Assistants are not eligible to participate in Georgia</li> <li>• Eligible Hospital type (acute care, critical access and children’s hospitals)</li> <li>• Licensure, active Medicaid status and sanctions will be verified</li> <li>• DCH will all verify the correct state code and duplicate payment</li> </ul>	
Error reports will be created for internal review as needed	<b>July 2011 Update:</b> DCH building interface between MAPIR and CMS R&A
Daily batch files will be sent to the R&A rejecting (with reason codes) or confirming provider registration	
If a provider applicant is successfully registered, DCH will use the email and contact information provided by the R&A to notify the applicant of the state application process and required attestations and documentation. DCH will also advise the provider of the projected payment timeframes and the TIN provided by the R&A for payment. Note: if DCH determines the provider does not have access to the DCH portal, the applicant will be given instructions for setting up access prior to registration with DCH.	
If a provider applicant fails registration, DCH will send a written notification, via email, with the reason for ineligibility. The notification will include details on the provider appeals and steps for submitting an appeal. Further, applicants will be notified that any updates to the R&A registration information must be made through the R&A.	
<b>Note:</b> DCH will store all of the provider registration data: <ul style="list-style-type: none"> <li>• Through the portal and MAPIR, DCH wants to ensure provider view capability to provider data received from the R&amp;A.</li> <li>• Further, it is imperative that DCH stores payee TIN from the EHR incentives program applicant separately from the current provider payment information in the provider file.</li> </ul>	

Table 3 - Provider Verification and Determination Processes

Action	System Modification	Provider Attestation
<p>Provider applicants must have access to the DCH portal and the MAPIR application. For applicants without access, including any out-of-state providers, DCH will send instructions to the provider via email.</p>		
<p>The EP or EH applicant must enter the portal to confirm the R&amp;A registration information:</p> <ul style="list-style-type: none"> <li>• Provider Name</li> <li>• Provider Type (based on HITECH listing)</li> <li>• Business Address/Phone</li> <li>• Email and contact information</li> <li>• NPI</li> <li>• CCN (for EHs)</li> <li>• Personal TIN (for EPs)</li> <li>• Payee Legal Entity Name</li> <li>• Payee TIN</li> <li>• Payee Address</li> <li>• Program choice (Medicare/Medicaid, plus Dual for EHs)</li> <li>• State selection (if Medicaid)</li> <li>• Confirmation number</li> </ul>	<p>MAPIR</p>	
<p>All provider applicants must respond “Yes” to the following inquiries or the application will be suspended or denied (DCH has to finalize process):</p> <ul style="list-style-type: none"> <li>• Confirmation of R&amp;A registration information</li> <li>• Confirmation that EP applicant is only pursuing payment from Georgia</li> <li>• Confirmation of no current or pending sanctions with Medicare or Medicaid in any state</li> <li>• Confirmation of compliance with HIPAA laws</li> <li>• Confirmation of license to practice (EP) or operate (EH) in Georgia</li> <li>• Attestation that supporting documentation is readily available for review at any time</li> </ul>	<p>MAPIR</p>	
<p>Applicant must indicate provider type:</p> <ul style="list-style-type: none"> <li>• The provider type must meet the HITECH requirements</li> <li>• If the provider type does not meet the requirements or doesn’t respond to the question, the application will suspend with a message to the provider</li> </ul>	<p>MAPIR</p>	
<p>The applicant must provide the unique ONC certification number for the EHR technology. If DCH does not have an automated interface with the CHPL list, DCH staff will manually verify the certification number. Enrollment application will be suspended or denied if the provider’s EHR technology is not included on the CHPL list.</p>	<p><b>July 2011 Update:</b> DCH building interface between MAPIR and</p>	

## 2010 STATE MEDICAID HIT PLAN V.1.0

Action	System Modification	Provider Attestation
	CMS R&A	
<p>Hospital based providers: applicant must answer yes/ no question as to location of services. If yes, the application will deny with an email to the provider and information on the appeals process. If no, an attestation is required.</p> <ul style="list-style-type: none"> <li>Audit review process: DCH will conduct review of applicant's claims and managed care encounter data to determine if 90% of services are provided in inpatient and emergency room settings (based on place of service codes). Based on outcome of the review, an incentive payment may be approved.</li> </ul>	MAPIR	<b>Yes</b>
<p>Applicant will be asked if an EP who is predominantly practicing at a FQCH or RHC (50% of time). If yes, the provider must provide an attestation and the following information:</p> <ul style="list-style-type: none"> <li>the 90-day consecutive period within the previous 12 months that the applicant is using to calculate patient volume (a pop-up calendar will be provided)</li> <li>Applicant must enter all service locations and the encounter volume for needy individuals (CHIP and uninsured) for the numerator.</li> <li>Applicant must provide total encounter volume information for the denominator (all service locations)</li> <li>The percentage will be calculated and used to determine the provider's eligibility</li> <li>If the provider does not meet the eligibility requirements, the application will be denied</li> <li>Note: EPs practicing predominantly in an FQHC or RHC are not subject to the hospital-based exclusion.</li> </ul>	MAPIR	<b>Yes</b>
<p>For all other EPs, the applicant must provide the following information:</p> <ul style="list-style-type: none"> <li>the continuous 90-day period within the previous 12 months that the applicant is using to calculate patient volume (a pop-up calendar will be provided)</li> <li>Applicant must enter all service locations and the Medicaid encounter volume for the numerator.</li> <li>Applicant must provide total encounter volume information for the denominator (all service locations)</li> <li>The percentage will be calculated and used to determine the provider's eligibility</li> <li>If the provider does not meet the eligibility requirements, the application will be denied</li> <li>EPs making application as a group practice level will follow the same process but must provide NPIs and associated encounter data for all participants.</li> <li>Note: Since EPs may not be able to exclude the CHIP patient volume from the numerator, DCH is considering a workaround, such as providing a CHIP member roster to</li> </ul>	MAPIR	<b>Yes</b>

## 2010 STATE MEDICAID HIT PLAN V.1.0

Action	System Modification	Provider Attestation
<p>providers.</p> <ul style="list-style-type: none"> <li>For out-of-state providers, DCH will work with SERCH states to develop processes for verifying patient volume. Applications for out-of-state providers may be suspended for review of encounter data.</li> </ul>		
<p>For EHs, the applicant must complete the hospital calculation template found in Appendix F.</p> <ul style="list-style-type: none"> <li>EH must attest to meeting requirements for Medicaid patient volume (except for children’s hospitals) and an average length of stay not greater than 25 days.</li> <li>If provider does not meet the eligibility requirements, the application will be denied.</li> </ul>	MAPIR	<b>Yes</b>
<p>The provider applicant must attest to adopt, implement or upgrade (AIU) of certified EHR technology, or meaningful use. Details on the definitions for AIU will be provided.</p> <ul style="list-style-type: none"> <li>DCH may require providers to submit copies of signed contracts, receipts or purchase orders as proof of AIU. If DCH doesn’t require such evidence at the time of application, the providers will be advised to retain the information in event of an audit.</li> <li>Note: DCH will provide additional information on how we process meaningful use attestations and supportive evidence in the next version of the SMHP.</li> </ul>	MAPIR	<b>Yes</b>
<p>All provider applicants must provide confirmation of voluntarily assigning the incentive payment to the payee TIN provided in the R&amp;A registration information. If the applicant does not provide confirmation, the application is suspended and an email is sent to the provider for additional information. If the provider wants to assign payment or change the assignment, the provider will be instructed to return to the R&amp;A.</p>	MAPIR	<b>Yes</b>
<p>The applicant will have an opportunity to confirm the R&amp;A registration information and all responses prior to completing the application. The provider may make any changes or edits at that time. If needed, a partially completed application may be saved so that the provider can return to the application at a later time without losing information.</p>	MAPIR	
<p>When the provider is ready to submit the application, digital signatures will be required for the provider applicant and preparer.</p> <ul style="list-style-type: none"> <li>Upon completion, DCH will send the provider applicant confirmation via email along with contact information</li> </ul>	MAPIR	<b>Yes</b>

### July 2011 Update for Provider Registration, Verification, and Determination Process:

The Medical Assistance Provider Incentive Repository (MAPIR) is a web-based application that supports the CMS Registration & Attestation (R&A) interfaces,

data exchanges and state requirements for determining eligibility, attestation, and issuing eligible provider incentive payments. MAPIR has components for both the provider end user and administrative user support. The core MAPIR application was designed by a multi-state collaborative, however, OHITT identified specific customizations related to instructional content, look and feel, branding, and email communications in order to improve usability and make the application process easy to use by Georgia Medicaid providers.

Once the Georgia Medicaid EHR Incentives Program is launched on September 5, 2011, MAPIR will be accessible by active Georgia Medicaid providers via the MMIS Web Portal. Providers must be authenticated into the web portal in order to access links navigating them into the MAPIR application.

MAPIR supports work flows associated with confirming eligibility for professional providers and hospitals, attestation requirements, suspending applications for additional review, pre and post-payment error reporting, updates that may be received from the R&A, appeals tracking, issuance of incentive payments, and data storage. The system has been designed to interface with MMIS for provider enrollment and claim information, to create transactions for payment within the MMIS and to store payment information within MAPIR. Customer support will be available via phone and email to address any Georgia Medicaid provider questions regarding the MAPIR application and overall incentive payment program.

**Provider Payment Frequency and Process**

As stated earlier in the SMHP, DCH intends to utilize its MMIS to make incentive payments. The following table provides the information on incentive payments to EPs and EHs for Year 1.

**July 2011 Update for Provider Payment Frequency and Process:**

The frequency of Georgia’s EHR Medicaid Incentive payments is **monthly**. Providers shall be paid within 30-45 days, on the last Thursday of each month.

**Table 4 - Payment Process**

Action	System Modification
DCH will interface with the R&A to search for duplicate payment history, exclusions, payments from other States, and payments from Medicare. <ul style="list-style-type: none"> <li>• DCH’s interface updates the R&amp;A and locks the applicant’s record so that, if DCH paid a provider for MIP, no other states will make MIP payments to that provider.</li> <li>• If the R&amp;A notifies DCH of an exclusion(s), the application will be</li> </ul>	MAPIR

## 2010 STATE MEDICAID HIT PLAN V.1.O

Action	System Modification
<p>suspended for review by Medicaid Provider Enrollment and DCH Program Integrity. The applicant will be notified via email of the reason for the suspension and next steps, including the provider appeals process.</p> <ul style="list-style-type: none"> <li>• If the R&amp;A notifies DCH of a prior payment (duplicate), the application for payment will be denied. The applicant will be notified via email to contact CMS.</li> </ul>	
If the payment is approved, DCH will notify the provider of the approval via email and the timeframe for payment.	MAPIR
DCH will calculate payments and verify that EP and EH patient volume requirements are met, as well as all other requirements for EHs and EPs.	MAPIR
DCH will re-verify the provider's Medicaid status and sanctions.	MAPIR
The financial information will be transmitted to MMIS to generate payment.	MAPIR
MMIS will generate an incentive payment via Electronic Fund Transfer (using the MMIS' provider enrollment file)	MAPIR
DCH will notify the R&A via the interface of the provider payment.	MAPIR
The provider will be notified via email of the incentive payment.	MAPIR

## Assumptions

### Role of CMS

DCH identified the following assumptions relating to the planning and implementation of the program:

- State budget constraints may impact timelines and staffing
- CMS will provide clear instructions and timely updates on the R&A and ICD requirements and revisions
- CMS will provide adequate support and conduct sufficient R&A testing that will allow Group 2 states to launch the program within the timeframes stated in this SMHP
- CMS will give timely feedback to DCH on the SMHP and I-APD for revisions and updates by DCH
- After launch, CMS will provide daily batch updates to DCH from the R&A.

