Georgia State Medicaid Health Information Technology Plan

Georgia Department of Community Health
Division of Health IT

Submitted to:
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Revision History

Date	Description	Submitted/Approved
08/31/2010	Initial submission	Approved
04/07/2011	Modified to add infrastructure costs to support the Medicaid EHR Incentive Payment Program and MAPIR development.	Reviewed by CMS and responses/questions provided.
07/18/2011	Revised per CMS feedback and re-submitted. See Attachment 1 for details of specific changes.	Submitted on 07/18/2011 Approved by CMS in August 2011
12/22/2011	Modified to add Georgia MIP Audit Guide	Submitted on 12/22/2011 Approved by CMS in February 2012
02/21/2012	Modified to add Georgia's Meaningful Use Strategy and update SMHP with the latest information about the statewide activities.	Submitted on 02/21/2012 Approved by CMS in March 2012
10/01/2012	Modified to updated the Medicaid Health IT Roadmap and various other sections	Submitted on 10/01/2012
10/27/2014	Modified for Flex Rule update	Submitted 10/29/2014
07/12/2015	Annual Update - GaHIN status and performance - GaHIN as SDE - EHR incentive program performance	Submitted 07/24/2015
7/18/2017	Annual update	
10/27/2017	SMHP updated based on CMS's recommendations	Submitted 10/27/2017

Introduction

This section of the State Medicaid Health Information Technology Plan (SMHP) provides an executive summary that describes what members, providers, and the Georgia Department of Community Health (DCH) can expect after successfully implementing the five-year Health IT vision: FFY 2015 to 2017. Additionally, this section of the SMHP outlines key components of the plan, describes how the plan aligns with the SMHP template issued by the Centers for Medicare and Medicaid Services (CMS) and identifies where key terms and abbreviations used throughout the document can be found.

1. Executive Summary

Transformation of the Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) will be realized through improvements in the health care system, ensuring better quality of care, better health outcomes, and reduced costs for beneficiaries and eventually, as the improvements extend beyond Medicare, Medicaid and CHIP, for all Americans. Such a transformation requires a new delivery system, a new knowledge transfer and an information technology infrastructure. While the availability of electronic health record technology, health information exchange and related technologies are central to actualizing transformative care, it is the providers' adoption, implementation and meaningful use of such technologies that is the most critical element in achieving transformative health care in this country. Without full provider implementation and utilization of health information technology into their practice or health care delivery system, the three-part aim of better care, better health and lower costs will likely never be completely realized.

In order for Georgia Medicaid to provide its members with healthcare that meets 21st century standards of quality, reliability, and cost-effectiveness, it is important that Medicaid providers move from the paper-based systems of yesterday to interconnected electronic health information technology (Health IT) systems, especially the replacement of paper patient files with electronic health records (EHR).
The Georgia State Medicaid Health Information Technology Plan (GA-SMHP) has been revised in accordance with all Section 4201 Medicaid provisions of the Recovery Act. It provides CMS with detailed descriptions of Georgia Department of Community Health's plans to implement the health information technology and health information exchange provisions of the Recovery Act across the Georgia Medicaid program.

This document focuses on the development of the patient-centered Health IT capabilities and initiatives across the Georgia Medicaid program, including the design, development and implementation of administrative mechanisms and information systems to encourage the adoption and meaningful use of certified electronic health record technology.

The Georgia Department of Community Health (DCH) Division of Health Information Technology, in collaboration with the Georgia Health Information Network, Inc. (GaHIN, Inc.), the Georgia Health Information Technology Extension Center (GA-HITEC), and several health-related state agencies is developing and implementing the overall Health IT strategic plan to support both the public and private healthcare sectors.

The GA-SMHP details the Georgia Medicaid plans to develop and implement the Medicaid EHR incentive program and the Medicaid Health Information Exchange capabilities within the Medicaid program, while the DCH Division of Health IT continues to serve as the coordinating agency for Health IT initiatives statewide, focusing on the development of the eHealth infrastructure.

1.1. Background

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 Georgia Department of Public Health (DPH) is responsible for serving these populations many of whom are eligible for Medicaid services.

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 2011, the Division of Medical Assistance provided access to health care for 2 million Georgians at a cost of nearly $13.6 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 Medicaid regions, the CMOs are under contract to participate in all six regions.

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 incorporates 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 intellectual 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 permanent residents 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 few 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:

Table 2.1 – Average Monthly Enrollment in Medicaid

Fiscal Year	Average Members
2000	947,054
2001	996,901
2002	1,268,225
2003	180,953
2004	1,326,909
2005	1,376,730
2006	1,390,497
2007	1,283,940
2008	1,268,661
2009	1,353,191
2010	1,447,865
2011	1,496,881
2012	1,540,666
2013	1,588,074
2014	1,633,977
2015	1,807,586
2016	1,862,573

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.

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, enhance medication therapy management , enhance care transitions 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.

1.2. Georgia Health IT Key Issues and Trends

E-Prescribing

E--Prescribing among Georgia pharmacies has risen to 95 percent[1] with more than 2,000 pharmacies being added to the e-Prescribing network in the last few years. The Georgia Pharmacy Association continues its campaign targeting the last 5 percent of non-e-Prescribing pharmacies in the state. These efforts will be folded into the overall health IT adoption campaigns developed and executed by DCH and its partners. Between 2010 and 2013, e-Prescribing among pharmacies grew from 76 percent to 93 percent of all pharmacies actively using these capabilities. However, the 2014 scan revealed that only 65 percent of physicians in Georgia are e-Prescribing. But this was a significant improvement from 5% in 2008.

Electronic Delivery of Structured Lab Results and Orders

GAP: ***The electronic exchange of clinical laboratory results and orders is limited among unaffiliated providers.*** The E-Scan showed that Georgia has 7,307 Clinical Laboratory Improvement Act (CLIA) recognized laboratories. Of these laboratories, 437 are CLIA accredited and an additional 736 are CLIA compliant. Approximately 43 percent of the accredited and compliant labs are part of physician offices and clinics, independent hospitals or hospital systems. Independent laboratories form the next greatest category of laboratories, followed by university, CDC labs and government labs. In addition, the four top independent labs comprise approximately 75 percent of all independent laboratory business in Georgia. These laboratories are Quest Diagnostics, Inc., Laboratory Corporation of America, Inc., Bioreference Laboratories, Inc., and Pathology Laboratories, Inc

RESULTS:

The 2010 E-Scan found that only a limited number of providers in Georgia electronically sent or received lab data. In 2013, less than half of the office-based physicians had lab modules (48

percent) in their EHR. Further, a 2012 survey found that around half (52 percent) of clinical laboratories were sending lab results electronically in a structured format, and 21 percent were using the LOINC format

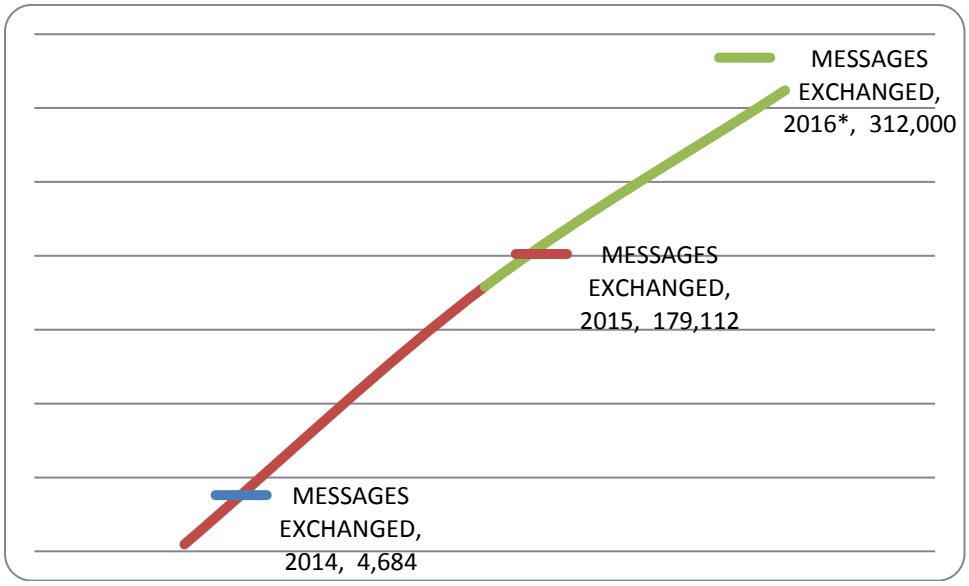
The 2016 scan showed almost 90% of Georgia providers now send or receive lab data.

Clinical Summary Exchange for Care Coordination & Patient Engagement

DCH and GaHIN, Inc launched GeorgiaDirect, direct secured messaging in July 2012. To date there are approximately 2,700 providers registered to use this service to electronically exchange CCD's (Continuity of Care Documents) and other clinical information.
In August 2013, Medicaid became the first member (node) to go-live on the GaHIN query-based exchange making available 1.8 million Medicaid members claims information available on the network.

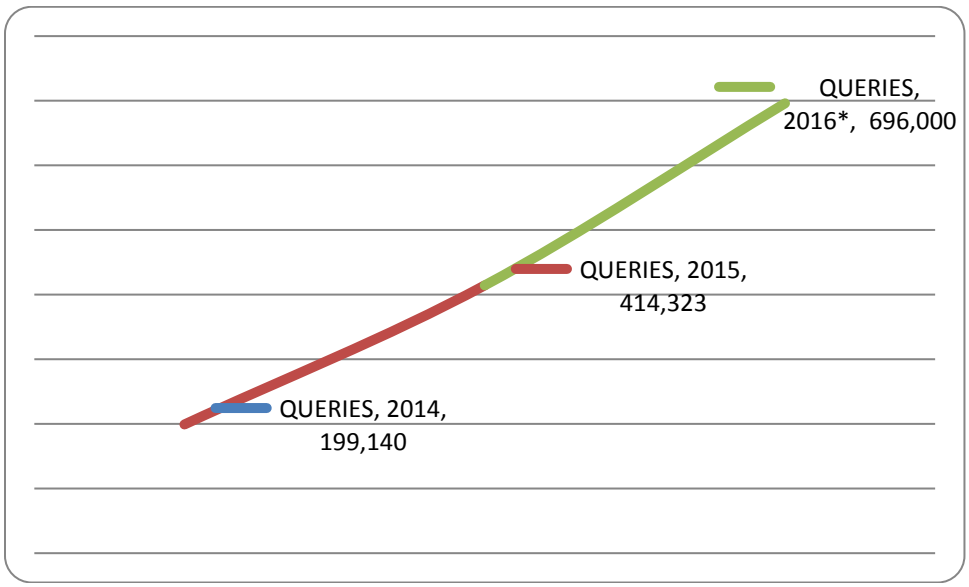
In 2010, only 12 percent of Georgia hospitals were exchanging data via an HIE, with 65 percent of Georgia hospitals not participating in any HIE.

GeorgiaDirect Growth: Participation and Volume



Number of GeorgiaDirect Messages Exchanged
*Anticipated increase of more than 42% in 2016 based on average rate of 26,000 transactions per month.

GaHIN ConnectedCare Growth (Query-Based Exchange): Participation and Volume

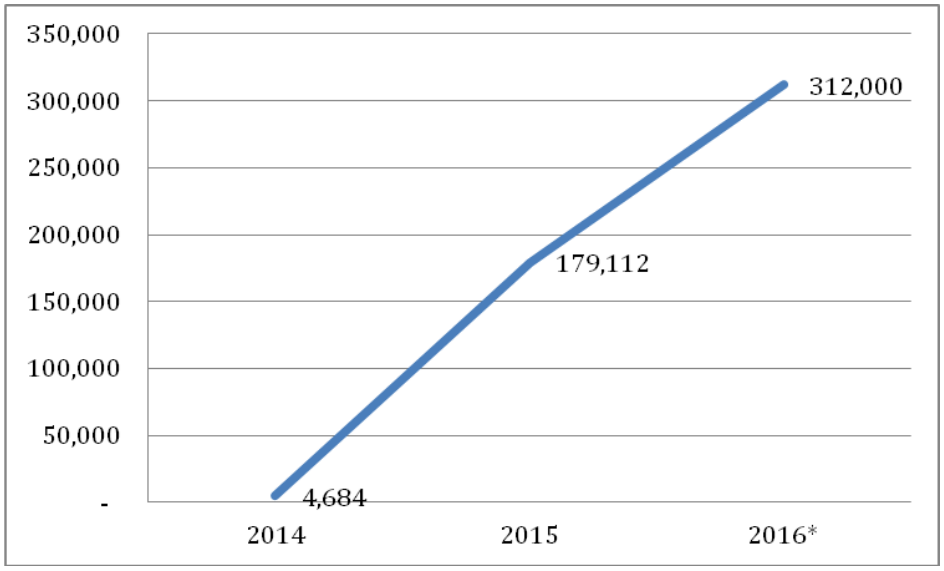


Number of Queries to the Georgia Statewide HIE Per Year

*Anticipated increase of more than 40% in 2016 based on average rate of 58,000 transactions per month.