### Status/Availability of Certified EHR Technology

DCH identified the following assumptions relating to the incentive program:

- DCH will identify a qualified CPA firm able to commit to carrying out responsibilities to be defined by DCH and on the schedule desired by DCH
- ONC will maintain and update the CHPL on a timely basis
- ONC will assist DCH in automating the interface for matching EHR data submitted by the provider applicant with the CHPL.
- Georgia providers will be able to use certified EHR, and EHR vendor support, in their geographic regions

### Role and Plans of the Regional Extension Center

DCH identified the following assumptions relating to the incentive program:

- The GA-HITREC continues to enroll providers in its program within the timeframes established by ONC
- The GA-HITREC will provide technical assistance toward a provider's adoption, implementation or upgrade of certified EHR technology
- The GA-HITREC will help facilitate providers' efforts to achieve meaningful use
- DCH and GA-HITREC will collaborate in provider outreach and education on the Medicaid EHR Incentive Program.

### Role, Approved Plans and Status of the HIE Cooperative Agreements

DCH identified the following assumptions relating to the incentive program:

- The State HIT Coordinator and the State Medicaid Director will continue to actively collaborate
- The State HITT Advisory Board will continue to provide advice and support to the OHITT.

DCH submitted its HIE Strategic and Operational Plans to the ONC on August 30, 2010 and has received some limited feedback from the ONC. DCH has provided supplemental information to the ONC.

## **Section D: Georgia's Audit Strategy**

**Methods to Identify Suspected Fraud and Abuse; Use of Audit Elements**

DCH intends to implement an audit strategy that ensures the integrity of the Medicaid EHR incentives payments. Audits and reviews will be conducted in a manner that appropriately focuses audit efforts, including risk-based procedures based on the assessment of risk factors, random sampling of some or all of the population, or audits/reviews of certain types of providers or categories of information. Other review procedures may involve reasonableness tests utilizing claims data or cost report data. Automated procedures will be implemented where appropriate.

DCH intends to leverage existing resources in its audit processes. The DCH Office of Inspector General (OIG) and its staff auditors and Program Integrity staff will manage the audits (in accordance with DCH Policy 630 Audit Coordination), in collaboration with the DCH HIT team. The audit functions have been designed by an independent audit and actuarial firm that DCH engaged for its expertise and familiarity with Georgia Medicaid. The HIT legal team, including two Special Assistant Attorneys General who are supporting HIT work, are providing legal review of the audit strategy, in order to provide another level of multi-disciplinary professional oversight. Operational work will be done by the OIG Program Integrity staff, with statewide scope and experience, supplemented as necessary and appropriate by additional project staff (projected to be one or two temporary positions) working under the direction of the OIG and qualified contract staff as needed.

After payments begin, DCH plans to conduct audits of the incentive payments, both pre- and post-payment on a continuous basis. DCH will utilize a risk-based audit approach by stratifying providers into different risk pools. Some incentive payment audits will take place at the physical location of the provider to whom the payment is designated (field audit), while other audits may be conducted at the office of the contracted auditors (desk review). Audits will be conducted according to standards promulgated by the American Institute of Certified Public Accountants (AICPA) and/or other protocols specific to the provider group or risk area. Some high risk pools will be selected for 100 percent review. Lower risk pools will be subject to random audits while high risk pools may be subject to 100 percent auditing. DCH intends to annually review the proposed audit approach to determine if new risk areas, not previously considered, have developed or if existing procedures are not sufficient to mitigate potential risks. DCH will use a stratified random sampling methodology as a part of the annual audit strategy. The overall sampling strategy will account for the volume of payments, number of providers, risk assessments, and materiality thresholds consistent with current DCH and Program Integrity audit and review procedures. Certain risk pools may be sampled at 100 percent. EHR-specific sampling procedures will be documented and refined no less than annually based on findings identified throughout the year.

**Payment Integrity Assessment**

Certain risk areas have been identified for pre-payment review. These include a review of excluded individuals and entities to determine if any providers are, or should be, excluded from participating in the program. DCH also will verify the providers' National Provider Identifier (NPI) and Tax Identification Number (TIN), provider type, and CMS Registration and Attestation System (R&A) status. DCH will review the providers' attestations for an assertion of adoption, implementation, upgrading, or meaningful use of certified EHR technology. Minimum documentation standards will be communicated to EPs and EHs enrolled in the incentives program. This documentation will be required and will be requested and reviewed for those selected for an audit. DCH will use existing fee-for-service and managed care encounter claim records submitted to the state's MMIS to monitor and validate asserted Medicaid patient volumes. DCH will also utilize existing hospital cost reports and other financial data submitted to verify payment eligibility or to validate EHR payments. DCH may consider additional sources of information not currently available for future implementation years, including the potential development of an EHR-specific cost-reporting mechanism. During this process, certain providers will be placed into the high risk pool and receive a greater chance of audit. New Medicaid providers will receive additional scrutiny.

DCH will also implement post-payment audit procedures. Audit procedures will be conducted continuously throughout program implementation. Providers receiving incentive payments will be stratified based on a risk assessment. Risk factors may include the possibility/likelihood of EHR funding from other sources, provider type, incentive payment amount, as well as other potential risk factors. Audits will be conducted via random sampling but the high risk stratum will receive a larger audit presence.

The scope of post-payment audits may include a review of acquisition costs, sources of income, patient volume, bad debts, meaningful use evaluations, clinical measures, other payment or grant offsets of EHR costs or other measurable and auditable requirements for receipt of an incentive payment by a provider. Actual audit volume, scope, and methodology will be based on the DCH's risk assessments and payment materiality. Some examples of those procedures placing a provider into the high risk pool include patient volumes at or just above the threshold, submitted patient volumes which do not coincide with information maintained in DCH's MMIS and provider expenses utilizing a significant volume of existing staff hours.

**Fraud and Abuse**

Under DCH's current scope of practice, DCH does not investigate fraud cases. DCH's Program Integrity unit currently has a process for handling potential or suspected provider fraud. If potential fraud is detected or suspected by the

Program Integrity Unit, Program Integrity staff meet with the Inspector General (IG) to discuss the case. If the IG agrees with the information presented by Program Integrity staff, the case is forwarded, in writing, to the Georgia Medicaid Fraud Control Unit (MFCU). The Georgia MFCU is located within the Georgia Office of the Attorney General and is responsible for investigating and ensuring the prosecution of Medicaid fraud by providers.

The MFCU, the IG, the Program Integrity Unit and any contracted service firm will all work closely together to coordinate data and information on potential or suspected fraud cases. DCH's Program Integrity Unit will also complete its procedure to allow for the initiation of the recovery of mispayments, suspension of future payments, the termination of provider agreements, or other action that may be necessary while the MFCU investigates the potential fraud. DCH may also notify State licensing boards, other State agencies and/or other units within DCH of the potential fraud if appropriate.

Depending upon the outcome of the investigations by the Program Integrity Unit and the MFCU, recoupments of mispayments may occur and will be tracked under the tracking procedures described above.

### **Payment Recoupment for Overpayments**

DCH has plans to develop a data warehouse containing all provider incentive payment data. DCH's goal is to integrate this data warehouse with the MMIS at some future date. Until that time, DCH will separately maintain this data.

In the event that DCH's oversight activities determine that payments have been made inappropriately, a recoupment process will be initiated to recoup the funds. For each inappropriate payment identified, DCH will track the mispayment amounts, dates of provider notification(s), recoupment amounts, interest amounts, appeal information, other correspondence with the provider, and any other details pertinent to the mispayment or recoupment thereof. DCH will utilize the data warehouse information to monitor the overpayments and recoupment.

As mispayments are recouped, the funds will be handled in accordance with applicable federal and state laws and regulations and, when appropriate, refunded to CMS via a CMS-64 adjustment. If appropriate, mispayments will be recouped by establishing accounts receivable in the MMIS for the provider and funds will be recouped from future claim payments to the provider. Accounts Receivable recoupment will be identified in the MMIS as Electronic Health Record Incentive Program recoupments. All recoupments via the MMIS or via direct provider repayment/refund will be reported in the data warehouse and quarterly reports from this data warehouse will be used when reporting to CMS and will reduce the amount of the provider incentive payment federal fund draw.

**DCH's Response to Fraud and Abuse**

Under DCH's current scope of practice, DCH does not investigate fraud cases. DCH's Program Integrity unit currently has a process for handling potential or suspected provider fraud. If potential fraud is detected or suspected by the Program Integrity Unit, Program Integrity staff meets with the Inspector General (IG) to discuss the case. If the IG agrees with the information presented by Program Integrity staff, the case is forwarded, in writing, to the Georgia Medicaid Fraud Control Unit. The Medicaid Fraud Control Unit is located within the Georgia Office of the Attorney General and is responsible for investigating and ensuring the prosecution of Medicaid fraud by providers.

**Leverage Existing Data Sources to Verify Meaningful Use**

DCH will leverage the clinical data submitted by EPs and EHRs, information stored in the data warehouse, and audit procedures to verify meaningful use. DCH is evaluating other data sources that may be leveraged, such as immunizations through the Georgia Registry of Immunization Transactions and Services (GRITS), e-prescribing data, and public health data.

**Sampling and Audit Strategy**

DCH may use a stratified random sampling methodology as a part of the annual audit strategy. The overall sampling strategy may account for the volume of payments, number of providers, risk assessments, and materiality thresholds consistent with current DCH and Program Integrity audit and review procedures. Sampling may also consider types of provider spending. Certain risk pools may be subject to one hundred percent audit. EHR-specific sampling procedures will be documented and refined no less frequently than annually based on findings identified throughout the year.

**Methods to Reduce Provider Burden and Maintain Program Integrity and Efficacy of Oversight Process**

To reduce provider burden and maintain the integrity of the oversight process, DCH plans to leverage existing fee-for-service and managed care encounter claim records submitted to the state's Medicaid Management Information System (MMIS) vendor to monitor and validate asserted Medicaid patient volumes. DCH plans to use existing hospital cost reports, disproportionate share hospital (DSH) payment reports and audits, and other financial data submitted to verify payment eligibility or to validate EHR payments. DCH may consider additional sources of information not currently available for future implementation years, including the potential development of an EHR-specific cost-reporting mechanism. When possible, DCH will combine existing and recurring audit programs so that

providers will not receive multiple audits. For example, utilizing existing resources from a different project, such as DSH audits, will reduce the burden on hospital providers.

**Program Integrity and Allocation of Payment Oversight**

The Medicaid Fraud Control Unit, the OIG, the Program Integrity Unit and any contracted service firm will work closely together to coordinate data and information on potential or suspected fraud or abuse cases. DCH’s Program Integrity Unit will also complete its procedure to allow for the initiation of the recovery of mispayments, suspension of future payments, the termination of provider agreements, or other action that may be necessary while the MFCU investigates the potential fraud. DCH may also notify State licensing boards, other State agencies and/or other units within DCH of the potential fraud if appropriate.

Depending upon the outcome of the investigations by the Program Integrity Unit and the Medicaid Fraud Control Unit, recoupment of mispayments may occur and will be tracked under the tracking procedures described above.

**Audit and Review Processes for Medicaid EHR Incentives Payments**

The following table presents a high-level overview of the steps DCH will take to mitigate erroneous payments, fraud, waste, and/or abuse in the determination of provider eligibility and the distribution of payments under the Medicaid Incentive Program. Systems and processes related to MAPIR are under development and have not yet been finalized as noted in brackets “{}”.

<b>Leg</b>	System/process not yet defined
*	Automated audit process
+	Manual audit process
#	Automated and manual audit

Table 5: Medicaid EHR Incentive Payment and Audit Processes

<b>Medicaid EHR Incentive Activity/Process</b>				
	Data Subject to Audit/Review	Audit/Review Definition	Audit/Review Process	
<b>1. Provider registration and eligibility</b>				
1.1	Provider NPI, CCN, TIN, payee NPI, and payee TIN from R&A registration	Identify mismatched provider data between R&A and State enrollment information	{State Portal} interface with {MMIS} to determine if data elements are mismatched	*
1.2	Provider properly licensed/qualified	Verify that providers are appropriately licensed and qualified	{State Portal} interface with {MMIS} provider enrollment information	*
1.3	EP is eligible practitioner type	Verify that EP is a physician, dentist, certified nurse midwife, or nurse practitioner. Physician assistants are not eligible in Georgia.	{State Portal} interface with {MMIS} to determine if provider is actively enrolled under appropriate specialty	*
1.4	Hospital is eligible hospital type	Verify that hospital is acute care hospital, critical access hospital, or children's hospital based on CCN	{State Portal} interface with R&A and {MMIS} to determine if hospital CCN falls in appropriate range	*
1.5	Children's hospital patient population	Verify children's hospital is predominantly treating patients under the age of 21	{State Portal} interface with R&A to verify provider attestation	*
1.6	Provider ineligible to receive payments due to Federal sanctions	Identify excluded/sanctioned providers per Death Master File and Federal OIG	{State Portal} interface with R&A to identify Federal sanctions	*
1.7	Provider ineligible to receive payments due to State sanctions	Identify excluded/sanctioned providers per information source	{State Portal} interface with Provider Enrollment file or manual review of State sanctions	#
1.8	EP election to participate in Medicare or Medicaid incentive programs	Verify EP elected to participate in Medicaid incentive program and is not participating in Medicare	{State Portal} interface with the R&A to verify provider election and identify if Medicare payments issued to provider	*

			for payment year	
1.9	Hospital election to participate in Medicare or Medicaid incentive programs	Verify if hospital elected to participate in the Medicare and Medicaid incentive programs	{State Portal} interface with the R&A to identify hospital election information	*
1.10	Dual-eligible hospital Medicare calculations	For hospitals eligible for Medicare and Medicaid incentive programs, verify that Medicaid calculations are recorded in {State Portal}	{State Portal} interface with the R&A and manual review of {State Portal} information for all dual-eligible hospitals	#
1.11	EP and EH election to participate in Georgia Medicaid incentive program	Verify that provider has elected to participate in Georgia incentive payment program	{State Portal} interface with R&A to verify provider election and identify if any other state issued MIP payment to provider for payment year	*
1.12	R&A changes reflected in {State Portal}	Verify that the R&A changes are appropriately reflected in {State Portal} at the expected frequency and within the expected time frame	Periodic manual review/testing of {State Portal} and R&A batch transmission process	+
1.13	{State Portal} changes reflected in the R&A	Verify that {State Portal} changes are appropriately reflected in the R&A at the expected frequency and within the expected time frame	Periodic manual review/testing of {State Portal} and R&A batch transmission process	+

<b>Medicaid EHR Incentives Activity/Process</b>			
Data Subject to Audit/Review	Audit/Review Definition	Audit/Review Process	

## 2. Provider attestations

2.1	EP attests he/she is not hospital-based	Verify EP is not hospital-based	Audit of MMIS FFS and managed care encounter claims data for previous fiscal/calendar year to verify that < 90% of services provided in inpatient hospital or ER setting (POS 21 and 23)	+
2.2	EP attests to Medicaid patient volume threshold	Verify EP meets the 30% volume Medicaid patient volume threshold (pediatricians may meet a lower threshold of 20%)	Annual audits (risk-based and/or random sample), including audit of provider records and/or audit of MMIS FFS and managed care claims data to validate attestation	+
2.3	Hospital attestation of average length of stay	Verify hospital has an average length of stay of 25 days or fewer	Annual audits (risk-based and/or random sample), including audit of cost reports and/or audit of MMIS FFS and managed care claims data to validate attestation	+
2.4	Hospital attestation of Medicaid patient volume threshold	Verify hospital meets the 10% Medicaid patient volume threshold except for a children's hospital	Annual audits (risk-based and/or random sample), including audit of cost reports and/or audit of MMIS FFS and managed care claims data to validate attestation	+
2.5	Provider identification of 90-day patient volume period	Verify provider selected an appropriate, representative 90-day period for patient volume threshold measurement for first payment year	Annual audits (risk-based and/or random sample), including audit of MMIS FFS and managed care claims data to validate attestation	+
2.6	Children's hospital attestation of patient population predominantly under age 21	Verify children's hospital is predominantly treating patients under the age of 21.	Annual audits of all children's hospitals, including audit of provider records and/or audit of MMIS FFS and managed care claims data to validate hospital	+

			attestation/records	
2.7	Provider attests to adoption, implementation, or upgrade (AIU) of certified EHR technology in first year	Verify provider demonstrated adoption, implementation, or upgrade of certified EHR technology	Annual audits of attestations (risk-based and/or random sample)	+
2.7.1	Audit of provider AIU attestation	Verify presence of documentation supporting AIU	Audits will focus on sufficient and appropriate documentation of AI//U	+
2.8	Provider attests to meaningful use of certified EHR technology in years other than first year	Verify provider demonstrated meaningful use of certified EHR technology	Annual audits of attestations (risk-based and/or random sample)	+
2.8.1	Audit of provider AIU	Verify existence of documentation supporting AIU	Audits will focus on sufficient and appropriate documentation	+
2.9	EP attests EHR technology is certified and provides product number	Verify product number matches certified EHR technology on CHPL	{State Portal} interface with CHPL to verify that product number for EHR appears as certified on CHPL .	*
2.10	EP assignment of payment			
2.10.1	Voluntary assignment	Assignment must be voluntary	Annual audits of providers assigning payments (risk-based and/or random sample)	+

<b>Medicaid EHR Incentives Activity/Process</b>			
Data Subject to Audit/Review	Audit/Review Definition	Audit/Review Process	

### 3. Pre-payment

3.1	Pre-payment verification of provider R&A registration	Verify provider R&A registration before payment is issued.	{State Portal} interface with R&A	*
3.2	Pre-payment verification of payee TIN	Verify payee TIN before payment is issued.	{State Portal} internal validation MMIS? and interface with R&A	*
3.4	Pre-payment verification of Federal and state exclusions/sanctions	Verify absence of sanctions before payment is issued.	{State Portal} internal validation and interface with R&A	*
3.3	Pre-payment verification of EP Medicare/Medicaid election	Verify EP has elected participation in the Medicaid program before incentive payment is issued.	{State Portal} internal validation and interface with R&A	*
3.5	Pre-payment verification of EP and EH's election to participate in Georgia Medicaid Incentive Program	Verify EP or EH elected participation in Georgia MIP before payment is issued.	{State Portal} internal validation and interface with R&A	*

<b>Medicaid EHR Incentive Activity/Process</b>			
Data Subject to Audit/Review	Audit/Review Definition	Audit/Review Process	

#### 4. Post-payment

4.1	Payment made to one TIN	Verify payment made to only one payee TIN	{State Portal} interface with {Payment System}. Annual audits (risk-based and/or random sample)	#
4.2	Payments recorded in {State Portal}	Verify payments are recorded in the state's incentives payment portal	{State Portal} interface with {Payment System}. Annual audits (risk-based and/or random sample)	#
4.3	Payments recorded in R&A	Verify payments are recorded in the R&A	{State Portal} interface with R&A. Annual audits (risk-based and/or random sample)	#
4.4	EP payments do not exceed Federally-mandated limits			
4.4.1	Payments to EPs (except for pediatricians with lower Medicaid patient volume)	Payments to EPs, other than pediatricians with Medicaid patient volume between 20%-29%, must not exceed \$21,250 in first year and \$8,500 annually for years 2-6 (cumulative total of \$63,750)	{State Portal} validation of internal MMIS payment history and interface with R&A payment history. Annual audits (risk-based and/or random sample)	#
4.4.2	Payments to pediatricians with Medicaid volume lower than EP Medicaid volume	Payments to pediatricians with Medicaid patient volume between 20%-29% must not exceed \$14,167 in first year and \$5,667 annually for years 2-6 (cumulative total of \$42,500)	{State Portal} validation of internal payment history via MMIS and interface with R&A payment history. Annual audits (risk-based and/or random sample)	#
4.5	Hospital payments amounts do not exceed Federally-mandated limits	Payments to hospital must not exceed 50% of aggregate incentive payment in one year and 90% of aggregate incentive payment in two years	{State Portal} validation of internal payment history in MMIS and interface with R&A payment history. Annual audits (risk-based and/or random sample)	#

4.6	Payments do not exceed calculated amount	Payments do not exceed calculated incentive payment for month/year	{State Portal} internal validation and interface with {Payment System}	*
4.7	No first payment made after 2016	EPs and EHs may not receive first payment after 2016; DCH intends to make EH incentive payments on a 3-year basis with 40% in the first year, 40% in the second year and 20% in the third year.	{State Portal} internal validation and interface with {Payment System} and R&A payment history.	*
4.8	Consecutive payments to hospitals after 2016	Payments to hospitals after 2016 must occur in consecutive years after 2016	{State Portal} internal validation and interface with {Payment System} and R&A payment history.	*
4.9	Mispayments			
4.9.1	Duplicate payments	Verify whether duplicate payments have been made	{State Portal} internal validation and interface with {Payment System} and R&A payment history. Annual audits (risk-based and/or random sample)	#
4.9.2	Payments to inappropriate TIN	Verify whether payments have been made to inappropriate payee TIN	{State Portal} internal validation and interface with {Payment System} and R&A payment history. Annual audits (risk-based and/or random sample)	#
4.9.3	Recoupment of inappropriate payments	Verify whether inappropriate payments have been recouped	{State Portal} interface with {Payment System} and R&A payment history. Annual audits (risk-based and/or random sample)	#

- Become familiar with effective strategies and best practices for selecting, adopting, implementing, upgrading, or meaningfully using EHRs in health care organizations
- Receive information about how to adopt, implement, upgrade or meaningfully use EHRs in health care organizations
- Receive information on how to access/acquire “just-in-time” technical assistance and support (post implementation) for their EHR system

## **SECTION E: GEORGIA'S HIT ROADMAP**

## Descriptions of Graphical and Narrative Pathways

DCH is deferring some of its long-term planning and benchmark development for HIT and HIE in order to focus on the immediate implementation requirements for the EHR Incentive Program, parts of the HIT Roadmap will be deferred. The strategy for achieving Georgia's long-term vision, goals, and objectives and the benchmarks and measures for assessing them over time will be discussed in a future iteration of the SMHP.