Georgia Health Information Network (GaHIN) HIE Growth 2014 – 2016

GeorgiaDirect Growth: Participation and Volume



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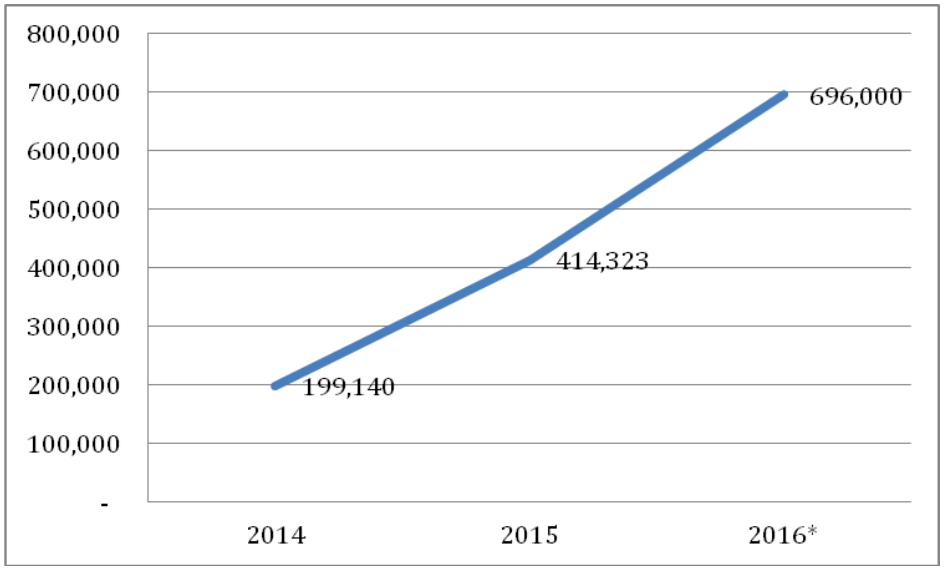
GaHIN ConnectedCare Growth (Query-Based Exchange): Participation and Volume



Number of Queries to the Georgia Statewide HIE Per Year

*Anticipated increase of more than 40% in 2016 based on average rate of 58,000 transactions per month.

Broadband Connectivity

GAP: ***Scattered geographic areas appear to lack Internet and broadband connectivity throughout Georgia.*** The latest Georgia Broadband Connectivity map indicates that many rural portions of Georgia do not have access to broadband services.

STRATEGY: DCH currently coordinates with the Georgia Technology Authority (GTA) to drive deployment of broadband and other Internet capabilities throughout the states. GTA uses mapping technologies to conduct an assessment and continuously monitor broadband access throughout the state.

RESULTS: While Georgia does not yet have 100 percent broadband coverage throughout the state, conditions are improving. In 2013 and 2014, Georgia has experienced significant deployment of new technologies and an increase in connectivity. This implementation has resulted in producing systems capable of speeds in excess of 100 Mbps, AT&T rolled out U-Verse providing up to 24 Mbps, and Verizon and AT&T 4GL LTE in rural areas of Georgia. For the latest information on Georgia's broadband expansion effort please go to http://georgiabroadband.net/ or for detailed map information, go to http://digital.georgia.gov/map/

Patient Access to Health Information

GAP: ***Patients lack access to their personal health information.*** Less than 10 percent of Americans actually use a Personal Health Record (PHR).

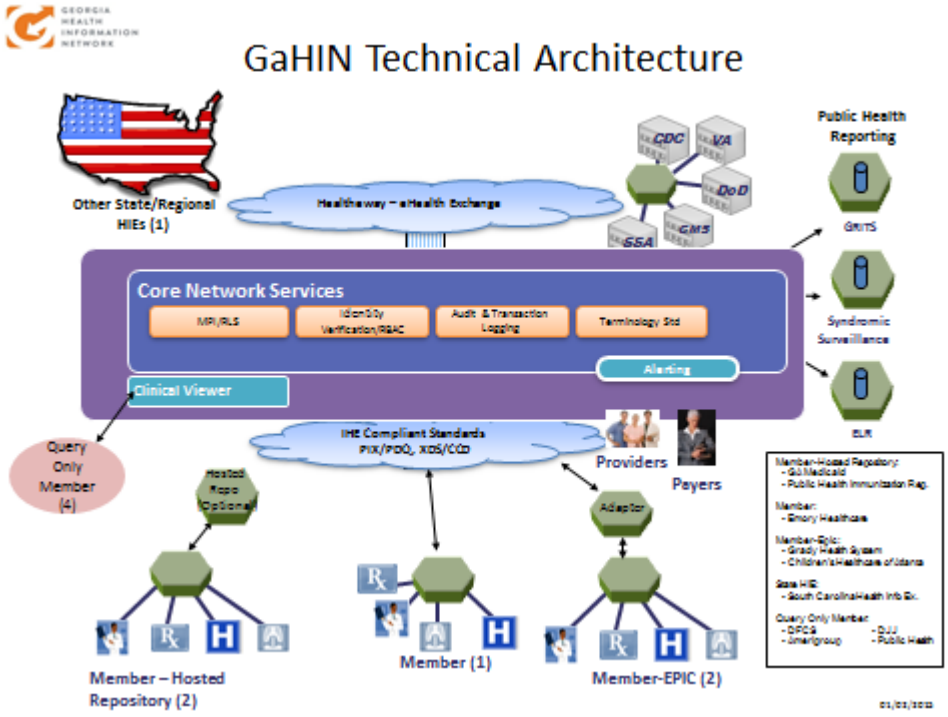
STRATEGY: With the launch of Directed Exchange, the Georgia HIE will also offer a marketplace of Personal Health Records (PHRs). These online tools will range from PHRs available to consumers at no cost, such as Microsoft HealthVault and No More Clipboard, to Dossia and eDoc4u, PHRs that are usually only available to consumers through their employer's wellness programs. Georgia will employ patient engagement tactics with the deployment of the Rome Challenge Grant. This project focuses on newly diagnosed breast cancer patients and the use of a PHR to enhance their care delivery and patient safety. Other consumer engagement tactics include marketing campaigns encouraging individuals to connect their doctors and track their information using a PHR.

1.3. Statement of Direction for Georgia Health Information Exchange Initiatives

The Georgia Medicaid program is in a unique position among the state's community of healthcare payors. While one of the primary functions of the program is to administer Medicaid benefit to Medicaid members and issuance of payments to Medicaid healthcare providers, it also plays a significant role in shaping public healthcare policy. It is with this unique position within the healthcare industry in mind that the Georgia Medicaid program will: 1) define its role in the health information exchange (HIE) arena, 2) implement the Medicaid EHR Incentive Program, and 3) support adoption of meaningful use as defined by the CMS.

Georgia Medicaid's Health Information Exchange Activities

With respect to Georgia HIE network activities, the Georgia Medicaid program will assume a more traditional insurance payor role. Working with Medicaid providers and other duly authorized organizations, Georgia HIE network activities will focus on the delivery of information that will add value to the clinical experience of the Medicaid insured population. Specifically, the Department of Community Health, Division of Medicaid, which has program and policy responsibility for Georgia Medicaid, is pursuing a number of activities to implement the Medicaid Program Technical Architecture. DCH has successfully connected Georgia Medicaid to the statewide health information network, GaHIN



2. Planning Process Summary

A series of structured activities was completed to develop the update to Georgia SMHP, including provider outreach activities. These activities included the construction, distribution, compilation, and analysis of provider survey instruments; development and distribution of educational materials to promote the use of HIT and EHRs; provider focus groups; and analysis of focus group data. This analysis included review of the distribution of providers servicing Medicaid, Medicare, and other populations, as well as issues associated with policy and procedure development.
There are five primary sections of the Georgia State Medicaid Health Information Technology Plan:

2.1. Section A: The State's "As-Is" Health IT Landscape

Section A provides an overview of the current landscape for Health Information Technology in Georgia. It includes descriptions of key Health IT initiatives within Georgia, governance structure, and summary of current EHR adoption.

Prior Authorization Portal (PA Portal)

Georgia has completed a Prior Authorization Integration Project which now allows for one single point of entry for all prior authorizations for all Medicaid members regardless of which CMO (Care Management Organization) they belong. Georgia has four CMO's (Amerigroup, Wellcare, CareSource and Peach State) and prior to the integration PA Portal and provider would have to enter a PA request on each portal (Medicaid, Amerigroup, Wellcare, CareSource or Peach State) portal site.

Georgia Health Information Network (GaHIN)

The Georgia Health Information Network went live in July 2012 with GeorgiaDirect as it first product offering. GeorgiaDirect is direct secure messaging that allows and authorized provider to send securely patient clinical and treatment information to another authorized provider. This offering is provided to Georgia Medicaid Providers as no cost.

In July 2013 the GaHIN went live with Connected Care (Query-Based Exchange), making available to connect members the ability to query for patient information be exchanged on the network. Georgia Medicaid was the first member to connect and go-live in August 2013. Current usage statistics for GaHIN are below

- Cumulative number and percentage of total providers successfully connected to GaHIN for Query Based Exchange (QBE) services. The following statistics are as of May 2016.
    - Providers: Approximately 7,400 with a QBE HIE connection.
    - Medicaid Registered Patients: 5,754,725
    - Large Hospitals/Health Systems: 3. All contribute care summaries to GaHIN.
        - Children's Healthcare of Atlanta (CHOA) – 1800 providers; 489,000 registered patients.
        - Emory Healthcare – 2000 providers; 2,100,000 registered patients.
        - Grady Health System – 1400 providers; 322,000 registered patients.
    - Regional HIEs: 3. All contribute care summaries to GaHIN.

- Georgia Health Connect (GaHC) – 41 providers; 21,500 registered patients.
- Georgia Regional Academic Community Health Information Exchange (GRAChIE) – 1800 providers; 471,000 registered patients.
- HealtheConnection – 100 providers; 114,000 registered patients.

- Payers: 4
  - Amerigroup
  - Blue Cross Blue Shield of Georgia
  - PeachState
  - Wellcare

- State Agencies: 5. Most contribute care summaries to GaHIN.
  - Georgia Department of Community Health (DCH) Georgia Medicaid
  - Georgia Department of Public Health (DPH)
  - Georgia Department of Families and Children's Services (DFCS)
  - Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) – 252 providers; 1,100 registered patients.
  - Georgia Department of Juvenile Justice (DJJ)

- National Connections (through eHealth Exchange): 5. All contribute care summaries to GaHIN.
  - Alabama
  - East Tennessee
  - South Carolina
  - Texas
  - Veteran's Health Administration

- Specialty Connections: 2. All contribute care summaries to GaHIN.
  - Georgia Partnership for TeleHealth (GPT)
  - School-Based Health Clinics (SBHC)

- GeorgiaDirect-GaHIN joined DirectTrust in 2014 and is in the process of transitioning all GeorgiaDirect members to access to DirectTrust.
  - Total number of GeorgiaDirect providers: 3158
  - Total number of GeorgiaDirect member organizations: 298
  - Exchanged nearly 200,000 messages in 2015 and 122,000 in the first five months in 2016.

2.2. Section B: The State's "To-Be" Landscape

Section B describes the vision for the future of Health IT in Georgia. This section includes an overview of identified key goals, objectives and specific tactics that must be met to implement the Georgia Health IT vision by 2018:
deploy several health IT initiatives in Georgia:

- Adoption and Meaningful Use of Electronic Health Records
- The Georgia statewide Health Information Exchange Network (GaHIN) and related services

The Georgia Health Information Network offers a series of services under the ConnectedCare umbrella with includes:

- Medicaid and Public Health Collaboration for Population Health Improvement & Meaningful Use

- Enterprise Data Solution
- Enhanced Georgia Medicaid Member Portal includes enhancement to the current Georgia MMIS (GAMMIS) member portal which include:

Behavior Change Focus Areas and Solutions

Personal Health Record functionality that will allow Medicaid member to perform the following:

1. **Depression prevention** – personalized topics, tracker, journal, articles meditation and tip of the day
2. **Fitness & Exercise** – trackers, set reminders, journal, personalized tip of the day, Yoga, walking programs, personalized exercise plan
3. **Healthy eating** – personalized healthy eating topics, healthy eating assessment, track servings, recipies, journal, tip of the day, interactive web-based/iPhone game
4. **Stress Management** – personalized stress management topics, stress simplifier – how to understand the signs, stress journal, tips to de-stress the home, articles,
5. **Tobacco Cessation** – access to QuitNet, personalized quit topics, cessation support, tobacco craving tool, trackers, journal, tip of the day
6. **Weight Management** – track servings, track weight, meal plans for weight loss, journal, recipes, and stay committed daily action tracker
7. **Self-management** – gender specific health check-ups, trackers and journals, articles and tip of the day
8. **Appointment adherence** –personalized health record tracker (is it up to date), journal and articles
9. **Medication adherence** – personalized medication adherence (up to date/taken timely), trackers, reminders, journal, tip of the day, articles, medication barrier busters,

2.3. Section C: Activities Necessary to Administer the Incentive Program

Section C describes the major business processes that will be utilized by DCH to administer the Medicaid EHR Incentive Payment Program. Processes include assurance that eligible professionals and hospitals have met federal and state statutory and regulatory requirements to education and inform providers about all aspects of the incentive eligibility or payment decision. Additionally, this section provides a description of the system that will interface with the CMS Registration and Attestation System (CMS R&A), accept provider's attestations, and issue and report on payments referred to as the Medicaid Assistance Provider Incentive Payment Repository (MAPIR).

2.4. Section D: The State's Audit Strategy

Section D describes the actions DCH will undertake to avoid making improper payments with the Medicaid EHR Incentive Payment Program. These include methods for program monitoring, pre-post-payment auditing, fraud, and abuse prevention and detection, federal claiming and federal reporting.

2.5. Section E: The State's Health IT Roadmap

Section E contains a roadmap that includes two major components: DCH's Operational Plan for implementing the Medicaid EHR Incentive Payment Plan and the Three-Year Strategic Plan for Health IT that identifies the major IT projects required to achieve the agency's Health IT vision. This section also provides information regarding the additional staff resources required to implement and administer the Medicaid EHR Incentive Payment Plan.

Section A: The State's "As Is" Health IT Landscape

Section A of the GA-SMHP describes the current environment of Health Information Technology initiatives in Georgia from the Medicaid perspective. The assessment of the "As Is" Health IT Landscape was conducted in collaboration with the Georgia Institute of Technology (Georgia Tech) and several other key internal and external healthcare stakeholders. The section describes the current Health IT landscape in terms of governance structure, key initiatives within and across state borders, and EHR adoption.

A-1. Current EHR Adoption by Practitioners and Hospitals

The Georgia "As-Is" health IT landscape reflects a steady progression toward the increased adoption of electronic health record technology. This document contains supplemental information regarding the "As-Is" HIT landscape initially published in August 2010. The following describes what is known as of **June 2012**. The DCH, Division of Health IT will continue to update this document and produce future submissions of the State Medicaid Health Information Technology Plan (SMHP).