Also, it is important to note that the formation of a statewide HIE known as the Georgia Health Information Exchange, Inc. (GHIE) was officially announced on November 9, 2010. The details of the formal organizational structure for that public/private non-profit organization are still being finalized. DCH plans to discuss the details of the GHIE in a future version of the SMHP.

### Incentive Program Roadmap for 2011

<b>Activity</b>	<b>Estimated Date</b>
MAPIR Customization	01/02/11 - 02/28/11
MAPIR Testing with R&A	03/01/11 – 03/30/11
Development of payment system	02/01/11 – 4/30/11
Testing of payment system with MAPIR and R&A	05/01/11 - 05/30/11
Provider Outreach	11/01/10 – 11/30/11
Provider Registration with R&A	01/02/11 (begins)
Provider Registration with Georgia Medicaid	05/01/11 (begins)
Provider Validation	08/01/11 (begins)
Provider Payment	09/01/11 (begins)

### Expectations Concerning Provider Adoption Over Time

DCH expects EHR technology adoption by Medicaid providers in Georgia to steadily increase over time. This expectation is based on the affirmative responses received to DCH's recent survey of providers, the results of which were discussed in Section C. According to the statistical analysis of eligible hospitals and eligible professionals performed by Myers & Stauffer at DCH's request, the following EHs and EPs are projected as eligible for incentive payments. These projections assume that program participants will be able to show that they adopted, implemented or upgraded certified EHRs and can meet all other applicable criteria.

<b>Eligible Hospitals</b>	<b>Projected Participation in MIP in 2011</b>		<b>Percentage of Total</b>
Acute Care	106	61	57.55%
Children's	2	2	100.00%
Critical Access	34	13	38.24%
<b>Eligible Professionals #</b>	<b>Projected Participation in MIP in 2011</b>		<b>Percentage</b>
Physicians	19,813	3,006	18.59%
Nurse Midwives	188	37	19.68%
Nurse Practitioners	2,853	81	2.84%
Dentists	1,025	219	21.37%
Pediatricians	N/A	678	N/A

**Annual Benchmarks for Goals**

For the first year of participation, the following benchmarks for each of DCH's goals should function to serve as measurable indicators of progress. As previously stated, DCH expects to discuss the long-term objectives, benchmarks and measures in a future version of the SMHP

<b>Goal</b>	<b>Objective</b>	<b>Measure</b>	<b>Benchmark</b>
Georgia providers adopt, implement or upgrade certified EHRs	Increase provider awareness of program	Number of Medicaid providers receiving incentive payments by type	Assess by survey
	Increase outreach and training for EPs and EHs		Assess by survey and feedback from professional organizations
Create payment and audit infrastructure	Design procedures to manage payment and audit functions	Proper and timely payments made Calculations verified and validated by audit process	Assess by survey and feedback

**Annual Benchmarks for Audit and Oversight Activities**

As discussed in Sections C and D, the incentive payment process will require interface with the R&A, MAPIR (the core elements of that system), and customization of the payment process by DCH. During the first year of administering the program, DCH plans to use a combination of random and non-random audits. Section D above describes both the audit and oversight processes for the first year in considerable detail. As those processes evolve and are fine-tuned, DCH expects to provide updates to the audit and oversight activities in future versions of the SMHP.

## **APPENDIX A: EHR Adoption by Provider and Vendor Type**

## EHR Adoption by Provider Type and Vendor Type

Provider Type	Vendor Type	Number of Installations
<b>Acute Care Hospitals</b>	Meditech	9
	CPSI	5
	Cerner Millennium Product Suite	3
	McKesson	3
	Siemens Soarian	3
	Meditech CS 5.64	2
	McKesson Paragon, McKesson Horizon Patient Folder	2
	Cerner	1
	Cerner – Millennium (for hospitals)	1
	Cerner Millennium	1
	Eclipsys	1
	Eclipsys, NextGen	1
	EMDS-EHR	1
	EMSTAT	1
	GE-Centricity	1
	Healthcare Management Systems	1
	LSS Data Systems – MPM	1
	McKesson for IPs/AllScripts for Ambulatory	1
	Meditech Magic 5.64	1
	MEDITECH PCM (Physician Care Manager), part of ACS (Advanced Clinical Systems) Suite for inpatient care; AllScripts for ambulatory care at our clinics	1
Meditech/eClinicalWorks/AllScripts	1	
Moving from CPSI to McKesson Paragon	1	
NextGen and GEMMS	1	
Siemens; NextGen	1	
<b>Children's Hospitals</b>	EPIC (CPOE, Clinical Documentation, Inpatient, Ancillary (Radiology, Pharmacy, Surgical Services, Revenue Cycle)	2
<b>Critical Access Hospitals</b>	Health Management Systems (HMS) Patient Care including Electronic Medication Administration, Clinical View, Scheduling, Patient Accounting, General Ledger, Materials, Laboratory, NovaPacs outbound interface, Pharmacy with Medispan, Order communications)	3
	Healthland (Clinicals, Financials, etc.)	3
	CPSI	1

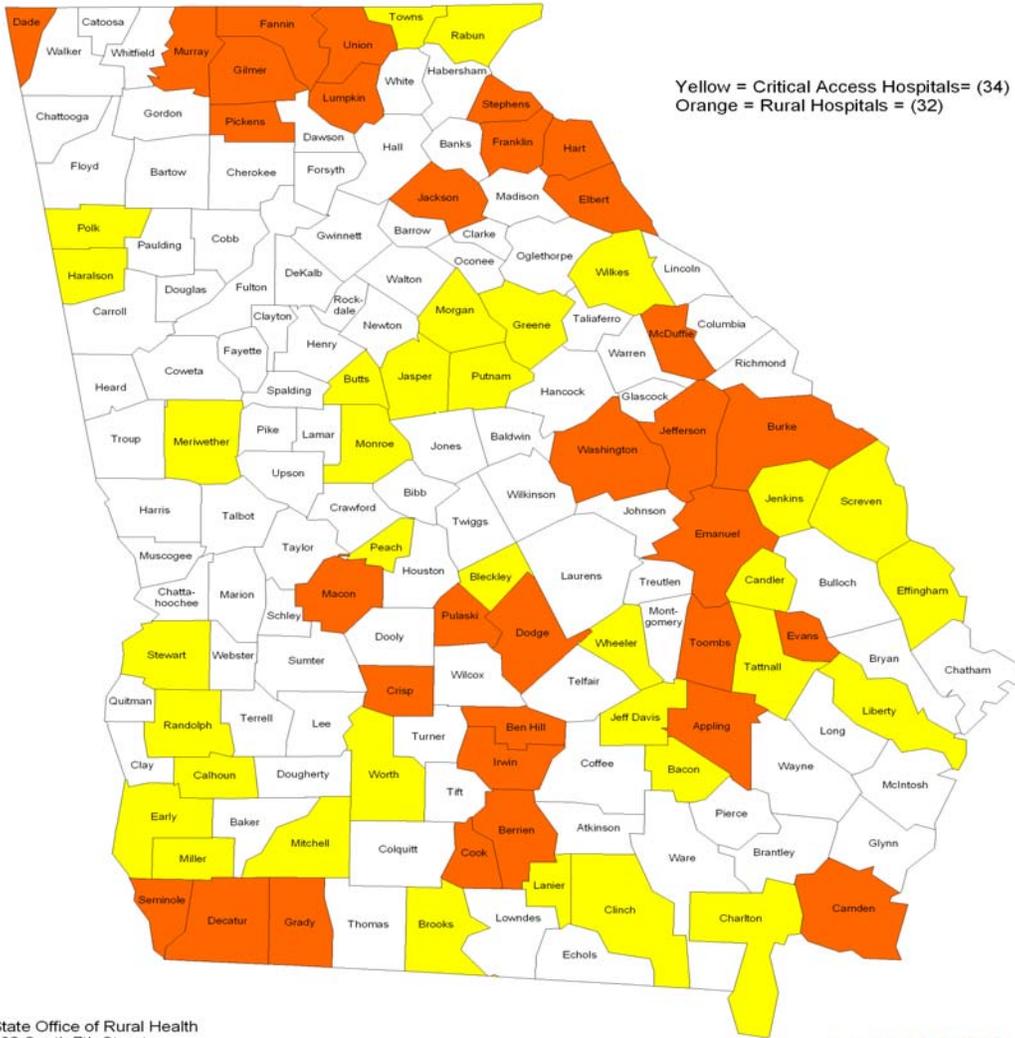
Provider Type	Vendor Type	Number of Installations
	CPSI CPOE, Escrip,eClinical Works	1
	HSR	1
	Meditech	1
	Meditech CS 5.64	1
	NextGen	1
	Siemens Medical Soarian EHR	1
	SRSsoft	1
<b>Dentists</b>	Dentrix	4
	Eagle Soft	2
	Easy Dental	2
	Henry Schein Dentrix Enterprise	2
	Patterson Dental, EagleSoft	2
	MOGO	1
	NEIC	1
	Patterson Dental	1
	Practiceworks/Kodak	1
<b>Nurse Practitioners</b>	AllScripts, Misys EMR	1
	Encounter Pro	1
	Practice Partners	1
<b>Pediatric Physicians</b>	AllScripts	6
	EncounterPro	6
	PRACTICE PARTNERS	4
	eClinicalWorks	3
	Centricity	2
	Connexin Software - Office Practicum	2
	Abraxas Medical Solutions	1
	Amazing Charts	1
	CPSI - Point-of-Care	1
	EPIC HealthConnect	1
	Greenway Primesuite	1
	Intergy-Sage	1
	NextGen	1
	Practice Fusion	1
<b>Physicians</b>	AllScripts	13
	eMDs	13
	eClinicalWorks	8
	NEXTGEN	5
	McKesson Practice Partner	4
	MISYS	3
	practice partner	3
	AllScripts PeakPractice	2