In October 2010, DCH determined the extent of EHR adoption by physicians and hospitals generally by using the environmental scan report prepared by Georgia Institute of Technology's Enterprise Innovation Institute (EI2). DCH then supplemented that report with the findings of a survey targeting Medicaid professionals and hospitals expected to have significant Medicaid populations. DCH also 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.

DCH conducted another environmental scan in 2016 and did its own analysis. Georgia subscribed to SK&A and received the survey data. The raw data in a zip file is attached.

Current EHR Adoption – Physicians and Hospitals

Using a study from IMS (formerly SK&A), a private sector firm providing health care solutions and research, and its own research, the EI2 performed a customized analysis to estimate the adoption rates for EHRs among Georgia physicians. The results of the analysis are shown below.

Table 3 – EHR Adoption

Provider Type	2010	2016
All GA Physicians	47%	73%
All GA Hospital	80%	88%

Detailed scan results are available to DCH including demographic and contact information. This detailed data was obtained from the eScan and will help strategize future outreach efforts including geo-spatial analysis.

We concluded that physician adoption rates in Georgia for EHRIs "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.

EI2 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 – Medicaid Specific Information

DCH supplemented the report by the EI[2] through surveys specifically targeting Medicaid providers. DCH obtained assistance from the following organizations to gather data used in this document: 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 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.

A-2. 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.

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 62 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 2016:

Increasing Georgians' access to—and use of—the Internet and application of technologies is Job One for the Digital Georgia Program, a state initiative from the Georgia Technology Authority (GTA). The following graphic depicts Georgia's broadband status as of March, 2014. For the latest information on Georgia's broadband expansion effort please go to https://gta.georgia.gov/broadband-main-page or for detailed map information, go to http://digital.georgia.gov/map/. Please note that GTA was the lead agency on the concluded ARRA broadband grants.

A-3. FQHCs and HRSA HIT/EHR Funding

Federally Qualified Health Centers (FQHCs) and Health Resources Services Administration HIT/EHR

The Georgia Association of Primary Health Care (GAPHC), the state primary care association, has received $1.6 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:

- Development of an overall statewide FQHC HIT/EHR plan
- Implementation of a centralized network hub
- Establishment of centralized HIT/EHR Network Operations Center
- Implementation of HIT/EHR statewide in 100 percent of all FQHCs
- Evaluation of the network's readiness for interoperability with the state HIE

GAPHC has created an IT services subsidiary to support the 34 affiliated FQHCs in 111 counties across Georgia. The subsidiary provides governance and health information technology implementation to each of the 203 clinic sites. Developed as a revenue source, GAPHC has begun to assist other states (e.g. California, New York and Michigan) with the development of HIT and EMR technology. During their assessment, Grant Thornton determined that all clinical sites have engaged EMR technology and that some clinical sites are already exchanging information through sub-state level HIEs. Grant Thornton provided feedback regarding the overall readiness for state-wide HIE implementation highlighting the technical improvements necessary for integration. Their insight provided guidance and timelines regarding the system's provider directory, patient matching capabilities, and interoperability services among other facets. Grant Thornton also rendered policy recommendations for the GAPHC to meet requirements of the state HIE in the areas of privacy and security, and consent management.

With regard to Health Information Technology, GAPHC serves as the lead and coordinating organization for Electronic Health Records and Practice Management. This effort involves the management of a Central Data Center along with a 2nd backup/disaster recovery site that serve as the hub for all FQHC data. Currently all Georgia FQHC organizations have fully functional integrated EHR/PM systems.

Click this link for further information; http://www.gahin.org/service-area-hie/georgia-association-primary-health-care-inc).

A-4. Veterans Administration and Indian Health Services Clinical

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, Albany, Austell, Blairsville, Brunswick, Columbus, Decatur, East Point, Hinesville, Kathleen, Lawrenceville, Macon, Marietta, Newnan, Oakwood, Rome, Savannah, Stockbridge, Valdosta, and Waycross. 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.

Georgia has no Indian Health Service clinical facilities.

A-5. Georgia Stakeholder Governance Structure and Engagement in Existing Health IT and HIE Activities

Georgia Statewide HIE Governance

Current HIE Governance and Policy Structures

The Georgia statewide HIE Network governance model is a public-private collaborative ("Collaborative") consisting of the Georgia Health Information Network, Inc. (GaHIN), an established non-profit 501(c)(3)

corporation, the state's Medicaid agency – Georgia Department of Community Health (DCH), Georgia Department of Public Health and various other state agencies, the Georgia Health Information Technology Regional Extension Center (GA-HITEC), and 25 other key stakeholders from Georgia's business, healthcare, technology and academic communities. Collectively these organizations form the "Governance Organization." The Governance Organization has worked to establish each of the foundational components of the Georgia HIE Network: Directed Exchange, Query-Based Exchange and Consumer-Mediated Exchange. Between 2010 and 2013, DCH was responsible for developing and implementing the technology, policies, and agreements supporting the Georgia statewide HIE Network. While the GaHIN Board of Directors and its committees recommended policies and requirements for the Georgia exchange, it was DCH with responsibility to approve and enforce the policies and agreements supporting the Georgia HIE Network. As envisioned and designed by the Collaborative, these responsibilities transitioned from the public sector, DCH to the private sector, GaHIN in 2013. Stakeholders from all across Georgia, as well as leadership in Georgia's state government agreed that this type of governance structure was best suited to quickly adapt to ever-changing requirements, standards, and best practices of the Georgia statewide HIE Network. The GaHIN Board of Directors meets on a quarterly basis to provide strategic direction for the Network.

GaHIN plays a critical leadership role in fostering effective and efficient exchange of health information that leverages existing regional and state efforts and is based on HHS-adopted standards and certification criteria. GaHIN uses its authority, programs, and resources to:

- Develop state-level directories and enable technical services for HIE within and across Georgia;
- Remove barriers and create enablers for HIE, particularly those related to interoperability across laboratories, hospitals, clinician offices, health plans and other health information trading partners;
- Convene health care stakeholders to ensure trust in and support for a statewide approach to HIE;
- Ensure that an effective model for HIE governance and accountability is in place;
- Coordinate an integrated approach with Medicaid(DCH) and public health programs(DPH) to enable information exchange and support monitoring of provider participation in HIE as required for Medicaid meaningful use incentives;
- Develop or update privacy and security requirements for HIE within and across Georgia's borders; and
- Coordinate activities across Medicaid and state public health programs, to avoid duplicate efforts and to ensure integration and support of a unified approach to information exchange.

Advisory and Policy Committees of GaHIN

GaHIN maintains six committees, three advisory committees and three policy committees. The following GaHIN committees are comprised of volunteer subject matter experts including those from Georgia Medicaid, Public Health, payers, health system/hospital leaders and many others. The committee members provide advice and recommendations to the Board in their respective areas of focus. The Governance Organization determines the strategic direction of the Georgia HIE Network and ensures that it serves the interests of the entire Georgia healthcare provider and patient community.

The three advisory committees and their areas of focus are:

- Regional HIEs Committee —operational experience
- Clinical Committee — quality measures and provider participation in e-Prescribing, lab exchange, and use of clinical care summaries
- Secondary Use Committee — public health and biosurveillance

The three policy committees are and their areas of focus are:

- Technology Committee — use cases architecture, standards, and interoperability
- Legal and Privacy Committee — policies and privacy and security processes and procedures
- Financial Committee — business operations and financial sustainability

GaHIN Board of Directors

The current list of board of directors can be found at ***http://www.gahin.org/board-directors***

GaHIN Operations & Leadership Team

GaHIN is responsible for oversight of the Georgia Health Information Exchange Network. In October 2013 GaHIN established a full-time leadership and operations team to support GaHIN's on-going operations, business development, and product marketing and outreach efforts. This team is led by Denise Hines, DHA, PMP, FHIMSS, a highly regarded executive with more than 25 years of healthcare, technology and policy expertise. Dr. Hines works closely with the GaHIN board of directors and multiple stakeholders to set the strategic vision and direction of the Network. Dr. Hines leads a team of experienced operations staffers responsible for new GaHIN Member on-boarding, technology project management, provider outreach and education, on-going analysis of any new requirements, protocols, or standards to support statewide and national HIE, maintenance of legal and policy framework, and supporting the overall HIE governance structure. Dr. Hines holds a doctorate in Healthcare Administration, is the CEO of eHealth Services, a recognized consulting firm, and is a member of the National Health Information & Management Systems Society (HIMSS) Board of Directors.

GaHIN Policy Framework

All Network Participants who have been accepted by the Vendor and Network Facilitator for participation in the Network as a Network Participant and have entered into a written agreement with Vendor concerning the Network Participant's use of the Network, are required to comply with these Policies. In addition, all Network Participants must require their Member Affiliates to comply with these Policies. Where appropriate, or where required by the operational models and/or governance structures of the Network Participant, a Network Participant may delegate certain of the responsibilities set forth in the policies to its Member Affiliates. The following is a list of the current polices for GeorgiaDirect (Direct protocol) and Georgia Connected Care (query-based HIE Network). These policies apply to Health Data (including Health Care Provider Health Data, Health Plan Health Data, and HIO Health Data), as defined herein, that is exchanged via the Network.

GeorgiaDirect
Policy 1001: Administration of the Network
Policy 1002: Use of Health Data
Policy 1003: Technical Requirements for Direct Secure Messaging Service
Policy 1004: Requirements for Participants
Policy 1005: Enterprise Security
Policy 1006: Breach Notification
Policy 1007: Representations, Warranties, and Disclaimers
Policy 1008: Proprietary Information
Policy 1009: Business Associate Agreements

Policy 1010: Liability Policy 1011: Term, Suspension, and Termination Policy 1012: Insurance Policy 1013: Indemnification Policy 1014: Dispute Resolution Policy 1015: Notices Policy 1016: Miscellaneous/General Policy 1017: Definitions
Georgia Connected Care
Policy 1001: Data Practices of Georgia Health Information Network Policy 1002: Identify Verification Policy 1003: Notice of Privacy Practices Policy 1004: Minimum Necessary and User Authorization Policy 1005: Account of Disclosures Policy 1006: Workforce Members, Agents, and Contractors Policy 1007: Opt-Out Policy 1008: Permitted Purposes Policy 1009: Restrictions on Sensitive Health Information Policy 1010: Digital Certificate Policy Policy 1011: Password Policy Policy 1012: Patient Record Matching Policy 1013: Master Patient Index Policy 1014: Data for Research and Analytics Policy 1015: Breach Notification Policy 1016: eHealth Exchange

GaHIN as State Designated Entity for HIE

Based on the strength of the organization, high level of performance, and it's acknowledged position as a national leader in the field of health information exchange GaHIN is the State Designated Entity for HIE in Georgia since feb 5th 2016.

Georgia Stakeholders Involvement in HIE and Health IT Activities

Georgia Department of Community Health – Division of Health IT

Georgia Health Information Exchange Network

On June 29, 2012 DCH launched *GeorgiaDirect*, Directed Exchange secure messaging. Directed Exchange specifies a simple, secure, scalable, standards-based way for participants to send encrypted health information directly to known, trusted recipients over the Internet. The Georgia Medicaid Web Portal is currently being enhanced to make G*eorgiaDirect* available to all Georgia Medicaid providers – giving each provider the opportunity to securely and electronically exchange patient health data for purposes of treatment.

Georgia Medicaid EHR Incentive Payment Program

Georgia Medicaid is participating in the Centers for Medicare and Medicaid Services (CMS) EHR Incentive Program. This Program will provide incentive payments to Eligible Professionals (EP) and Eligible Hospitals (EH) including critical access hospitals (CAHs) and children's hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. This Program is supported through CMS as part of the American Recovery and Reinvestment Act of 2009.

As of March 2017, Georgia has distributed over $278M Medicaid EHR incentive payments to 130 eligible hospitals and 4,026 eligible professionals.

Georgia Testing Experience and Functional Tools (TEFT)

In April 2014, the Centers for Medicare & Medicaid Services (CMS) awarded the Georgia Department of Community Health the Testing Experience and Functional Tools grant (TEFT). The purpose of the four year grant is to test quality measurement tools and demonstrate e-health in Medicaid community-based long term services and supports (CB-LTSS). The TEFT initiative supports state Medicaid agencies in collecting and reporting on the adult core measures found in section 2701 of the Patient Protection and Affordable Care Act. Georgia will demonstrate all four TEFT components by working collaboratively with the DCH Community-Based Waiver Programs (Independent Care Waiver Program (ICWP) and Community Care Services Program (CCSP)), CMS, Georgia Tech Research Institute (GTRI) and the Office of the National Coordinator (ONC). The TEFT components are designed to field test a cross-disability experience of care survey and a set of functional assessment items, demonstrate personal health records, and create an electronic LTSS service plan standard.

The four components of TEFT are as follows:

- Experience of Care Survey (EoC) – Elicits feedback on members' experience with the services they receive in Medicaid CB-LTSS programs via the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Home Health survey.
- Functional Assessment Standardized Items (FASI) – CMS invested in the development of standardized functional assessment items for assessing Medicaid post-acute care recipients.
- Personal Health Record (PHR) - Demonstrate the utility of a Personal Health Record tool for the Medicaid CB-LTSS population by leveraging the Regional Health Information Exchange (Georgia Health Connect) via the Georgia Health Information Network (GaHIN).
- electronic Long Term Services and Supports Service (eLTSS) – Identify and harmonize a service plan standard to enable electronic exchange of information relevant to the care of individuals receiving CB-LTSS in conjunction with the ONC Standards and Interoperability (S&I) Framework.
    - Additionally, Georgia is awarded a supplemental to augment the eLTSS scope of work with CMS and ONC including a reference data model to support the LTSS information. This will allow for development of a data standard (HL7) to share information across the LTSS ecosystem.

Additional source information: https://www.medicaid.gov/medicaid/ltss/teft-program/index.html

A-6. Georgia Medicaid HIE and Health IT Relationship with Other Entities

Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD)

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) is the state agency that focuses solely on policies, programs, and services for people with severe and persistent mental illness, substance use disorders, and developmental and intellectual disabilities.

The DBHDD system of services is administered through six (6) Field Offices. DBHDD operates five (5) regional state institutions/hospitals and a nursing home and provides and oversees provision of community-based services across the state. Through its direct service provision and partnership with community-based service providers, DBHDD served 163,800 people in Fiscal Year 2015. The majority of services provided were for mental illness. The state-run institutions/hospitals provide a spectrum of care from 23-hour observation through residential services.

DBHDD has deployed an integrated Electronic Medical Record system (myAvatar) across each of their regional state institutions/hospitals. The department has also joined the Georgia Health Information Exchange (HIE) system, an Electronic Health Record (EHR) initiative, that connects the five Georgia state institutions/hospitals with other members of the Georgia HIE system (Emory Healthcare, Grady Health System, other State Agencies, etc.) . Once the Query-Based Exchange Georgia HIE is established, the Georgia Department of Community Health will initiate a project to connect with the DBHDD EHR system. By creating HIE and DBHDD EHR interoperability, Georgia's behavioral health hospital system will have the tools to provide better coordinated care by presenting primary care data within a behavioral health setting.

Georgia Department of Juvenile Justice (DJJ)

The Georgia Department of Juvenile Justice (DJJ) operates 26 secure facilities and 97 Community Services Offices throughout the state with a mission of providing a safe, secure environment for juvenile offenders. Including those placed on probation, approximately 50,000 youths are diverted each year to evidence-based community programs, sentenced to short-term incarceration and/or committed to long-term custody by Juvenile Courts.

While under DJJ supervision, youths are provided with medical and mental health treatment, as well as specialized education and a variety of other programming. Every juvenile that is committed to DJJ receives a medical service plan and each is enrolled in Medicaid (by his/her case worker).

DJJ health services include nursing care, pharmacy services, annual health screenings and assessments, dental services, immunizations, daily sick call, ongoing care for chronic conditions, nutritional services and health education. Current DJJ policy is that within two hours of admission, all youths are screened for medical and mental health issues, traumatic experience, substance abuse and suicide risk. The goal is to identify at-risk youth as early as possible and provide them the care required.

In March 2014, DJJ connected with Georgia' statewide health information exchange (HIE), the Georgia Health Information Network (GaHIN). Using an internet-based clinical viewer that leverages the query functionality of GaHIN, DJJ staff members are able to retrieve real-time patient health information about the youths in their care.

Through GaHIN, DJJ clinicians have access to individual patient records as well as the Georgia Registry of Immunization Transactions and Services (GRITS).

Georgia Department of Corrections (DOC)

The Department of Corrections (DOC) is an organization that provides corrective services to an inmate population of about 53,000 in Georgia. The Department operates 31 State prisons (housing 350 to 2,000 inmates each) and four private prisons. There also are 48 County Correctional facilities, which include County Camps and Jails. Medical intake for the inmates takes place at Georgia Diagnostic Prison for men and Lee Arrendale for women.

DOC manages a prison hospital in Augusta (ASMP-the Augusta State Medical Prison) and occupies a wing of the Atlanta Medical Center (AMC) hospital. It also contracts with a facility in Columbia, South Carolina for long-term care (GeoCare). All prisoners go through ASMP en route to GeoCare.

DOC currently does not use EHRs at any of its facilities; all health records are paper-based. As prisoners move around over the course of their time in a Corrections institution, their paper records follow them. However, if the inmate requires a hospital stay, the paper-based records are not transferred to the hospital. Similarly, DOC does not receive any discharge records from the hospital after an inmate's discharge. The medical records are archived after the inmate is released from the system and are updated if the inmate returns to the system. Corrective Dental Systems (CDS) is in about 6 facilities and has eRecords (ASMP provides more intense dental care like reconstructed jaw surgery to the inmates).

DOC is partnering with Georgia Health Science University (GHSU) for implementing EHR technology. A pilot program will start at 4 DOC facilities and the initial assessment for the same was completed in January 2012. The EHR pilot will have EHR technology implemented at all four women's prisons (Lee Arrendale State Prison, Pulaski State Prison, Emanuel Facility, and Helms facility). These four prisons serve the entire female population and includes the diagnostic and classification center for our females. When all facilities are up-and-running, EHR technologies will be at 50 sites (which include probation sites). Cerner is the EHR vendor selected for this implementation.

In the past, providers that practiced in prisons and jails were not eligible to receive incentive payments due to eligibility requirements. Those requirements stated that demonstrating a Medicaid patient volume of 30%, needed encounters to be paid encounters. Medicaid, per section 1905 of the Social Security Act, cannot pay for medical services in correctional institutions. In August 2012, a new regulation, Meaningful Use Stage 2, was published and now the requirement is that providers need to have 30% of their encounters be with Medicaid enrolled patients as opposed to paid encounters. This change now allows the providers who see Medicaid enrolled inmates in prisons and jails to count those patients toward their patient volume and may be eligible for the incentive payments. Because of that change, Georgia Department of Community Health would like to further explore with the DOC, the possibility of their providers qualifying for HIE onboarding

Georgia Department Family and Child Services (DFCS)

Georgia Families 360 went live on the GaHIN network February 2014.

Georgia Technology Authority (GTA)

The Georgia Technology Authority (GTA) currently manages the delivery of IT infrastructure services to 85 Executive Branch agencies and managed network services to 1,300 state and local government entities. IT infrastructure services encompass mainframes, servers, service desk, end user computing, disaster recovery and security; 14 agencies receive all of these services through GTA, while the remaining agencies may receive two or three of these services. Managed network services include the state's wide and local area networks, voice, cable and wiring, and conferencing services.

Both categories of services are provided as shared services through a public-private partnership called the Georgia Enterprise Technology Services (GETS) program. A Multisourcing Service Integrator is responsible for coordinating and overseeing the delivery of services by multiple providers.

GTA's Sourcing Management Organization is responsible for service provider oversight and management while our Sourcing Governance Organization is responsible for governance.

Meanwhile, GTA's Enterprise Governance and Planning promotes an enterprise approach to technology by establishing statewide policies, standards and guidelines based on industry best practices and federal requirements. EGAP works closely with the Governor's Office of Planning and Budget and state agencies to ensure an individual agency's IT strategy aligns with its overall business strategy and business continuity planning. EGAP is involved in managing the state's portfolio of technology projects to ensure they meet established goals and are completed on schedule and within budget.

Information security is a critically important concern at GTA, and the Office of Information Security gives particular attention to supporting the development of training for state employees so they understand their role in protecting sensitive information. In compliance with statutory requirements, GTA gathers data from state agencies on an annual basis regarding their IT security programs and IT expenditures. The data are compiled into reports that are useful in guiding state leaders in their decision making.

GTA manages the state's official online portal, www.georgia.gov, and enterprise web-publishing platform. The portal provides information and services from more than 115 state agencies and links to city and county government websites. The enterprise platform supports 78 state agency websites. Both the portal and the enterprise platform are carefully designed to ensure friendly navigation, accessibility for users with disabilities, and robust search capabilities.

GTA's vision - A transparent, integrated enterprise where technology decisions are made with the citizen in mind

GTA's mission - To provide technology leadership to the state of Georgia for sound IT enterprise management

Georgia Institute of Technology Research Institute (GTRI)

In April of 2012, the Georgia Department of Community Health (DCH) partnered with researchers from Georgia Tech's Institute for People and Technology to conduct research and gather community input on the goals, motivations, and concerns of Georgia healthcare professionals regarding health information technology (IT).

The initiative informs a customer-centric approach to DCH and its partners' programs in support of health IT, including electronic health records (EHRs), meaningful use, and health information exchange.

Georgia Tech's research consisted of three complimentary efforts:

- Interviews with over 40 individuals across a range of roles and organizations
- An online survey which solicited input from over 3,000 Georgia physicians
- A literature review of nearly 100 papers and articles

The research conducted by Georgia Tech resulted in the following key findings:

- Overall, physicians feel that health IT will improve patient outcomes and quality of care. However, they do not feel that health IT will improve cost savings (large organizations are a notable exception).
- Larger organizations, fewer years of experience, and higher levels of technology adoption correlate to more positive views regarding health IT
- Smaller organizations, more years of experience, and lower levels of technology adoption correlate to more negative views regarding health IT
- Out of seven possible options, "Impact on Workflow" and "Ease of Use" were selected as the most important criteria for evaluating health IT by a strong margin; "Cost" was a distant third.

Project: **Health IT User Experience Research Project**

Problem: To uncover and assess the behaviors and motivations that drive healthcare providers' adoption of health information technologies.

Solution: Recommendations to DCH on how the statewide health information network can support optimization of providers' health IT investment.

Impact:

- Informed a customer-centric approach to DCH's statewide health information network.
- Initiated provider relationships that Georgia Tech has leveraged in subsequent DCH-Georgia Tech HIT research projects.
- Spawned additional HIT collaborations with Georgia providers that utilize the statewide health information network.

Medicaid Member Research.

Project: **Medicaid Member Portal (MMP) Research Project**

Problem: To identify and understand the health information needs of Medicaid Members and their caregivers in support of their chronic disease management.

Solution: Recommendations for the MMP redesign and member engagement.

Impact:

- Member access to credible, tailored information.
- Redesigned MMP that is useful to Medicaid members.
- Supports providers' MU Stage 2 and 3 attestation.

Project: **Patient Profile/MD Portal Medicaid Project**

Problem: To understand the information needs of healthcare professionals accessing MMIS data and clinical data via the GaHIN; to identify compelling use cases for data analytics and predictive modeling.

Solution: Provider engagement via research study. The study culminated with a functional requirements document for a data-driven care management and quality improvement (CM/QI) solution that will perform analysis on claims and clinical data available via the GaHIN.

Impact:

- Outlined research-informed plan for the statewide health informatics initiative.
- Physician Hospital Organization (PHO) and Independent Practice Association (IPA) engagement.
- Expanded knowledge base of Georgia HIT landscape which was used in crafting the successful TEFT Grant proposal.

A-7. Existing HIEs within Georgia

Georgia Service Area Health Information Exchanges and Other Partners

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.

TABLE 6.2 – GEORGIA SERVICE AREA HEALTH INFORMATION EXCHANGES
Working Table of Service Area HIE Initiatives in Georgia

HEALTH INFORMATION EXCHANGE	ACTIVE/INACTIVE	GEOGRAPHIC COVERAGE
Archbold HIE	Inactive	
Central Georgia Health Exchange	Merged	Became part of GRAChIE
Chatham HealthLink Consortium	Partnered	Partnered with GRAChIE in 2014
Emory Health System	Active	Limited to Emory health system and network of physicians
Georgia Regional Academic Community Health Information Exchange (GRAChIE)	Active	Statewide
Health One	Not active as an HIE	
HealtheConnection	Active	Northeast Georgia
West Georgia Health System	Merged	Merged with WellStar
Georgia Health Connect (GaHC)	Active	Statewide
HealtHIE Georgia	Active	Rural Georgia healthcare providers

A-8. Role of the MMIS in the Health IT/HIE Environment

Coordination of the Health IT Plan with the MITA Transition Plans

A new Georgia MMIS system was launched on November 1, 2010. The Georgia MMIS System has an important role within the landscape of Georgia health IT and the Georgia statewide Health Information Exchange (HIE). Georgia's Medicaid process, supported by the MMIS System, will be aligned and coordinated with the SMHP, which includes a roadmap for health IT 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 and training

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, waste, and abuse detection

The State Health IT Coordinator, State Medicaid Director, and DCH Chief Information Officer 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.

MITA Transition Plan Coordination

The following table outlines how Georgia's proposed IT solutions (specifically related to the MIP program and HIE project) will meet each of the 7 Standards and Conditions and how Georgia DCH will ensure that the Health IT-related systems are integrated within the total Medicaid IT enterprise, as appropriate, rather than being a stand-alone system.

Standard and Condition	Description	Georgia
1. Modularity Standard	Condition requires the use of a modular, flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces (APIs); the separation of business rules from core programming.	DCH Division Health IT has administered the MIP program in phases to support the various stages of provider attestation (ex: AIU, MU). MAPIR core and Georgia customized MMIS integration development and implementation is also produced in a modular and phased approach to ensure successful deployment without significantly impacting Medicaid system functionality. For all project phases and MAPIR enhancements Georgia employs project management best practices, including use of the system (software) development life cycle (SDLC) methodology for improved efficiency and quality of products and services. Georgia also emphasizes the flexibility of open interfaces and exposed APIs as components for the services layer whenever appropriate. These exposed APIs will be available to data service hubs for the reporting of data, verifications and the Georgia statewide health information exchange. These interfaces will be documented in the Interface Control Document (ICD) CMS template when available. The MAPIR Core product contains business rules developed by the multi-state collaborative. Georgia is a key stakeholder and provides input to the collaborative impacting development of the overall business rules engine. The MAPIR Georgia customization and MMIS integration In both cases, the business rules are contained separately from the core programming. Georgia is able to accommodate changes to business rules to enhance the customized version to create efficiencies where and when necessary using the HP/MMIS change request system. Georgia will make business rules in human-readable form to an HHS repository when CMS provides details and specifications as to how to submit the MAPIR and MIP program business rules.