Provider Type	Vendor Type	Number of Installations
	amazing charts	2
	Cerner PowerWorks	2
	encounter pro	2
	encounter pro JMJ	2
	EPIC	2
	GE Centrcity, Health Systems	2
	Greenway Medical Technologies, PrimeSuite/Prime Chart	2
	Practice Fusion	2
	Allmeds	1
	AllScripts- A4	1
	AllScripts EMR	1
	Alma Information Systems TexTALK Enterprise	1
	AllScripts	1
	Alteer/Visionary Healthware	1
	AMERICAN MEDICAL SYSTEMS	1
	Athena	1
	BizMatics PrognoCIS	1
	Cerner Powerchart	1
	Encounter Pro/Elligence	1
	Greenway Medical Technologies, Prime Practice and Chart	1
	GROUP ONE/ECLINICAL WORKS	1
	Healthmatics(A4)	1
	Hyperspace	1
	Medicus	1
	Medicare	1
	Medisys EHR, MEDISYS COMPANY	1
	MediTech LSS	1
	NextGen EMR	1
	Nightingale PWS	1
	NueSoft	1
	Office Practicum and same product	1
	Practice Partner/Automated Business Services	1
	Sage	1
	SAGE MEDWARE	1
	Soapware	1
	SpringCharts	1
	Vision Healthworks Alteer	1
	visionary - EHR is called dream	1
	XL-EMR	1

## **APPENDIX B: Georgia Hospitals**

Georgia has 161 hospitals. This total includes two children's hospitals, eleven acute care hospitals, and thirty-four critical access hospitals (and their network affiliates) and the thirty-two rural hospitals operating in Georgia. Many of these hospitals serve unique populations, such as the homeless. The rural hospitals and critical access hospitals are located in widely dispersed areas throughout Georgia. The map below depicts the distribution of critical access and rural access hospitals.

## State of Georgia Hospitals Certified for Critical Access Designation



State Office of Rural Health  
502 South 7th Street  
Cordele, GA 31015  
Ph: 229-401-3090  
September 30, 2010



## **APPENDIX C: Training Plan**

## Training Plan Components

The *Training Plan* consists of the following major components:

- Training Goals – Functional and Affective/Behavioral
- Target Audiences – Primary and Secondary
- Training Curricula – Topics/Content for Specific Target Audiences
- Training Metrics – Evaluation Process and Documents
- Training Logistics – Physical, Personnel and Financial Considerations
- Training Contingency Plans – Potential Training Issues and Risks Considerations
- Resources – Relevant Web sites and Other Training Aids
- Appendices – Documents and Templates

## Training Goals

The *Training Plan* addresses the following functional and affective/behavioral goals to be attained by participants in outreach, education and/or training for the Medicaid Electronic Health Record Incentives Program:

### Functional Goals

- Understand the purpose and scope of the Medicaid Electronic Health Record Incentives Program
- Determine the benefits to be gained from using an EHR system versus a paper-based record system
- Explore the role and use of an EHR in a health information exchange (HIE) system
- 

### Affective/Behavioral Goals

- Overcome possible anxiety regarding the adoption, implementation, upgrade or meaningful use of an EHR system
- Assist others in health care organizations in overcoming possible resistance to EHR systems

## Target Audiences

The *Training Plan* identifies the audiences for the Medicaid Electronic Health Record Incentives Program. The primary audiences are eligible professionals (EPs) and eligible hospitals (EHs) who will adopt, implement, upgrade or meaningfully use electronic health records in their practices. Secondary audiences include State staff, business analysts, educational institutions, patient/consumers, and medical office personnel.

## Needs Assessment

Audience/user profiles will help assess/identify training needs. A two-pronged strategy consisting of an “enterprise” approach and an “individual trainee” approach will be used.

The *enterprise* (or high-level) *approach* will focus on the professional associations of eligible professionals and eligible hospitals. This first step is intended to ensure efficiency and effectiveness in reaching as many potential trainees as possible.

The *individual trainee approach* will collect subsequent follow-up information by telephone interviews and online surveys. This approach is intended to ensure that specific needs not captured in the enterprise approach are not overlooked.

## Training Curricula

The *Training Plan* includes types of training, training topics, and training strategies/delivery methods. These components of the curricula will be designed to meet the specific needs of the target audiences for the Medicaid Electronic Health Record Incentives Program.

The curricula should ensure that all audiences understand:

- Georgia’s methodology for incentivizing eligible professionals and eligible hospitals who adopt, implement, upgrade or meaningfully use EHRs
- Georgia’s strategy for helping eligible professionals and eligible hospitals re-engineer their practices to effectively use EHR technology

Therefore, the overall curricula will address the following areas:

- Enrollment criteria for eligible professionals and eligible hospitals
- Strategies and practices for selection, implementation and meaningful use of a certified EHR
- Processes for assessing, monitoring, tracking, and reporting on the meaningful use of EHRs
- Interoperability of EHRs
- Quality features to fulfill EHR registry functionality, alerts and guidance to patients and data for public reporting
- Role of the Medicaid Management Information System (MMIS) and other system modifications required for payment and accounting of incentive payments
- Auditing procedures for monitoring and addressing potential instances of fraud and abuse and that facilitate data gathering for any provider disputes or appeals
- EHR technology for improvement of the quality and value of health care management, patient-provider relationships and patient self-management

## Multi-curricula/Modular Approach

The *Training Plan* includes a multi-curricula/modular approach to developing and delivering the content of the outreach, education and training program. This approach is appropriate since some of the content will be broad based (applicable to all target audiences) while other content will be audience specific.

## Training Delivery Methods and Materials

The *Training Plan* includes delivery methods and materials that will be designed to meet specific needs of the target audiences.

### Delivery Methods

- **Classroom Forums:** Facilitator-led face-to-face sessions conducted by Medicaid EHR Incentives Program “Champions” to include both lectures and hands-on activities
- **Web-based Training:** Online learning that highlights specific areas of the Medicaid EHR Incentives Program for independent study (including tutorials, simulations, and EHR demonstrations)
- **Audio Conferences:** Sessions featuring CMS, ONC, DCH and other program experts who will provide in-depth information on current issues relevant to Medicaid EHR Incentives Program target audiences

### Training Materials

- **Classroom Modules:** Slides and accompanying notes pages
- **Trainer/Facilitator Guides:** Instructions, assignments keys, master copies, etc.
- **Trainee User Guides/Workbooks:** Copies of slides, handouts, exercises, etc.
- **Toolkits:** Fact sheets, websites, public service announcements
- **Use Cases** – Depictions of the requirements for EHR implementation
- **Case Studies** – Descriptions of successful and failed EHR implementations and the corresponding lessons learned

### Training Topics

The *Training Plan* will include modules that address the following topics, categorized according to types of training.

**Outreach/Awareness** - A “marketing type” series of modules that may include an overview of health information technology (HIT); review of pertinent acronyms/terms and definitions; overview of major provisions of the Medicaid EHR Incentives Program from a national perspective; the Georgia Health Information Technology Regional Extension Center (GA-HITREC); frequently asked questions (FAQs); and sources for more information (including fact sheets and web sites).

**Education** - A “know why” (pertinent knowledge) series of modules that may include an overview of health information exchange in Georgia; benefits of EHR technology; major provisions of the Medicaid EHR Incentives Program from a state perspective; and sources for more information regarding the State program.

**Technical Training/Assistance** - A “know how” (application of skills/knowledge) series of modules that may include provider practice assessment; EHR system and vendor selection; purchase facilitation; workflow redesign; interoperability; disaster recovery; and IT support and maintenance.

### **Pilot Implementation**

The *Training Plan* will include a prototype of a pilot test of sample training materials and processes. This test will be conducted with a small representative group of the target audiences and will include training modules, trainer/facilitator materials, hardware/software, and test data collection instruments.

### **Training Metrics**

The *Training Plan* will include a process for continuous evaluation and improvement of all components of the outreach/awareness, education and training program. Metrics will be gathered and maintained on such areas as scope and relevance of course modules (including time and length), appropriateness of objectives, usefulness of course materials, adequacy of facilities, trainee progress and performance and effectiveness of facilitators/trainers.

The entire training program will be reviewed internally by the Training and Outreach Workgroup at formal and informal evaluation milestones.

### **Training Logistics**

The *Training Plan* describes logistical considerations for outreach/awareness, education and training that include contracts and administrative support for external trainers / facilitators, venues, and equipment.

**Contracts for External Facilitators/Trainers** - The Training and Outreach Workgroup will determine who will conduct the sessions for each target audience of trainees. If an external facilitator/trainer is used, DCH expects that answers to certain items will be discussed and agreed upon including materials production, standards development, administrative support, scheduling, and costs.

**Venues** - The Training and Outreach Workgroup will determine the locations for face-to-face sessions (including utilities, furniture and equipment).

**Supplies and Equipment** - The Training and Outreach Workgroup will determine the supplies and equipment needed for each training session that best support the training delivery methods.

### **Training Contingency Plans**

The *Training Plan* will include information on areas of risk that might disrupt and/or impede the training and suggested strategies for coping with those risks. Issues for which contingency plans should be developed include:

- Workplace needs that might prevent trainees from attending scheduled sessions
- System/equipment failures and how they will be handled
- Training staff emergencies and how backup trainers will be deployed

### **Resources**

The *Training Plan* will include a composite list of relevant resources for all aspects of the outreach, education and training curricula. Links to several of these resources follow:

- Look for updates on the Medicaid Incentive Program @[www.dch.georgia.gov](http://www.dch.georgia.gov) under Health IT Programs.
- To learn more about the Medicare and Medicaid EHR incentive programs, visit the CMS-dedicated website to this program, <http://www.cms.gov/EHRIncentivePrograms/>. Information there discusses eligibility, requirements, upcoming events and more.
- To learn more about EHRs and certification standards, visit the HHS/ONC website at <http://healthit.hhs.gov/portal/server.pt>. This website is the premier place to learn about the benefits of using EHR technology in a meaningful way, local resources to assist in EHR adoption and more.
- More information on the Medicaid Incentive Program and on health care can be found at [www.georgiahealthinfo.gov](http://www.georgiahealthinfo.gov), Georgia's consumer health care website.

**APPENDIX D: PROVIDER COMMUNICATIONS AND  
OUTREACH**

## Introduction

With funding received from the American Recovery & Reinvestment Act (ARRA) of 2009, Georgia will administer a statewide incentives program designed to encourage adoption and meaningful use of EHRs among eligible professionals and hospitals. Georgia plans to begin incentive payments in 2011.

The communications outreach for Georgia's Medicaid EHR Incentives Program ("Program") will employ a phased-in approach starting in the summer of 2010 and continuing throughout 2011.

- Eligible providers, including professionals (physicians, dentists, nurse practitioners, and certified nurse-midwives) and hospitals (acute care, critical access and children's), will be targeted for Program participation, which will include an EHR "value" story.
- Provider trade associations and other "centers of influence" will also be targeted as well.
- Consumers will be targeted with the EHR "value" story within the context of health information technology and the "coming soon" statewide health information exchange.