Standard and Condition	Description	Georgia
2. Advance MITA Condition	This condition requires Georgia to align to and advance increasingly in MITA maturity for business, architecture, and data.	The DCH Division of Health IT, specifically, the MIP program team shall work with Georgia Medicaid and IT office to complete and continue to make measureable progress in implementing the agency's MITA Maturity Model Roadmap, including: MITA self-assessments, and development of a concept operations and business work flows for different business functions. The MIP program team continuously evaluates the program's operations and MAPIR functionality to streamline and standardize operational approaches and business work flows in an effort to minimize customization demands.
3. Industry Standards Condition	This condition requires that Georgia ensure alignment with and incorporation of, industry standards regarding: HIPAA, accessibility, ACA 1104 Operating Rules, Sec. 1561 health insurance exchange.	The DCH Division of Health IT, specifically, the MIP program team in conjunction with the MAPIR multi-state collaborative, actively pursues identification of all industry standards relevant to the scope and purpose of the MIP program and produces development and testing plans to ensure full compliance when necessary. Both the MAPIR Core and Georgia customization SDLC and project plan include system development phases such as requirements analysis, technology build, system testing, and user acceptance testing (UAT). MAPIR incorporates ADA Section 508 Compliance Testing for all applicable enhancements and modifications to User Interface screens.
4. Leverage Condition: Medicaid Enterprise Technologies	This condition requires that Georgia solutions shall promote, sharing, leverage and reuse of Medicaid technologies and systems within and among states.	DCH has entered into a multi-state agreement for purposes of sharing system programming and design to support the MIP program with automated provider application functionality, allowing for Georgia-specific customization. The DCH Division of Health IT is currently exploring and evaluating MMIS/HIE integration,

Standard and Condition	Description	Georgia
		HIE/GRITS (immunization) data exchange, and other possible system integration and exchange opportunities. DCH also received an ONC Challenge Grant related to Consumer-Mediated Information Exchange, enabling bi-direction data exchange between clinician's EMR to patients PHR. The project is intended to leverage Phase 1 of the Georgia statewide HIE (Direct Project protocols) to enable the bi-directional functionality. As part of the grant and overall initiative, the project components will be packaged for dissemination to communities within Georgia and across the nation to provide patient/provider bi-directional communication supporting various patient populations and conditions. **Note:** *GeorgiaDirect* was launched on June 29, 2012 and is in the pilot phase with major urban and rural hospitals, all Georgia Medicaid providers, and several local area HIEs.
5. Business Results Condition	This condition requires that Georgia shall support accurate and timely processing of claims (including claims of eligibility), adjudications, and effective communications with providers, beneficiaries and the public.	The DCH Division of Health IT is part of the MAPIR multi-state collaborative (including HP as the vendor) to produce a highly-automated system to process MIP applications. HP provides 21st century customer and partner experience for all individuals (provider applicants, GA-HITEC sub-recipients, and providers). DCH enters into an agreement with the MAPIR collaborative and HP through amendments to the DCH/HP MMIS contract. The MAPIR amendments are linked to the service level agreements (SLAs), performance standards and testing of the original MMIS Master Contract. MAPIR amendments may also include additional performance guarantees specifying invoice reductions or other mechanisms to ensure quality product functionality and services.
6. Reporting Condition	This condition requires that Georgia shall produce transaction data, reports, and performance information that would contribute	The DCH Division Health IT, specifically the MIP program team and shall produce reports related to program oversight, administration, evaluation, integrity, and transparency. These

Standard and Condition	Description	Georgia
	to program evaluation, continuous improvement in business operations, and transparency and accountability.	reports shall demonstrate MIP program and MAPIR system utilization, provider application processing, provider engagement, communication and outreach.
7. Interoperability Condition	This condition requires that Georgia ensure seamless coordination and integration and interoperability with the statewide health information exchanges.	The DCH Division Health IT is currently developing strategies based upon evaluation of opportunities for systems integration and interoperability between the statewide HIE and MMIS, GRITS, and other systems that would benefit Medicaid members and providers.

A-9. Current State Activities to Facilitate EHR and HIE Adoption in Georgia

The following section describes Georgia's activities currently underway or in the planning phase to facilitate HIE and EHR adoption. This section also outlines how Georgia Medicaid, Public Health, the GA-HITEC and other stakeholders play a significant role in establishing and benefiting from statewide health information interoperability.

Medicaid EHR Incentives Program (MIP)

The EHR Incentive Program provides incentive payments to Eligible Professionals (EP) and Eligible Hospitals (EH) including critical access hospitals (CAHs) and children's hospitals as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.

The following outlines the MIP payments made through March 2017

Life of the Program (September 2011 - March 31, 2017)						
	Adopt / Implement / Upgrade (AIU/MU YR1)		Meaningful Use (MU YR 2-6)		Totals	
	Number Of Payments	Amount Paid	Number Of Payments	Amount Paid	Number Of Payments	Amount Paid
EH	**130**	**$ 61,981,662.93**	**239**	**$ 106,019,538.08**	**369**	**$ 168,001,201.01**
EP	**4026**	**$ 84,872,524.00**	**2988**	**$ 25,143,030.00**	**7014**	**$ 110,015,554.00**
Nurse Midwives	148	$ 3,145,000.00	115	$ 977,500.00	263	$ 4,122,500.00
Dentists	382	$ 8,117,500.00	11	$ 93,500.00	393	$ 8,211,000.00
Nurse Practitioners	791	$ 16,808,750.00	476	$ 4,046,000.00	1267	$ 20,854,750.00
Physicians	2678	$ 56,227,524.00	2366	$ 19,856,030.00	5044	$ 76,083,554.00
Physician Assistants	27	$ 573,750.00	20	$ 170,000.00	47	$ 743,750.00
Grand Total	**4156**	**$ 146,854,186.93**	**3227**	**$ 131,162,568.08**	**7383**	**$ 278,016,755.01**

Provider Interface for the Medicaid Incentive Program

DCH with its fiscal agent, HP has developed and deployed the Medical Assistance Provider Incentive Repository (MAPIR) product part of 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.

Establishing the Georgia HIE Network

The following outlines recent activities taking place in Georgia to establish the statewide HIE network. ***The Georgia Medicaid is a beneficiary of the statewide planning and implementation activities.***

Governance Structure: Public-Private Collaborative
The governance structure supporting the Georgia HIE is a public-private collaborative comprised of the Georgia Department of Community Health (DCH), the Georgia Health Information Network, Inc. (GaHIN), a non-profit 501(c)(3) corporation and the Georgia Health Information Regional Extension Center (GA-HITEC). Together these organizations form the "Governance Organization" responsible for facilitating the governance, design, development, implementation, and sustainability of the Georgia HIE.

Governance: Policy Framework development and approval process
While the GaHIN, Inc. Board of Directors and the Committees recommend policies and requirements for the Georgia exchange, it is ***DCH is a member of the board that approves the policies and agreements supporting the Georgia HIN***. This type of governance structure is best suited to quickly adapt to ever-changing requirements, standards, and best practices.

Technology Infrastructure: Thin Layer of Connectivity
The Georgia HIN has been constructed to present a decentralized "thin layer" data exchange system and offer two types of data exchange products GeorgiaDirect (Directed Exchange) and Connected Care Query-Based Exchange (QBE). The "shared services" network will allow for secure data exchange and transport

between and with various Qualified Entities (QEs), such as local/regional service area HIEs in the state. This interoperability structure facilitates interactions between one HIE Participant and another. Both types of data exchange will be hosted by technology vendors in a SaaS model infrastructure. This approach is intended to provide the greatest opportunity for simple, low cost interoperability across Georgia while limiting the need for extensive operational support.

The Georgia Organizational Strategy: A Network of Networks Model

Based upon the unique needs of our state, the Georgia HIE Governance Organization is constructing an interoperable marketplace and a two-tiered organizational strategy that utilizes a network of Qualified Entities to assist in the deployment of a statewide health information network. This model was selected to allow Georgia to benefit from the health information exchanges already established, as well as provide a means to leverage a set of core and value-added services to benefit the entirety of the Georgia health care ecosystem. The range of QEs make up the core structure of the statewide HIE network while the Governance Organization provides policy guidance, core exchange services and interoperability.

Georgia HIE Sustainability Planning

The Governance Organization is constructing the Georgia HIE network to provide a very low cost, superior quality, and highly scalable technical infrastructure for both GeorgiaDirect and Connected Care Query-Based Exchange. In accordance with the requirements of the State Health Information Exchange Cooperative Agreement Program, DCH utilizes ONC funding for technology development, implementation, and maintenance, to establish the HIE business and ensure long-term sustainability through sound business practices. DCH will also leverage available funding from the Centers of Medicare and Medicaid Services (CMS) for the administrative build the statewide HIE network and production of related data exchange features and functionality. Other investment opportunities include private industry investment, subscription service fees, and private industry business partnership. Deployment of HIE network features (i.e.: core and value-added services), will be prioritized to best enable providers to achieve Meaningful Use and enhance services for Medicaid members where ever possible.

Georgia's Approach to Accelerated Adoption of Health IT

Georgia acknowledges that without full provider implementation and utilization of health IT into their practice or health care delivery system, the three-part aim of better care, better health and lower costs will likely never be completely realized. To accelerate health IT adoption and utilization among Georgia providers, specifically Medicaid providers, DCH contracted with the Georgia Institute of Technology to conduct user research and benchmarking. These activities were designed to discover provider behaviors and motivations regarding adoption and use of health IT within their health care practice. Georgia Tech's research produced a clear understanding of where the current health IT adoption experience falls short for providers and identified opportunities to rapidly increase deployment of key technologies across the provider landscape. Together with DCH, Georgia Tech is crafting a model to presenting a framework for technology vendors and other stakeholders to improve health IT product features to better meet providers' work flow needs and expectations as they navigate through the complexities of adopting health IT into their practice. The research specifically examined the Medicaid provider health IT experience to identify opportunities to improve adoption and utilization of such technology. The research also produced information regarding the health IT products and services meeting the specific clinical needs of Medicaid providers and others. As per the latest guidance on the SMD letter, Georgia has also begun to reach out to non-EPS as part of the outreach program.

In addition, DCH is contracting with the GA-HITEC to act as the Georgia HIE network "sales force", to execute both traditional and digital marketing campaigns, conduct outreach and education activities

directed at providers, and provide support to providers searching for process and technical assistance in their adoption of health IT.

Below is a list of Key Medicaid health IT efforts (currently underway and being planned) in Georgia that help support information exchange:

MMIS Certification: In April 2012, CMS granted Georgia DCH official notice of MMIS certification.

ICD-10, Integragted : Projects completed.

***GeorgiaDirect* Medicaid Provider Rollout Project:** DCH launched *GeorgiaDirect* (Directed Exchange) on June 29, 2012. DCH is the midst of designing a process with Medicity, the *GeorgiaDirect* vendor and Hewlett Packard (HP), the Georgia Medicaid Fiscal Agent, to deploy Direct addresses to all active and verified Georgia Medicaid providers. This will give more than 30,000 individual Medicaid providers the ability to securely exchange electronic patient data for purposes of treatment. DCH believes the greatest amount of electronic exchange with *GeorgiaDirect* will take place within the Medicaid provider community using well-established referral patterns. Self-service tools will be available to the providers to learn how to use *GeorgiaDirect* and discover the many benefits the service presents.

Medicaid Care Management Portal ("the Portal"): Currently exploring development of online tools that speed the exchange of a patient's relevant health information across the continuum of care in unique, interactive and collaborative care experience. These tools include a provider-facing care management portal with key features such as a triage dashboard giving providers real-time information about patients in need of care interventions based upon specific patient health data elements. Portal features and functionality will be a foundation and accelerator for providers considering adoption of the Patient-Centered Medical Home model. The individual provider and/or care team will have information available to them to monitor for any changes in a patient's health using the triage dashboard. This allows the clinician to enhance the patient's care experience by quickly responding to triggered alerts, thereby optimizing patient outcomes. The Portal would also present providers with their specific clinical quality measurements and advise them on ways to improve performance. This portal would be available to Medicaid providers through the Georgia MMIS Web Portal which is already part of the provider work flow.

Georgia Families 360. Medicaid and Inter-Agency Foster Care and Adoptive Assistance Initiative: The purpose of the Foster Care and Adoptive Assistance Initiative is to transition from Fee-for-Service to Managed Care services. Children in foster care often do not receive optimal health care because of frequent changes in placements and health care providers. Fragmented medical records, and inconsistent access to appropriate care. The rationale for moving children in foster care to managed care is to:

- Enhance the coordination of care and access to services;
- Improve health outcomes;
- Develop and utilize meaningful and complete medical records; and
- Full compliance with regulatory reporting requirements.

A joint task force has been convened and is comprised of the Georgia Department of Community Health (DCH), the Georgia Department of Public Health (DPH), the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), and the Georgia Department of Family and Child Services (DFCS). The Foster Care and Adoptive Assistance Joint Task Force is advisory in nature and its goal is to provide

input into the transition of the foster care and adoptive assistance populations to one of the Care Management Organizations (CMOs) currently participating in Georgia Families, a full-risk managed care program for certain Medicaid populations and PeachCare for Kids. These agencies are now utilizing the clinical viewer to coordinate care

A-10 Public Health Coordination

Because of a shared responsibility to provide health care services populations across the state, including a focus on indigent and underserved populations, there is a natural partnership between DCH and the Department of Public Health (DPH). DCH and DPH have identified a series of collaborative opportunities but are most focused on improving the cost and quality of care by enabling provider access to technology and supporting Meaningful Use. Over the last 3 years, the DCH-DPH collaboration has led to many successes and identified many new opportunities for future collaboration. The sections below summarize the completed and ongoing projects, as well as the projects that are anticipated for the future.

Completed Projects

Georgia Health Information Exchange Network: Connecting to Public Health's Syndromic Surveillance Disease & Immunization Registries

In 2013, DCH completed the infrastructure build, referenced above, for a statewide health information exchange, the Georgia Health Information Network (GaHIN), to connect Regional Area HIEs, large integrated health systems, payers, wellness partners and other healthcare stakeholders. GaHIN aims to close the patient information gap across care settings by electronically connecting disparate systems and data sources to support improved quality of care, better health outcomes, and reductions in costs.