## The Facts and More

On a national basis, studies have shown that health care providers and consumers are generally optimistic that health information technology (IT) will benefit health care quality.

However, many of those providers are resistant to the positive change that EHRs could bring about, raising concerns like: *My practice is struggling already, so how can I afford to use this new technology? What about the disruption caused by training and implementing something new like this? How can all these different systems work together? Isn't this just one more way for the government to try to mind my business?*

What about providers' patients? They also have concerns: *What's wrong with paper records? I just don't understand how these EHRs work? What happens when the power goes out? Will this technology make my physician less personal? Will my privacy and security be protected?*

The public generally overestimates the current prevalence of health IT usage; fewer than 25% of all physicians and less than 10% of all hospitals nationwide are even using *basic* electronic health record functionality. (Source: CDC's National Center for Health Statistics, 2008-2009 data.)

In Georgia, those percentages of use could be more – or even less. For starters, a 2010 e-mail survey conducted by the *Medical Association of Georgia (MAG)* found that about 51% of their physician-member respondents reported that they are already using electronic medical records (EMR). (Note: This study did not specify "basic" or "full"

*functionality of the system. A total of 269 responses were received, representing less than 5% of MAG's total membership.)*

In the summer of 2010, DCH conducted an introductory survey among six professional associations serving Georgia physicians, nurses, dentists and hospitals. When asked about EHR usage in their organizations, these combined audience percentages were noted:

- 53% responded "yes";
- 28% responded "no" (nor do they have plans to adopt EHR technology in the next 12 months); and
- 19% responded with "plans to adopt EHR technology within the next 12 months."

*(Note: This study represented a total of 391 responses. Respondents did not specify "basic" or "full" functionality of the system being used.)*

The bottom line on what we know? The value of electronic health records and health information exchanges is not clearly understood by health care providers or consumers, according to eHealthInitiative's *National Progress Report on eHealth* (July 2010). There is much work to be done in the world of health information technology understanding and appreciation.

### **Understanding Georgia's Communications Environment**

Successful outreach of Medicaid EHR Incentives Program and EHR messaging requires an understanding of the target audience populations throughout the state. While Georgia is sometimes viewed as two separate entities – Atlanta and the other Georgia – that delineation is fading away with the advent of significant economic development and population growth throughout the state.

In reality, Georgia is patchwork of urban, suburban, exurban and rural...metro avenues and Main Street...mountains, foothills, coastal plains and islands ...educated and affluent...uneducated and in poverty...predominantly English-speaking with growing accents in Spanish, East Indian, Chinese and more.

### **Health Care in Georgia**

Health care delivery in Georgia is provided by a statewide network of 188 hospitals, including specialized facilities; 29,000 physicians; and more than 5,000 dentists, many of whom came from one of the state's four medical schools. We also know:

- Georgia has 159 counties, 118 are rural counties.
- Poverty rates for rural counties exceed those in urban counties by 58 percent.
- Rural counties have approximately half as many physicians...and dramatic shortages of nurses, therapists and nutritionists (per capita) as the metro counties.\*
- Rural Georgians are less healthy than those living in urban areas. \*\*

- Rural Georgians are more likely to be under-insured or uninsured. \*\*
- Rural Georgians are more likely to suffer from heart disease, obesity, diabetes and cancer. \*\*
- Safety net clinics in Georgia provide health care services to the medically underserved in Georgia and face challenges adopting electronic health records.

All above data was taken from the Georgia Economic Development website except as noted: \*Georgia Health Disparities Report 2008; \*\* State Office of Rural Health (GA).

The following table provides additional “at-a-glance” detail about Georgia.

GEORGIA AT-A-GLANCE

<p><b>Population</b></p> <p>Pop. under 18</p> <p>Pop. 65 and over</p> <p>Population Change 2000 –2009</p>	<p>9,829,211</p> <p>26.3%</p> <p>10.3%</p> <p>20.1%</p>	<ul style="list-style-type: none"> <li>• <b>Growth:</b> Georgia is the eighth fastest-growing state in the U.S. More than 100,000 people move to the state each year, and a population expected to exceed 12 million people by 2030.</li> <li>• <b>Age:</b> Georgia’s population is getting younger: more than half of Georgians are between the ages of 20 and 54.</li> <li>• <b>Place of Origin:</b> More than 30 percent of Georgia’s population was born outside the state.</li> <li>• <b>Higher Education:</b> Georgia’s university system is the fourth-largest in the country, totaling 13 state universities, four research universities, seven state colleges, two regional universities, nine two-year universities, plus an integrated network of 34 technical colleges with multiple campuses.</li> <li>• <b>Corporate HQs:</b> Many of the world’s best-known blue-chip companies – including 14 Fortune 500 -- make their home in Georgia. These include <a href="#">AFLAC</a>, <a href="#">The Coca-Cola Company</a>, <a href="#">The Home Depot</a>, <a href="#">UPS</a>, <a href="#">Delta Air Lines</a>, <a href="#">Newell Rubbermaid</a> and NCR.</li> <li>• <b>Georgia/National Media Outlets for Health Care Coverage:</b> Daily newspapers and news services (76+/-); weekly/monthly newspapers (26+/-); TV stations (28+/-); Radio stations (23 +/-); National Print Media (10+/-); Health IT National Print &amp; Online (32+/-)</li> </ul>
<p><b>Households &amp; Income</b></p> <p>Total Households (HH)</p> <p>Median HH Income</p> <p>Persons below poverty</p>	<p>3,006,369</p> <p>\$50,834</p> <p>14.7%</p>	
<p><b>Race</b></p> <p>White, non-Hispanic</p> <p>Black</p> <p>Hispanic/Latino</p> <p>Asian</p> <p>Multi-racial</p>	<p>57.5%</p> <p>30.2%</p> <p>8.3%</p> <p>3%</p> <p>1.3%</p>	
<p><b>Language</b></p> <p>Language other than English spoken at home</p>	<p>9.9%</p>	
<p><b>Education</b></p> <p>High School Grads Age 25+</p> <p>Bachelor’s Degree or Higher</p>	<p>78.6%</p> <p>24.3%</p>	
<p><b>Geography</b></p> <p>Land area</p> <p># Counties</p>	<p>Mountains Piedmont Hills Coastal Plain &amp; Islands</p> <p>57,906 sq mi</p>	

Largest cities	159  Atlanta, Columbus, Savannah, Macon, Albany	<i><b>At-A-Glance Sources:</b> U.S. Bureau of Census; 2009, 2008 and 2000 data; Georgia Department of Economic Development. Statewide Media Lists compiled by Georgia Department of Community Health. InfoPlease, Georgia.</i>
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**Marketing Georgia’s Medicaid EHR Incentives Program**

While this Communications Plan is focused on recommended communications goals and strategies for Georgia’s Medicaid EHR Incentives Program, we recognize that there is audience and message overlap with the Communications Plan for Georgia’s Statewide Health Information Exchange (HIE). We will use that synergy to “cross-sell” leveraging resources and assets where possible. In addition:

- On the list of recommended strategies/tactics that follows, we have noted where specific cost sharing occurs.
- Any communications vehicle (i.e., a brochure, e-newsletter, etc.) specifically executed for the Program will have a primary emphasis on the Program and where appropriate, a secondary message about the HIE.
- Conversely, any communications vehicle specifically developed for the HIE will have a primary emphasis on the HIE and only a secondary message about the Program, as appropriate.

For the Program, our overarching marketing goal is to promote the adoption, implementation, upgrade and meaningful use of certified EHRs to achieve health and efficiency goals. This will be accomplished through the use of financial incentives awarded to eligible professionals and eligible hospitals. In year one of program participation, attestations of adoption, implementation, upgrade or meaningful use are required. Starting in year two of provider participation, meaningful use must be demonstrated for eligible providers.

With our key target audiences grouped and defined as primary and secondary, we are recommending a “push and pull” marketing strategy. This strategic combination increases overall plan effectiveness.

- The “pull” is communicating with Medicaid providers (eligible professionals and hospitals); the “push” is communicating with provider trade associations who influence provider decision-making in their practices and hospitals.
- To a lesser degree, the “push” continues with some targeting to consumers, patients and their families as well as the health care/IT/general media.

- We will utilize both direct and indirect channels of delivery...direct to providers and indirect to those influencing the providers...i.e., medical associations, etc.
- And finally, we recognize that we have two kinds of audiences that influence our success: external (i.e., providers, provider associations, consumers, etc.) and internal audiences (i.e., state and federal departments, agencies, offices).

Throughout our plan's implementation, we will collaborate with our stakeholders, build and maintain a trusting relationship with Medicaid providers and consumers, and leverage assets and initiatives such as Georgia's Statewide HIE and the Medicaid Management Information System (MMIS).

### Target Audiences

**Primary** – Includes key decision-makers within eligible medical practices and hospitals as well as the professional organizations that will influence EHR system adoption and use.

- **Eligible Medicaid Professionals** – Including Physicians, Dentists, Nurses, Nurse Practitioners, Certified Nurse-Midwives and Physician Assistants in PA-led FQHC or RHC facilities. (As of this writing there are no PA-led facilities in GA.)
- **Eligible Medicaid Hospitals** – Including Acute Care, Critical Access and Children's Hospitals.
- **Key Partners** – Georgia Health Information Technology Regional Extension Center (**GA-HITREC**); Plus **Provider Associations**, Medicaid Care Management Organizations, state and federal departments/agencies and others.

**Secondary** – Includes the following:

- **Consumers**
- **Health Care/Health Care IT Media**
- **Consumer Media**
- **General Business Media**

### Communications Principles

The following will serve as our guiding principles throughout program development, implementation and monitoring.

- Adhere to approved messages.
- Utilize consistent branding in all communications materials, delivered with the necessary levels of continuity within our budgets.

- Use a creative tone and manner that is friendly, respectful, easy-to-read and use.
- Capitalize on specific opportunities to capture interest and coordinate with other entities working toward similar goals.
- Use research, focus groups, audience feedback where feasible to gauge communications effectiveness.
- Influence the audiences over time through the use of opinion leaders, subject matter experts, and “Champions.”
- Be sensitive to the different socio-economic, cultural, racial and ethnic segments of each target audience.
- Respond openly and accurately to public concerns about health IT, EHRs, the Medicaid EHR Incentives Program and Georgia’s Statewide HIE.

## Communications Goals

The following goals are segmented by stakeholder audience.

### Target: Eligible Medicaid Providers & Provider Associations

- **Create awareness of and positive interest in the Medicaid EHR Incentives Program** (i.e., what it is, how it works, etc.) and how it will financially benefit Program participants.
- **Encourage Program registration and participation** among eligible Medicaid providers.
- **Build awareness, credibility and provider participation** in Georgia’s Statewide HIE.
- **Provide cohesive messaging from CMS and ONC** to support national and state goals for adoption and use of health IT, EHRs and the HIE.