As a key partner, DPH was engaged early on in an effort to identify services that provide value to provider participants and support the mission of the two agencies. After connecting GaHIN to Medicaid as a seed of initial patient information, DCH, DPH and GaHIN completed a bi-directional connection to Georgia Registry of Immunization Transaction Services (GRITS) in October of 2013. The GaHIN-GRITS connection allowed providers to utilize their GaHIN connection to both query for patient's immunization history and submit immunization updates as required by Stage 2 of Meaningful Use. Currently, the GRITS database contains approximately 10 million patient records. 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.

In April of 2014, DPH and GaHIN completed the DPH connection to the State Electronic Notifiable Disease Surveillance System (SendSS) platform to support syndromic surveillance and electronic lab reporting. As with the GRITS connection, providers are able to leverage their GaHIN connection to fulfill syndromic surveillance reporting requirements for Meaningful Use.

Ongoing Projects

DCH & DPH Memorandum of Understanding

In August 2012, DCH signed a Memorandum of Understanding to use CMS 90/10 HITEC funding to support enhancements that aligned with MU standards and prepared DPH for HIE participation. The following list outlines the projects DPH and DCH are working to complete as part of this MOU:

- **Lab Information Systems:** Modifications to DPH Laboratory Information Systems to enable receipt of electronic orders and transmission of results for development of a crosswalk to logical observation identifiers names and codes.
- **Technical Staff:** Assessment of improved technological resources for DPH and DCH in preparation of HIE implementation.
- **Requirements Gathering:** Requirements gathering and business process analysis for connecting the Georgia Comprehensive Cancer registry to the Georgia HIE
- **GRITS Enhancements:** Enhancements to DPH's immunization registry, GRITS, including system upgrades.
- **GRITS WebServices:** Installation of GRITS web services to augment the Public Health Information Network Messaging System
- **Technical Resources:** Maintenance of the State Electronic Notifiable Disease Surveillance System, (SENDSS)
- **DPH Onboarding:** Public health clinic EPs have successfully attested to HER incentive payments

Asthma Collaboration Project

Grantees from the Office of National Coordinator for Health Information Technology are required to select a State Health Goal demonstrating how Health Information Technology impacts health outcomes. Georgia selected the reduction of Childhood Asthma as the State Health Goal. DCH is currently partnering with DPH and external providers in the project to implement a consistent clinical protocol, collect baseline and future data on childhood asthmatics, and evaluate the impact of the protocol using electronic medical records and HIE.

The objectives of the project are to:

- Connect selected provider practices using information technology to successfully exchange health information related to asthma;
- Support selected practices in completing practice improvement training opportunities;
- Collect pre and post connectivity descriptive practice and patient data;
- Collect qualitative data about provider and practice experiences and perceived asthma patient care improvements;
- Inform the State of Georgia's understanding of asthma and how to control this important chronic disease, particularly among children, and inform approaches taken by Georgia to connect provider practices to health information exchanges; and to
- Generate lessons learned for a future rigorous pre-post asthma outcome analysis, as funding permits.

The expected outcomes of this collaboration project are to reduce costs associated with childhood asthma; decrease emergency department utilization for uncontrolled asthma and hospitalizations; reduce missed days of school and missed days of work for parents and children; and to implemented best practices in primary care settings.

Future Projects

Georgia has developed a replicable & highly collaborative model for DCH and DPH to advance Meaningful Use of Health IT and advance its use in addressing some of Georgia's leading health challenges. In the future, the two agencies will focus on enhancing the GRITS connection, developing public health registries and supporting HIV initiatives, including:

- **Enhanced GRITS Offerings:** In a third phase of the GaHIN-GRITS implementation, DCH and DPH are pursuing a service to allow providers connected to GaHIN to provide the official immunization form required by Georgia schools natively from their EHR. This service is expected to support greater utilization of the GaHIN-GRITS service and Meaningful Use reporting. Implementation is expected in 2014.

- **Cancer:** DCH is exploring ways to utilize the GaHIN as an avenue for sharing cancer surveillance data and supporting provider Meaningful Use attestation for reporting.

- **Alzheimer's:** DPH expects to receive funding from the Georgia state legislature to establish an Alzheimer's registry to track and analyze the proliferation of Alzheimer's cases across the state.

- **HIV Initiatives:** In response to legislative discussions about better supporting HIV patients, DPH and DCH are currently engaged in discussions about using health information technology to connect providers and patients across the state. Options include establishing an HIV-specific health information exchange and exploring options for using telemedicine to support HIV positive patients.

DPH and DCH remain committed to and focused on maximizing these and other opportunities to improve the health of our residents.

Provider Outreach Strategy

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

- Co-developed a unified "message" to the provider community recognizing that the GA-HITEC 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 a DCH Division of Health IT resource to act as the GA-HITEC liaison in order to improve cross-organization communications, improve collaboration efforts, and participate in numerous outreach activities. She also participates in the GA-HITEC's monthly sub-recipient meetings.

- DCH consistently co-sponsors events with GA-HITEC. 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, is often in attendance to personally inform and encourage providers to take the necessary steps to participate in the incentive program.

- The DCH and the fiscal agent updated the web presence to include the information. MIP marketing materials have been updated to display GA-HITEC co-branding.

- DCH partners with the GA HITEC and participates in the semi-annual Georgia Medicaid Fair that targeted ALL Medicaid providers.

- MIP currently contract with GA-HITEC to increase education and enrollment efforts targeting Georgia Medicaid Specialists.

- Currently developing strategies with GA-HITEC to promote the statewide Health Information Exchange to those providers who signed with the GA-HITEC and easily transition them to the Georgia HIE.

- DCH is also working closely with GA-HITEC technical team to develop strategies to benefit their members. For instance, GA-HITEC recently selected Health Information Exchange Technologies to develop a Regional HIE to connect providers to the GaHIN. This action was taken in order to further support the Georgia statewide Health Information Exchange (HIE) deployment initiative. Strategic initiatives conducted with GA-HITEC, 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.

- DCH organizes webinars for providers on multitude of topics including Security Risk Assessments

- MSLC organizes outreach to provide guidance on audits

HP Enterprise Services

The HP Enterprise Services MAPIR Outreach team is responsible for leading and conducting outreach to the providers eligible for incentive payments when implementing Certified EHR systems. They are also responsible for educating providers about Meaningful Use, updating requirements.

HP Enterprise Services MIP Enrollment and Outreach Staff:

Role	Functions to be Performed
Operations Supervisor (1)	Meet with DCH EHR staff. Review MIP/HP enrollment applications Submit MIP/HP weekly, monthly and quarterly reports Resolve escalated provider calls Server as the point of contact for DCH, GA-HITEC and MSLC regarding HP staff inquiries Conduct weekly staff meetings. Participate in monthly MIP vendor meetings Develop enrollment projections for the HP Outreach staff Serve as the liaison regarding issues and or concerns escalated from GA hospitals Submit documentation to MSLC as needed for post payment audits. Responsible for ensuring the MIP/HP team completes pre-payment enrollment applications Reports all concerns received by Georgia providers related to MIP Report to DCH.
Outreach Representatives (2)	Contact providers daily to promote EHR. Review e-mails and respond to all contacts with 72 business hours. Create CTMS tickets for every contact, whether phone, e-mail or onsite. Develop EHR marketing materials to assist in the sale of EHR. Conduct onsite visits with providers with the objective of convincing providers to proceed with EHR. Attend association meetings. Present materials by webinars for EHR. Transition providers who are set to HITREC for completion of application, and so on. Submit weekly Status Reports. Submit time recording (Tempus Carta, CAT-W, TMS) weekly. Other duties as assigned.
MAPIR Enrollment Specialist (3)	Review Enrollment Applications daily. Create CTMS tickets for every applicant contact, whether phone or e-mail. Review e-mail daily. Submit weekly Status Reports. Submit time recording (Tempus Carta, CAT-W, TMS) weekly. Other duties as assigned.
Hospital Outreach Representative (1)	Assist Hospital applicants in the EHR process Create CTMS tickets for every applicant contact, whether phone or e-mail. Market EHR to hospitals who have not submitted applications and are currently in an incomplete status Work with associations to ensure hospitals are aware of the incentive program Verify information in hospital e-mail box four times each day at minimum Submit weekly Status Reports. Submit time recording (Tempus Carta, CAT-W, TMS) weekly.

Role	Functions to be Performed
	Other duties as assigned.

General Performance Standards

CMS and DCH mandate that certain MIP activities be completed in specific time frames. The MIP staff is responsible for the following performance standards:

1. MIP applications must be reviewed within 10 business days of receipt.

2. HP Enterprise Services MIP/HP Enrollment staff must review a minimum of 80% of received MAPIR applications monthly.

3. HP Enterprise Services MIP/HP Outreach staff must conduct a minimum of 45 contacts per month.

4. HP Enterprise Services MIP/HPEnrollment staff will submit accurate, completed applications for incentive payments to the DCH MIP team.

5. HP Enterprise Services MIP/HP team will submit weekly and monthlymonthly reports to the DCH MIP team reporting Key Performance Indicators, including the progress of enrollment applications and provider contacts by the fifth business day of each month.

Digital Marketing and Advertising Services

DCH has employed a marketing leader and partnered with a marketing and advertising firm to provide the following support:

- **Digital Presence and Online Media Campaign and Strategy**
  - Development of digital and online media strategy and plan presentation with a round for revisions based on client feedback.
  - Search marketing strategy presentation and execution against approved plan
  - Paid media strategy and media buying based on approved plan
  - PR/Media relations strategy presentation and execution against approved plan

- **Push Media**
  - Execute emails and landing pages (text and graphics)

- **Marketing and Communications Materials and Campaign**
  - Development of brochure and collateral templates for events
  - Messaging strategy and positioning statement for Health IT marketing
  - Signage template development for both MIP and HIE
  - Personalized patient mailer for HIE that will be downloadable from the HIE website
  - Create design comps and execution of campaigns
  - GaHIN also conducts multi-pronged marketing and communications campaign.

A-11. Activities Across State Borders

Southeast Regional Collaborative

The DCH Division of Health IT 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. The DCH Division of Health IT is actively collaborating with other states in the region on a regular basis through the Medicaid Multi-state Collaborative and the Southeast Regional Collaborative on EHR and 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. The DCH Division of Health IT will 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.

Georgia EHR incentive program staff coordinate with surrounding states to validate patient volume for EPs whose patient volume might include Medicaid enrollees from adjacent states

Medical Assistance Payment Incentive Repository (MAPIR)

The Medical Assistance Provider Incentive Repository (MAPIR) is a web-based tool that supports the administration of the federal Electronic Health Record (EHR) Incentive Payment Program. Working with a multi-state collaborative of 14 states, Hewlett Packard (HP) is developing a core MAPIR application that will be customized and implemented by each state in their specific Medicaid Management Information System (MMIS) to issue incentive payments to providers. Georgia joined the collaborative in mid-December 2010. MAPIR will support workflows associated with confirming eligibility for professional providers and hospitals, attestation requirements, suspense processing, data exchanges with the Medicare & Medicaid EHR Incentive Program Registration and Attestation System (R&A), appeals tracking, issuance of incentive payments, and meaningful use data storage. Providers will access MAPIR through a Secure State Portal. MAPIR interfaces with a state MMIS for provider enrollment and claims information, to create transactions for payment, and to store payment information to be returned to the R&A. Georgia's MIP program launched in September 2011 and to-date has issued more than $217 million in incentive payments to Georgia providers.

Section B: The State's "To-Be" Health IT Landscape

This section of the State Medicaid Health Information Technology Plan (SMHP) provides an executive summary that describes what members, providers, and the Georgia Department of Community Health (DCH) can expect after successfully implementing the five-year Health IT vision. Additionally, this section of the SMHP outlines key components of the plan, describes how the plan aligns with the SMHP template issued by the Centers for Medicare and Medicaid Services (CMS) and identifies where key terms and abbreviations used throughout the document can be found.

B-1. Health IT/HIE Goals for Georgia Medicaid

The DCH strategic vision for health information technology and data exchange focuses on improving health outcomes for all Georgians and lowering health care costs. While the Medicaid enterprise provides leadership in solving the problems of information exchange, it suffers from several inherent inefficiencies such as incomplete or absent health status and outcomes data which impedes the agency's ability to implement policies to prevent illness and treat diseases effectively. However, DCH has developed a strategic health IT roadmap focused on data exchange, system interoperability, and is built upon a strong business, legal and privacy framework to support and sustain the operations of a statewide HIE network benefiting Georgia Medicaid and healthcare improvement throughout the state. The foundation of this roadmap is based upon driving ubiquitous provider adoption, the use of certified EHRs and fostering participation in the statewide HIE, DCH expects to improve health care delivery and access to members across Georgia. For details see **Section E – Georgia's Health IT Roadmap** for the State's health IT and HIE goals and objectives supporting Georgia Medicaid.

Health IT Overarching Goals - FY17 and Beyond

Medicaid EHR Incentive Program

- Increase the number of Eligible Professionals transitioning from AIU (Payment Year 1) to MU (Stage 3) by 33% from 2017 to 2020.

Health Information Exchange

- Promote advanced statewide interoperable activities including care plan exchange, medication management, medical image exchange, medical event notifications, lab results delivery, public health registries and CMO transition of care initiatives among hospitals, providers, state agencies and regional HIEs.

Population Health Management

- Pilot an electronic Clinical Quality Measure system to ensure all Georgia Medicaid providers report actionable clinical information; ultimately improving the quality of care within the health care delivery system.

Innovation and beyond

- Pilot a personal health record system to demonstrate and improve managed care efforts and timely delivery of clinical and non-clinical information among Medicaid long-term services and supports waiver programs.
- Engage strategic public-private health IT partnerships to pursue initiatives in telehealth/telemedicine, Health Level Seven (HL7) eLTSS data standards, patient engagement including Medicaid member portal enhancements, clinical data warehousing, and future innovative Health IT activities.

B-2. Supporting and Promoting EHR Adoption

Georgia's Steps to Encourage EHR Adoption

DCH is undertaking specific steps to encourage provider adoption of EHR technology. DCH will continue to build upon the success that the Division of Health IT 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 adopt and use certified EHR technology, and to continue to meaningfully use certified technology to add Medicaid patients.