### Target: All Audiences

- **Increase the awareness and understanding** about the value of health IT, highlighting privacy and security.
- **Build appreciation for EHRs as a transformative health IT tool** for reducing administrative costs, increasing patient safety and quality of care delivering connectivity through Georgia’s Statewide HIE.
- **Promote understanding of the privacy and security laws** protecting individuals’ health information.
- **Monitor and measure communications program effectiveness.**

## Communications Objectives

Medicaid EHR Incentives Program Communications Objectives % - By Target Audience Segment	2011	2012	2013	2014	2015	2016
Medicaid Provider & Provider Association Program Awareness	55%	63%	75%	82%	89%	96%
Consumer EHR Awareness	10%	20%	35%	50%	65%	75%

*Note: Above estimates are subject to further research measurement and regular updating.*

## Program Message Topics

These core message topics will be expanded and delineated for the appropriate audiences.

- Medicaid EHR Incentives Program Overview
- Medicaid EHR Incentives Program Detail  
(2 versions: Professionals, Hospitals)
  - Brief Overview
  - Eligibility
  - Requirements
  - EHR Certification
  - Adopt, Implement, Upgrade, Meaningful Use
  - Incentives/Timelines
  - Registration
- EHR value story
  - basics, functionality levels
  - benefits
  - return on investment
  - testimonials
- EHR, HIE privacy and security protections
- Health IT overview, benefits, value
- Statewide HIE overview, benefits, value

## Program Messages

These messages are currently being developed, based on findings shown below.

**For Providers** – Messages around these **barriers** will be developed to help drive EHR Adoption and Meaningful Use.

- *Costs (i.e., soft costs like communications and hard costs like patient flow)*
- *Workflow disruption*

- *Culture and age of practice personnel*
- *Lack of IT knowledge*
- *Lack of interoperability standards*
- *Unreliable systems and access to data*
- *Misleading, over-promising vendors*
- *Privacy and security concerns*
- *Increased liability risks (i.e., malpractice, privacy and security breaches)*
- *Lack of broadband and hi-speed data infrastructure*
- *Provider inertia*

**For Providers** – Messages around these **benefits** will be developed to help drive EHR Adoption and Meaningful Use.

- *Workflow efficiencies*
- *Administrative cost reductions*
- *Patient safety quality improvements*
- *Younger generational workforce acceptance of IT*
- *Ready access to patient information*
- *Documentation and mandatory data reporting to meet regulatory requirements*
- *Prescription and treatment histories*
- *Consumer expectation and expression of need*

**For Consumers** – Messages around these **barriers** will be developed to help drive support for EHR Adoption and Meaningful Use.

- *Privacy and security breaches*
- *Stolen records*
- *Lost, damaged or corrupted data*
- *Unauthorized/misuse of data*
- *Lack of general awareness and understanding*
- *Lack of appropriate consent and control options*

**For Consumers** – Messages around these **benefits** will be developed to help drive EHR Adoption and Meaningful Use.

- *Key drivers: quality, access, patient satisfaction*
- *Improve health care quality overall*
- *Ability to provide consent before medical data stored or shared*
- *Increased ease of navigating the health care system and managing their care*
- *Increased consumer use of and trust in information technology*
- *Better, faster, easier access to patient data*
- *Ability to obtain optimum treatment more quickly*
- *Increased communications effectiveness (i.e., E-mails to providers)*

- Increased ease of RX orders and re-fills
- Consent education

## Communications Strategies

- **PLANNING** **Summer 2010 – Spring/Summer 2011**
  - **Branding**
    - Program branding under the GAHealthConnect umbrella for DCH's health information technology initiatives
    - Core messaging for each stakeholder group
    - Brochures or other printed materials (Shared with HIE)
    - Creative Style Guide
  - **Website**
    - New pages for the Medicaid EHR Incentives Program
    - A refresh of the Georgia HealthInfo.gov site...currently a Medicaid consumer health info site + updates/links on dch.ga.gov, etc.
  - **Interactive Marketing**
    - Webinars (DCH, guest speakers, GA-HITREC, others)
    - Videos (new + some repurposed from HISPC work)
    - Podcasts (overviews, key tips, facts, single topics, etc.)
    - E-mail marketing on-going, with bulletins, invites, e-newsletters, tips, FAQs, testimonials and more
    - *Note: Georgia provider e-mail lists will include those currently compiled by the state as well as those obtained through CMS and R&A registration. If needed to complete the provider/provider association universe in Georgia, list purchases will be evaluated.*
  - **PR & Media Relations**
    - Key messaging and talking points
    - Press kit – fact sheets, FAQs, Champion testimonials, announcements and updates
    - By-lined articles in health/health IT/general media
    - PSA's (TV, radio, print, online for use with a variety of media)
    - Speakers' bureau/speaking engagement calendars
    - PowerPoint slide decks for presentation use
  - **Provider Collateral Materials**
    - Provider Brochures, Fact Sheets, FAQs, etc.
    - Provider EHR Adoption Self-Promo Electronic Marketing Kit (for use w/ their local media, patients, etc.)
  - **Consumer Brochures**
    - For EHR/HIE consumer/patient education, English & Spanish (Shared with HIE)

- **Meetings/Special Events**
  - PowerPoint presentations, signage, hand-outs
  - Includes local and regional meetings, presentations and workshops (Some shared with HIE)
- **Partner Programs**
  - Georgia Health Information Technology Regional Extension Center (GA-HITREC) and medical trade associations
  - Specifically for GA-HITREC (with some costs shared between DCH and GA-HITREC)
    - Brochures for GA-HITREC use with providers
    - Brochures for GA-HITREC's providers' patients (EHR Consumer/Patient Education focused)
    - Self-Promo Kits for GA-HITREC's providers to "promote" their use of EHR technology within their community, and directly to their patients (Kit will be online, via downloading by provider from DCH website)
    - Joint webinars, meetings/events, speaking engagements, by-lined articles, press releases, etc. (Some shared with HIE)
    - Program promotion on websites...with linkage to/from the GA-HITREC and DCH websites
    - Sharing PowerPoint presentations, videos, podcasts
  - Details of partner programs with key medical trade associations are still being developed as of this date
- **HIT Provider Award Program** (Shared with HIE)
  - Announce and promote beginning in late 2011/early 2012
  - Award starting in 2012 or 2013
- **Measurement**
  - Measure awareness (and more) via focus group and email survey research methodologies and other forms of tracking
- **Special Opportunities/Contingency Reserve**
  - For special opportunities that arise throughout this period.
- **Education & Training**
  - The Communications Team will work with Education & Training to provide the necessary support materials, all Program-branded, including but not limited to...
  - E-mail invites to training/education sessions
  - Graphic template for PowerPoint slide decks
  - Signage for training sessions
  - Graphic template for 8-1/2x11 hand-outs including registrations, evaluations, questionnaires, etc.

- Binder cover inserts, spines and tabs for facilitator/trainer/participant notebooks; pocket folders and related materials
- Customized Education & Training session brochures including session speaker bios, agenda, host thank you
- Special Education & Training icons for use on GeorgiaHealthInfo.gov and Program web pages
- Name tags, giveaways, special graphics, charts and other as needed

- **IMPLEMENTATION**

**Spring/Summer – Fall/Winter 2011**

- **Branding**
  - Continue to update/reprint brochures, other printed materials (Shared with HIE)
- **Website**
  - Continue to update as needed
- **Interactive Marketing**
  - Continue to update and deliver based on Program and audience changes and needs
  - Webinars (DCH, guest speakers, GA-HITREC, others)
  - Videos (new content and some repurposed from HISPC work)
  - Podcasts (overviews, key tips, focused topics, etc.)
  - E-mail marketing with bulletins, invites, e-newsletters, tips, FAQs, Champion testimonials, etc.
- **Public Relations & Media Relations**
  - Continue to update/deliver below based on Program/Audience changes and needs
  - Press kit – fact sheets, FAQs, Champion testimonials, announcements, etc.
  - By-lined articles in health/health IT/general media
  - Public Service Announcement's (TV, radio, print, online for use with a variety of media)
  - Speakers' bureau/speaking engagement calendars
  - PowerPoint slide decks for presentation use
- **Provider/related Collateral Materials**
  - Continue to update/reprint/distribute below based on Program/Audience changes and needs
  - Provider Brochures (including FAQs, Fact Sheets, etc.)
  - Provider EHR Self-Promo Adoption Electronic Marketing Kit (for use with their local media, patients, etc.)
- **Consumer Brochures**

- Continue to update and reprint as needed (Shared with HIE)
  - **Meetings/Special Events**
    - Continue to update and deliver based on Program and audience changes and needs
    - PowerPoint presentations, signage, hand-outs
    - Includes local and regional meetings, presentations and workshops (Shared with HIE)
  - **Partner Programs**
    - Continue to update and deliver based on Program and audience changes and needs, per Partner Programs above
    - Georgia Health Information Technology Regional Extension Center (GA-HITREC) and key medical trade associations
  - **Measurement**
    - Continue monitoring and measuring awareness (and more) via focus group and email survey research and other forms of tracking
  - **Special Opportunities/Contingency Reserve**
    - For special opportunities that arise throughout this period
  - **Education & Training**
    - The Communications Team will continue to work with Education & Training to provide any additional support materials needed. Budgets for necessary items will be included in the Education & Training Plan.
- **Program Flexibility:** As regulatory and industry changes occur, our Communications Plans will be adjusted accordingly.

<b>Medicaid EHR Incentives Program – Communications Outreach at-a-Glance</b>	
<b>The Market</b>	<b>The Marketing Tools for External &amp; Internal Communications</b>
<b>All Targets</b>	<b>Branding, Messaging, Web pages...plus below by target market.</b>
<b>Providers</b> (eligible professionals and eligible hospitals)	PR/Media Relations (Releases, by-lined articles, etc.), Interactive Marketing (Webinars, E-mail campaigns), PSAs (print, electronic), Medicaid Provider Brochures, including Self-Promo Kit (electronic via Web), Medicaid Patient-

	Education Brochures
<b>Provider Associations</b>	PR/Media Relations, Interactive Marketing (Webinars, E-mail Campaigns), PSAs, Brochures; Plus joint endeavors including webinars, web postings, by-lined articles, speaking engagements and more
<b>Partner – GA-HITREC</b>	Joint endeavors including PR/Media Relations, Interactive Marketing, Speaking Engagements, Meetings, Brochures (for Providers) and more
<b>Consumers</b>	PR/Media Relations, Patient-Education Brochures
<b>Media – Health Care/IT/Consumer</b>	Press Kit, plus on-going Releases, Briefings, Story Pitches, PSAs
<b>GA State Orgs</b>	Intranets, eNewsletters, E-mails, Lunch ‘n Learns, SPA Newsletters, PIO briefing documents, special Exec/Legislative briefing packages
<b>Federal Orgs</b>	eNewsletters and other e-mail briefings

### The Impact of Communications

The adoption and meaningful use of EHRs by Georgia’s Medicaid health care providers will require an investment of their time, money, and behavior. Each provider will arrive at the EHR technology purchase/use decision a little differently, but each will start with a basic awareness of the Program. From there, many providers will move toward greater understanding and an appreciation of the technology’s value and the incentives available to them for investing in that technology. Other providers will be resistant and slow to change. Various providers will be at various stages along the adoption continuum and will need specific messages that speak to them.

Our job is to deliver the Program information needed, accurately and professionally, when and where it is needed. In addition, we will call on early and new adopters of health IT – from computerized patient order-entry systems to EHR systems, from e-prescribing to comprehensive care document sharing and more. We will ask them to share their stories in support of EHR use and Program participation. These “Champions,” along with influential bodies like the medical trade associations, will help to shape the providers’ EHR purchase decision and Program participation. And lastly, we will target the health care, business and consumer media for the pivotal role they will play.

Continuing throughout 2011, we will lay the foundation for the Program’s success. We expect exponential growth and acceptance of EHRs among Medicaid providers in 2012 and beyond as they see the positive clinical, administrative and financial benefits. During this process, we also anticipate learning more about how we can be most efficient and effective in our outreach and communications to all Medicaid stakeholders.



## **APPENDIX E: Medicaid EHR Incentive Payment Process**



## **APPENDIX F: Medicaid EHR Incentive Payment Calculator**

## **Georgia Department of Community Health**

### **Office of Health Information Technology & Transparency (HITT)**

Medicaid Incentive Program (MIP) for Adoption, Implementation, Upgrade, or Meaningful Use of EHR

#### **Hospital Incentive Payment Calculation Instructions**

- 1** The calculations in this model are derived from the CMS final rule regarding the Medicaid EHR incentive program (72 FR 44314 and 42 C.F.R. 495). This calculation model has not been reviewed or approved by CMS.
- 2** This calculation model is intended to assist hospitals in estimating the amount of potential incentive payments for the adoption, implementation, upgrade, and meaningful use of certified EHR technology, should the hospital be deemed eligible to receive such payments. The completion of the calculation worksheet should not be construed as an indication or guarantee that the State will provide incentive payments in the amount calculated using this template.
- 3** Information entered into this calculation should be obtained from the hospital's cost reports that are filed with the Department of Community Health (DCH). The cost reports used for this calculation estimate should be the hospital's most recent filed cost report and the previous 3 cost reporting years. The cost report information entered into this template is for purposes of deriving an estimate only. When the EHR incentive payment program is implemented, hospitals will be required to attest to the accuracy of the information that is reported for the actual calculation, and such information may be subject to additional review and/or audit by the DCH or its audit contractor.
- 4** The calculation template is the second tab of this workbook ('Calculation Template'). Cost report data should be entered into the highlighted cells. An example calculation is provided in the third tab ('Example Calculation').
- 5** Please note that for purposes of computing the Medicaid share percentage, Medicaid days (numerator) should not include days for dually-eligible individuals.

<b>Georgia Department of Community Health</b>									
<b>Office of Health Information Technology &amp; Transparency (HITT)</b>									
Medicaid Incentive Program (MIP) for Adoption, Implementation, Upgrade, or Meaningful Use of EHR									
<u><i>Hospital Incentive Payment Calculation Template</i></u>									
<b>Calculation Components:</b>									
A.	Annual EHR Amount = (Base amount + per-discharge amount) * transition factor								
	1. Base amount = \$2,000,000 for each of 4 years								
	2. Per-discharge amount for each of 4 years								
	Discharges 1 - 1,149		\$0						
	Discharges 1,150 - 23,000		\$200						
	Discharges > 23,000		\$0						
	3. Transition Factors								
	Year 1		1						
	Year 2		0.75						
	Year 3		0.5						
	Year 4		0.25						
B.	Overall EHR Amount = Sum of 4 Years' Annual EHR Amounts								
C.	Medicaid Share = Inpatient, non-charity care days attributable to Medicaid (estimated Medicaid inpatient-bed-days + estimated Medicaid HMO inpatient-bed-days) / (est. total inpatient-bed-days x ((est. total charges - est. charity care charges) / est. total charges))								
D.	Aggregate EHR Payment Amount = Overall EHR Amount * Medicaid Share								
Green Shaded Cells Represent Data Entry									
<b>Calculation Example:</b>									

<b>Step 1:</b>	<u>Determine the average annual growth rate in discharges over 3-year period preceding first calculation year</u>								
<b>Data Sources:</b>	Total discharges from hospital cost reports, worksheet S-3, Part I, Column 15, Lines 12, 14, 14.0x								
	<i>(include acute inpatient subprovider units, such as rehabilitation and psychiatric subprovider units)</i>								
	Number of Discharges	Increase / Decrease in Discharges	Percentage Growth / Decline						
FY 2007									
FY 2008		0	#DIV/0!						
FY 2009		0	#DIV/0!						
FY 2010		0	#DIV/0!						
Overall Incr./Decr.		0	#DIV/0!						
<b>3-year average (growth rate)</b>			<b>#DIV/0!</b>						
<b>Step 2:</b>	<u>Determine total discharge-related amount for each of 4 years</u>								
<b>Data Sources:</b>	Total discharges from hospital cost report for year prior to first payment year (FY 2010) and above growth rate								
	Discharges in FY 2010 =	0							
		Allowed Discharges (capped at 23,000)	Per-discharge Amount	Discharge-Related Amount: (Allowed Discharges - 1,149) * 200					
Year 1: (FY 2010)		0	\$200	\$0					
Year 2: (Year 1 + Growth Rate)		#DIV/0!	\$200	#DIV/0!					
Year 3: (Year 2 + Growth Rate)		#DIV/0!	\$200	#DIV/0!					



(Total Hospital Charges / Total Hospital Charges Excluding Charity Care)								
Total Hospital Days (w/s S-3 part I, col. 6, line 12, and if applicable, 14, 14.0x)								
Total Non-charity Hospital Days					#DIV/0!			
<b>Medicaid Share</b>					#DIV/0!			
(Total Medicaid and HMO Medicaid days) divided by Total Non-charity Hospital Days								
<b>Step 5:</b>	<u>Determine Aggregate EHR incentive amount</u>							
	Calculation :	Aggregate Incentive Amount = Overall EHR Amount * Medicaid Share						
Overall EHR Amount			#DIV/0!					
Medicaid Share			#DIV/0!					
<b>Aggregate EHR Incentive Amount</b>			<b>#DIV/0!</b>					

1 Report charity care charges, if available, and identify the data source. If charity care charges are not available, report Other Uncompensated Care Charges from worksheet S-10, line 30. If charity care charges or uncompensated care charges are unknown or unavailable, please enter \$0 or leave this value blank.



<b>Calculation Example:</b>									
<b>Step 1:</b> Determine the average annual growth rate in discharges over 3-year period preceding first calculation year									
<b>Data Sources:</b>		Total discharges from hospital cost reports, worksheet S-3, Part I, Column 15, Lines 12, 14, 14.0x <i>(include acute inpatient subprovider units, such as rehabilitation and psychiatric subprovider units)</i>							
	Number of Discharges	Increase / Decrease in Discharges	Percentage Growth / Decline						
FY 2007	20,000								
FY 2008	21,000	1,000	5.00%						
FY 2009	22,000	1,000	4.76%						
FY 2010	21,500	-500	-2.27%						
Overall Incr./Decr.		1,500	7.50%						
<b>3-year average (growth rate)</b>			<b>2.50%</b>						
<b>Step 2:</b> Determine total discharge-related amount for each of 4 years									
<b>Data Sources:</b>		Total discharges from hospital cost report for year prior to first payment year (FY 2010) and above growth rate							
Discharges in FY 2010 =		21,500							
		Allowed Discharges (capped at 23,000)	Per-discharge Amount	Discharge-Related Amount: (Allowed Discharges - 1,149) * 200					
Year 1: (FY 2010)		21,500	\$200	\$4,070,200					

2010 STATE MEDICAID HIT PLAN V.1.0

Year 2: (Year 1 + Growth Rate)		22,037	\$200	\$4,177,545			
Year 3: (Year 2 + Growth Rate)		22,587	\$200	\$4,287,570			
Year 4: (Year 3 + Growth Rate)		23,000	\$200	\$4,370,200			
<b>Step 3:</b>	<u>Determine overall EHR amount</u>						
Calculation :	Annual EHR Amount = (Base amount + per-discharge amount) * transition factor						
	Overall EHR Amount = Sum of 4 Years' Annual EHR Amounts						
	Base Amount	Discharge-Related Amount	Transition Factor	Overall Incentive Payment			
Year 1	\$2,000,000	\$4,070,200	1	\$6,070,200			
Year 2	\$2,000,000	\$4,177,545	0.75	\$4,633,159			
Year 3	\$2,000,000	\$4,287,570	0.5	\$3,143,785			
Year 4	\$2,000,000	\$4,370,200	0.25	\$1,592,550			
<b>TOTAL</b>				<b>\$15,439,693</b>			
<b>Step 4:</b>	<u>Determine Medicaid Share</u>						
<b>Data Sources:</b>	Hospital cost report, worksheets S-3, S-10, and C						
	<i>(include acute inpatient subprovider units, such as rehabilitation and psychiatric subprovider units)</i>						
Total Medicaid Days (w/s S-3 part I, col. 5, line 12, and if applicable, 14, 14.0x)				12,000			
Total Medicaid HMO days (w/s S-3 part I, col. 5, line 2)				10,000			
Total Medicaid and HMO Medicaid days					22,000		
Total Hospital Charges (w/s C part I, col. 8, line 103)				\$1,200,000,000			

2010 STATE MEDICAID HIT PLAN V.1.0

Charity Care Charges or Other Uncompensated Care Charges (w/s S-10, line 30) <sup>1</sup>		\$150,000,000					
Total Hospital Charges Excluding Charity Care Charges		\$1,050,000,000					
Non-charity percentage (Total Hospital Charges / Total Hospital Charges Excluding Charity Care)		87.50%					
Total Hospital Days (w/s S-3 part I, col. 6, line 12, and if applicable, 14, 14.0x)		110,000					
Total Non-charity Hospital Days			96,250				
<b>Medicaid Share</b> (Total Medicaid and HMO Medicaid days) divided by Total Non-charity Hospital Days				22.86%			
<b>Step 5:</b> Determine Aggregate EHR incentive amount							
Calculation:	Aggregate Incentive Amount = Overall EHR Amount * Medicaid Share						
Overall EHR Amount	\$15,439,693						
Medicaid Share	22.86%						
<b>Aggregate EHR Incentive Amount</b>	<b>\$3,529,072.78</b>						

<sup>1</sup> Report charity care charges, if available, and identify the data source. If charity care charges are not available, report Other Uncompensated Care Charges from worksheet S-10, line 30. If charity care charges or uncompensated care charges are unknown or unavailable, please enter \$0 or leave this value blank.