Technical Assistance to Georgia Providers

As the priority for Regional Extension Centers through the ONC contracts is to provide assistance to primary care providers, support of a similar level to Physician Specialists and Subspecialists (PSS) (includes dentists) and non-EPs has been identified as a gap area. CMS has approved DCH's IAPD and contract with the GA-HITEC to perform outreach and technical support services to address this gap. Under the plan, the GA-HITEC and its subcontractors are responsible for a full range of services to support the acceleration of EHR adoption and achievement of Meaningful Use by this segment of providers for its coverage area. To date, GA-HITEC has assisted 450 providers with acquiring and using certified EHR systems.

- ***Education and Outreach***
    - Develop core course materials and online resources consistent with information provided through the Health Information Technology Research Center (HITRC)
    - Disseminate EHR materials in its geographic region
    - Establish general EHR/IT training sessions for providers and their staff members to assist in EHR adoption. Training related to specific EHR software is the responsibility of the EHR vendors.
    - Conduct individual provider visits when necessary to assure that adequate support is being given to the Providers during their EHR assessment and implementation
- ***Vendor Term Sheet*—Develop standard terms and conditions for EHR vendors**
- ***Implementation and Project Management*—**Provide standards and guidance to support subcontractor efforts in providing technical assistance and project management services to individual PSSs working to achieve MU through the implementation of an EHR
    - Provide IT infrastructure assessments
    - Provide workflow assessments, incorporating the redesign and documentation of clinical and administrative processes to permit the PSS to achieve greater efficiency in the practice
    - Determine, if needed and requested by the PSS, the cause of delays in implementation deadlines
    - Troubleshoot issues with vendors to determine the cause of unreasonable software implementation delays
- ***Vendor Issue Resolution*—**Provide assistance and support to troubleshoot and address recurring performance issues with EHR vendors
- ***HIE Interoperability*—**Identify detailed technical and participation requirements for connecting to the statewide HIE; and working with any HIE functioning within the region to help maintain consistent standards for providers to access the statewide exchange through any HIE. Provide technical assistance to individual PSSs when a provider is attempting to connect to a local HIE or directly to a State or local HIE.
- ***Privacy and Security*—**Develop and publish best practices and share national standards relating to security and privacy of patient information. Prepare HIPAA Business Associate Addenda as needed. Ensure that individual PSSs are aware of national and State standards relating to security and privacy, and support providers in implementing best privacy and security practices.
- ***Subcontractor Provider Recruitment Objectives*—**Recruit at least 100 specialties in the subcontractor's geographic assignment area

- ***Practice Readiness Assessment—***Provide practice assessment programs to determine EHR readiness. Provide onsite assessment of workflow or, if requested, an assessment protocol to practices to assist practices in determining the current state of readiness for EHR adoption.

- ***Meaningful Use—***Implement procedures established by HITEC to assist PSSs in attaining meaningful use in a timely manner. Such procedures will be designed to comply with federal regulations and to assure that each contracting PSS practice is meeting the federal definition of EHR meaningful use.

- ***Local Workforce Support—***Coordinate with regional institutions of higher learning in the development and utilization of the local workforce trained to provide HIT services

- ***Special Needs Assessment -*** This activity was completed in 2014. All of the Georgia DCH Care Management Organizations (CMOs) are members of GaHIN, the statewide health information network. It is a requirement in all of the CMO contracts that the CMOs become members of GaHIN and use GaHIN in order to securely share member data with other authorized members of GaHIN for the legally permissible purposes of payment, treatment, health care operations, and certain legally required public health reporting purposes. GaHIN & the CMOs worked together, with input from DCH, to determine the specifications for the CCD which is exchanged via GaHIN when a member switches to a new CMO. The Georgia Families 360° Managed Care Program is designed to serve youth and young adults in foster care, receiving adoption assistance, and certain incarcerated youth. The program is administered by Amerigroup. The members of GA Families 360° receive many benefits including the assignment of a medical and dental home, along with case management services to ensure continuity of care. GA Families 360° was launched in March 2014. DFCS connected to GaHIN via the Clinical Viewer portal in October 2014. They began receiving GaHIN's ADT Care Alerts for the GA Families 360 population in February 2017.
- ***Payment Milestones—***DCH proposed three levels of outcome based provider-specific milestones for the REC outreach program which include:
  - One-third of the total payment amount to be payable upon receipt of the signed technical assistance contracts between GA-HITEC and the PSS
  - One-third of the total payment amount to be payable upon receipt of documentation of Go-Live status on a certified EHR, One-third of the total payment amount to be payable upon receipt of documentation of the PSS attesting to meeting the established meaningful use criteria

The REC Specialist will also report milestone documentation to the State Health IT Coordinator or the Project Leader.

B-3. Future Enhancement of MMIS and Eligibility System

Future Enhancement of Georgia MMIS, Eligibility and ICD-10

The architecture for the Medicaid IT systems is business process driven meaning changes to the business will directly correlate to changes in the architectural design. The driving force behind this is the directive by CMS that the Medicaid system will adhere to the architectural standards of the Medicaid Information Technology Architecture (MITA) version 3.0. The goals over the next 9 months is to conduct business

process analysis throughout the department to identify gaps in our business processes and make recommendation on how to improve our processes to better serve our member and provider community. These process changes will then be reflected in the MMIS so business policies, procedures and strategic objectives will be synchronized with Information Technology.

A second change to MMIS architecture involves the proposed Eligibility system. Currently, eligibility determination is done through the DHR SUCCESS application. The SUCCESS application is outdated and difficult to modify. It also requires downtime one to two days per month for batch processing, thereby affecting when staff can enter new applications and renewal information into the system. The number of change orders has grown and the amount of time taken to process those orders has risen to unacceptable levels. There are Medicaid change orders that were established as many as five years ago that are still waiting in the queue to be completed. Due to the amount of mandatory changes due to Federal and other state regulations, the items that could make a significant impact on workers' ease of use of the system have had to be delayed.

The new Integrated Eligibility System (IES) is an integrated system that utilizes an efficient single point of entry to allow seamless eligibility processing for Georgians requesting assistance. The system will support eligibility for Federal and State programs such as:

- Medicaid
- PeachCare for Kids®
- TANF -Temporary Assistance for Needy Families
- SNAP -Supplemental Nutrition Assistance Program(Food Stamps)
- WIC - Women, Infants and Children
- LIHEAP - Child Care and the Low Income Home Energy Assistance Program
- CAPS – Child and Parent Services

The IES system is called "Georgia Gateway". Georgia Gateway is now live in all 159 counties in Georgia. DCH implemented the Enterprise Master Person Index (eMPI) in March 2016.

The ICD10 initiative will also have some impact to the design, policies, system edits and audits for the Medicaid system. October 1, 2015 marks the date that ICD-9 (International Classification of Diseases Ninth Revision) Codes will be replaced by ICD-10. These code-sets are used to differentiate diagnoses and procedures in virtually all treatment settings. Diagnostic and procedural codes are connected to nearly every system and business process in health plans and provider organizations including *reimbursement* and *claim* processes. There are approximately 28,000 ICD-9 codes and approximately 141,000 ICD-10 codes that will have to be mapped.

Enterprise Data Solution/Georgia Medicaid Health Informatics

Will allow Medicaid to marry clinical data transmitted across the GaHIN to claims and other pertinent Medicaid provider and patient information that is stored in the Medicaid Data warehouse. This information will be used to inform policy as well as Medicaid providers and Members.

Medicaid Member Portal Enhancements

The current Medicaid portal allows all Medicaid members to access their Medicaid information (claims, eligibility, prior authorizations, and pre-certification electronically. The enhancements will seek to align the Medicaid Patient experience with commercial industry experiences, including development of a personal health component that will allow members to become more interactive with the tools. It will allow for specific health informations and interventions to be pushed to the Medicaid patient.

Providing Direct Secured Messaging capabilities within the Medicaid Member Portal that will allow Medicaid providers to transmit clinical information such as lab results to the patient securely.

Centralized access for Medicaid members enrolled in our Care Management Organizations. Provide a single sign-on solution that will allow Medicaid members to access information from their CMO's within the MMIS Member Portal.

TEFT Grant

The purpose of the Testing Experience and Functional Tools (TEFT) grant is to test quality measurement tools and demonstrate e-health in Medicaid community-based long term services and supports (CB-LTSS). DCH will leverage GTRI's applied research expertise to test the collection of adult quality measures for the Independent Care Waiver Program (ICWP) and the Community Care Services Program (CCSP).

The DCH-GTRI research collaboration aims to:

> Demonstrate the utility of a Personal Health Record tool for the Medicaid CB-LTSS population by leveraging the Regional Health Information Exchange (Georgia Health Connect) via the Georgia Health Information Network (GaHIN).

B-4. Georgia Statewide HIE Network

HIE Governance

The Georgia statewide HIE Network governance model is a public-private collaborative ("Collaborative") consisting of the Georgia Health Information Network, Inc. (GaHIN), an established non-profit 501(c)(3) corporation, the state's Medicaid agency – Georgia Department of Community Health (DCH), Georgia Department of Public Health and various other state agencies, the Georgia Health Information Technology Regional Extension Center (GA-HITEC), and 25 other key stakeholders from Georgia's business, healthcare, technology and academic communities. Collectively these organizations form the "Governance Organization." The Governance Organization has worked to establish each of the foundational components of the Georgia HIE Network: Directed Exchange, Query-Based Exchange and Consumer-Mediated Exchange. Between 2010 and 2013, DCH was responsible for developing and implementing the technology, policies, and agreements supporting the Georgia statewide HIE Network. While the GaHIN Board of Directors and its committees recommended policies and requirements for the Georgia exchange, it was DCH with responsibility to approve and enforce the policies and agreements supporting the Georgia HIE Network. As envisioned and designed by the Collaborative, these responsibilities transitioned from the public sector, DCH to the private not-for-profit sector, GaHIN in 2014. Stakeholders from all across Georgia, as well as leadership in Georgia's state government agreed that this type of governance structure was best suited to quickly adapt to ever-changing requirements, standards, and best practices of the Georgia

statewide HIE Network. The GaHIN Board of Directors meets on a monthly basis to provide strategic direction for the Network.

Advisory and Policy Committees of GaHIN

GaHIN maintains six committees, three advisory committees and three policy committees. The following GaHIN committees are comprised of volunteer subject matter experts including those from Georgia Medicaid, Public Health, payers, health system/hospital leaders and many others. The committee members provide advice and recommendations to the Board in their respective areas of focus. The Governance Organization determines the strategic direction of the Georgia HIE Network and ensures that it serves the interests of the entire Georgia healthcare provider and patient community.

The three advisory committees and their areas of focus are:

- Regional HIEs Committee —operational experience
- Clinical Committee — quality measures and provider participation in e-Prescribing, lab exchange, and use of clinical care summaries
- Secondary Use Committee — public health and biosurveillance

The three policy committees are and their areas of focus are:

- Technology Committee — use cases architecture, standards, and interoperability
- Legal and Privacy Committee — policies and privacy and security processes and procedures
- Financial Committee — business operations and financial sustainability

Georgia HIE Network Marketing, Outreach and Education Strategy

DCH has contracted with GA-HITEC to provide a full range of support services to market the Georgia HIE network to targeted Medicaid providers and other health care stakeholders. Services include outreach, education and training of providers to achieve Meaningful Use.

Scope of Services:

- Program Management
  GA-HITEC will submit all deliverables to the DCH Project Manager.

- HIE and Meaningful Use Outreach and Training Program
  GA-HITEC will create the HIE Outreach and Education Program Plan outlining the details of their approach to drive awareness and education regarding the Georgia statewide HIE network.

- HIE Member Management & Administrative Services
  GA-HITEC will provide coordinated HIE member management services for Qualified Entities in accordance with the Georgia Health IT Training Program objectives.

- Core Performance Measures
- GA-HITEC will conduct marketing and outreach activities to reach a minimum of 3000 providers and deliver no fewer than 15 marketing and outreach events in an effort to reach and convert the 18 public health districts and 25 CSBs in Year One. Additionally, GA-HITEC will convert no less than twenty (20) percent of the providers reached during marketing and outreach activities and provide direct in-person education and training to no less than fifty (50) percent of all providers

converted.HIE Marketing Program Director – The HIE Marketing Program Director is responsible for planning, development and implementation of the HIE Outreach and Training program.

- HIE Outreach Coordinator – The Outreach Coordinator is responsible for executing the marketing/outreach and education/training strategies developed in the program.

Section C: Medicaid EHR Incentive Payment Program Implementation Plan

This section of the plan provides a description of the major business process that will be utilized by DCH to ensure the Eligible Hospitals and Professionals have met Federal and State statutory and regulatory requirements for the Medicaid EHR Incentive Payment Program.

C-1. Introduction

DCH, including the Division of Health Information and Technology 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 Division of Health IT 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 DCH Division of Health IT, 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 and webinars 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.

C-2. Verify Identity Potentially Eligible Providers

Eligible Professionals cannot be hospital-based, and must meet a 30 percent minimum Medicaid patient volume threshold. For pediatricians, the minimum threshold is 20 percent with reduced incentive payments.

However, pediatricians may qualify to receive the full incentive payment if they can demonstrate that they meet the minimum 30 percent Medicaid patient volume requirements.

For those meeting all program requirements, Eligible Professionals (excluding pediatricians) may receive a total of up to $63,750 during their six years of program participation. The Year 1 payment is $21,250; each subsequent year is $8,500.

The total incentive for pediatricians who meet the 20 percent patient volume threshold but fall short of the 30 percent patient volume threshold is $14,167 in the first year and $5,667 in each subsequent year. This adds up to a maximum Medicaid EHR incentive payment of $42,500 that may be paid over a six-year period.

As stated in Section A, DCH engaged MSLC, 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). MSLC 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.

Eligible Hospital Payment Projection

Myers and Stauffer (MSLC) 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.

Licensure and Sanctions

Georgia Department of Community Health (DCH) will leverage MMIS data 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 H.P and MSLC pre-payment enrollment methodology to review 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.

C-3. Verifying Overall Content of Provider Attestations

DCH will utilize the MAPIR system for providers to report attestation information. DCH's MIP staff will closely review the attestation information provided through the portal. Utilizing MIP staff and external auditors (MSLC), 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 currently leverages existing resources by using existing MSLC resources, supplemented as necessary and appropriate by other contract services.

EPs will be required to attest using the MAPIR system that they are not hospital-based. For all EPs attesting to non hospital-based status and requesting incentive payments, reviews are conducted of FFS and managed care encounter claims data from the MMIS to verify that the EP is not hospital-based. This reviews are 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.

C-4. Communication with Providers

DCH implemented a communication approach that contains the flexibility to provide appropriate communication to providers in multiple formats. The preferred approach for routine communication will be DCH website, banner messages, marketing collateral distributed by HP and GA-HITEC. Formal communication with the provider such as monthly webinar and provider relations meetings are hosted by HP and GA-HITEC.

C-5. Patient Volume

DCH calculates 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 MSLC and HP 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.

C-6. 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 verifies 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 by H.P to ensure that the payment is valid. Details of the manual review are displayed below:

Pre-Payment Audits:

Prior to registration and attestation at the state level, DCH requires 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 processHP works closely with Eligible Professionals to answer questions and assist with completion of the calculators. For Eligible Hospitals, HP meets 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. In the near future, DCH will rely more on the MAPIR and MMIS databases directly for this process

The Patient Volume Calculator (PVC) database includes, 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/*Database***	**Tolerable Variance**
(Both EHs and EPs)		
Confirm reported Medicaid utilization meets minimum requirements for the provider type	CMS Final Rules; *Pediatricians; EPs, including Physician Assistants, practicing predominately in an FQHC/RHC; Hospital-Based Providers*	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	*Applications received to date*	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	*EP CHIP Factor; EP encounters by predominant county* ***Note:*** *Patients in standalone CHIP programs established under Title 21 are not to be considered part of the patient volume total (in Stage 1 or Stage 2)*	None
Procedures (EHs)		
DCH and its consultant, MSLC, 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.		
Procedures (EPs)		
Confirm eligible professional is an allowable provider type	*Pre-qualification list; Hospital-based Providers; EPs, including Physician Assistants, practicing predominately in an FQHC/RHC; Pediatricians;*	Exceptions will be reviewed on a case by case basis.

Pre-Payment Review		
Procedures	**Reference/*Database***	**Tolerable Variance**
	Providers associated by Medicaid payee ID	
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	*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*	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)	*Out-of-State Results issued by state contact identified for MIP*	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.	*Prequalification list*	15%

C-7. Verification of "Practices Predominantly" Requirement

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. A as part of the state's audit plan, MSLC reviews and audit claims and encounter claims data on a post-payment basis.

Update for FCHC/RHC Practices:

IHP utilizes 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.

C-8. Verify Adoption, Implementation, or Upgrade

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:** Training
- **Upgrade:** Expanded certified EHR functionality or upgraded to certified EHR technology.

DCH utilizes provider attestations as the initial data source for determining that the EHR technology is certified. Attestations 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 requires 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 informs providers that they should maintain the original documentation for audit purposes. To ensure that the provider is meeting requirements for certified EHR technology, MAPIR verifies 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 serve as evidence in the support the provider's attestation for meeting the AIU requirements. Both attestations and the certified EHR technology evidence are subject to audit or review.

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

Eligible Professionals and Eligible Hospitals are 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.

Eligible providers with access to 2014 ONC Certified Software will be able to apply for Medicaid EHR Incentive Payments in 2014 and going forward!

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:

- Training plan

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.

The Georgia 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.

C-9. Verify Meaningful Use for Providers' Second Participation Year

After DCH completes the AIU processing and payments, the MAPIR system is upgraded and modified to ensure applications are processed according to CMS standards.

Update for Verification of Meaningful Use:

The Year 1 Medicaid incentive payments are paid to eligible providers and eligible hospitals for adopting, implementing, or upgrading to certified EHR technologies. In order to be eligible for subsequent year payments, providers have to be meaningful users of the certified technology. Prior to making these payments the state Medicaid agency is required to verify that providers meet all eligibility requirements.

The meaningful use criteria include various measures which require the Medicaid agency to verify that the providers are electronically sharing/reporting information. As outlined by CMS, the meaningful use measures required are using an incremental approach. Georgia validates MU measures as required by stages and program years.

Georgia Direct

Beginning with Direct, DCH will utilize the Georgia Health Information Exchange (HIE) to validate providers attesting to meeting Stage 1 and 2 Meaningful Use prior to making year 2 payments to the providers. DCH has issued an RFP and selected Medicity as the vendor to implement GA Direct.. Medicity shall provide interoperability solution to all Eligible Professionals (EP)s and Eligible Hospitals (EH)s in time for EPs and EHs to meet Stage 1 and 2 Meaningful Use criteria. DCH will general administrative reports on the Direct Exchange HIE to validate the select MU criteria outlined above.

C-10. 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 including supporting contractors, will support the development and implementation of R&A interfaces, and installation of MAPIR
- DCH will support the R&A and MMIS interface development, patches and upgrades, as well as disbursement of incentive payments.
- DCH MIP Outreach Staff are responsible for supporting outreach efforts electronic communications, collateral
- DCH Division of Health IT staff are responsible for the development and implementation of DCH and REC website and collateral.

Timeframe for IT Rollout

On September 5, 2011, DCH converted its Medicaid Management Information System (MMIS) and the new MMIS vendor is Hewlett Packard Enterprise Systems (HP).

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 joined the multi-state collaborative led by the Commonwealth of Pennsylvania's Office of Medical Assistance Programs and HP. Thirteen states with an HP MMIS has worked 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.

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.

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.

DCH also serves as a voting member with CMC and particints on the reporting sub-teams.

C-11. Website and Assistance for Medicaid Providers

DCH has deployed a website for use by providers at 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. Frequently Asked Questions (FAQs) will be posted on the website. A complete description of DCH's communications and outreach efforts can be found in Appendix D of this document.

C-12. Medicaid Provider Appeal- 1st Level Reconsiderations

DCH works with Medicaid providers to alleviate the need for appeals; however, 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, upgrading, and meaningful use of certified EHRs, calculations of payment amounts, and adverse audit results. With the exception of adverse audit results, DCH makes 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 approaches the estimated payment calculations as follows:

Eligible Professionals

Identifications of likely EPs were completed. DCH notified these professionals of possible eligibility for incentive payments. DCH conducts outreach efforts to inform EPs with respect to patient volume calculations, including the continuous 90-day reporting period, the attestation requirements, and the exclusion of CHIP patients where applicable. All Eligible Professionals are required to complete the patient volume calculator. The finalized calculators must be uploaded to the provider's application during the attestation process. HPE works closely with Eligible Professionals to answer questions and assist with the completion of the calculators. DCH believes that this outreach effort will reduce the number of appeals sought by EPs.

Eligible Hospitals

DCH and its consultant, MSLC, will meet with each Eligible Hospital (EH) to finalize the EH's patient volume (if applicable) and incentive payment calculation addressing expectations regarding incentive payments, potential issues, or eligibility questions prior to the EH's registration and attestation at the state level. DCH's approach has greatly reduced the number of hospital appeals. The State HIT Coordinator has advised hospital leaders and hospital associations of this approach and it will be further communicated through webinars with hospital providers.

Appeals Generally

This policy applies to all providers enrolled in the Georgia Medicaid EHR Incentive Program.

The Medicaid EHR Incentives Program appeal process shall generally conform to and be comparable with the process and procedures for Georgia Medicaid provider appeals as set forth in O.C.G.A. § 49-4-153, and in accordance with O.C.G.A. § 50-13-19, O.C.G.A. § 50-13-41, O.C.G.A § 50-13-42(a),42 C.F.R. § 495.370 and 42 C.F.R. § 447.253 (e). The failure to comply with the requirements set forth in the appeal process below will result in the provider's waiver of appellate rights.

Initial Review Process-Reconsiderations

PROCEDURES

I. Administrative Review

1. A provider shall file a Request for Administrative 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) calendar days from the date of such decision by submitting a written Request for Administrative Review to the following address:

Georgia Department of Community Health
DCH Medicaid EHR Incentives Program
Request for Administrative Review
2 Peachtree Street, N.W., 32nd Floor
Atlanta, Georgia 30303

OR

Email your request to: HITAuditAppeals@dch.ga.gov

Note: Include REQUEST FOR ADMINISTRATIVE REVIEW in the subject line of the email.

Any appeal of an action for recoupment of Medicaid incentive funds initiated by the Office of Inspector General will be handled in accordance with the procedures set out in Part 1, Policies and Procedures for Medicaid/PeachCare for Kids®, Chapter 500

2. After review by the Medicaid Incentive Program staff of the Request for Administrative Review, DCH will issue an Administrative Review Determination in writing within thirty (30) calendar days from the date of receipt of the Request for Administrative Review. In the event that DCH needs an extension of time

before issuing this determination, DCH is authorized an additional period of time not to exceed thirty (30) days. In addition, if Medicaid EHR Incentive Program staff request additional information from the provider, then the time for issuing the Administration Review Determination shall be extended thirty (30) calendar days after receipt of the complete additional information so requested. Should the Administrative Review Determination be adverse to the provider and the provider desires to appeal the decision, the provider may file a Request for Administrative Hearing. The Administrative Review process must be completed in order for a provider to be entitled to file a Request for Administrative Hearing with Georgia Office of State Administrative Hearings ("OSAH").

3. In cases involving an audit of a provider, any documentation submitted with a Request for Administrative Review may, at DCH's sole discretion, toll the time frame set out herein, to allow adequate time to re-audit the provider or for a referral to the Program Integrity Unit for the purpose of consideration of the newly submitted documentation. Such determination shall be made by the Reviewer in writing.

II. Request for Administrative Hearing

1. A provider who is dissatisfied with the Administrative Review Determination shall have thirty (30) calendar days from the date of the Administrative Review Determination to file a Request for Administrative Hearing. The administrative hearing will be conducted by an Administrative Law Judge ("ALJ"), designated by OSAH. The issues for appeal of the Administrative Review Determination regarding the Medicaid EHR Incentives Program include the decision to deny eligibility for an incentive payment or the decision as to the amount of an incentive payment. The provider's Request for Administrative Hearing shall identify the issues under appeal and specify the relief requested by the provider.

2. The provider's Request for Administrative Hearing shall be filed with the DCH at the following address:

Georgia Department of Community Health
Legal Services Unit
Medicaid EHR Incentives Program Administrative Hearing Request
2 Peachtree Street, N.W., 40th Floor
Atlanta, Georgia 30303

OR

Email your request to: HITAuditAppeals@dch.ga.gov

Note: Include REQUEST FOR ADMINISTRATIVE HEARING in the subject line of the email.

3. DCH shall, within 15 business days of receiving the Request for Administrative Hearing, transmit a copy of the provider's request for hearing to OSAH.

4. OSAH shall assign an ALJ to hear the dispute within 15 days after receiving the request. The hearing is required to commence no later than 90 days after the assignment of the case to an ALJ, and the ALJ shall issue a written decision on the matter no later than 30 days after the close of the record except when it is determined that the complexity of the issues and the length of the record require an extension of these periods and an order is issued by an ALJ so providing, but no longer than 30 days. Such time requirements

can be extended by written consent of all the parties. Failure of the ALJ to comply with the above time deadlines shall not render the case moot.

5. Should the decision of the ALJ be adverse to a provider and should a provider desire to appeal that decision, the provider must file a request, in writing, with the Commissioner of DCH within ten (10) days of his or her receipt of the hearing decision. Such a request must enumerate all factual and legal errors alleged by the provider. The Commissioner, or the Commissioner's designated representative, may affirm, modify, or reverse the decision appealed from.

6. The provider's Request for Commissioner Review shall be filed with the DCH at the following address:

Georgia Department of Community Health
Department of Legal Services
Medicaid EHR Incentives Program Request for Commissioner Review
2 Peachtree Street, N.W., 40th Floor
Atlanta, Georgia 30303

OR

Email the request to: HITAuditAppeals@dch.ga.gov

Note: Include REQUEST FOR COMMISSIONER REVIEW in the subject line of the email.

7. Failure to comply with the procedural requirements of the Request for Administrative Hearing set out herein, including the requirement to timely submit necessary documentation, data or proper explanation shall constitute a waiver of any and all further appeal rights, including the right to Administrative Hearing, Commissioner Review and/or judicial review.

III. Final Administrative Decision of Reviewing Agency

1. DCH shall serve as the Reviewing Agency. The DCH Commissioner, or the Commissioner's designated representative, shall issue the Final Administrative Decision. The DCH Commissioner, or the Commissioner's designated representative, shall have a period of 30 days following the entry of the decision of the ALJ in which to affirm, reject, or modify such decision. The decision to affirm, reject or modify the ALJ's decision shall rest with the Commissioner of DCH, or the Commissioner's designated representative. If the Commissioner of the DCH, or the Commissioner's designated representative, fails to affirm, reject or modify the decision of the ALJ within such 30 day period, then the decision of the ALJ shall stand affirmed by DCH by operation of law.

2. DCH, may, prior to the expiration of the review period provided for in paragraph (1) of this subsection, extend such review period by order of the DCH Commissioner, or the Commissioner's designated representative, in any case wherein unusual and compelling circumstances render it impracticable for the DCH Commissioner, or the Commissioner's designated representative, to complete its review within such period. Any such order shall recite with particularity the circumstances which render it impracticable for the reviewing agency to complete its review within such review period. Any such extension by the reviewing agency shall be for a period of time not to exceed 30 days. Prior to the expiration of the extended review period, the review period may be further extended by further order of the reviewing agency for one additional period not to exceed 30 days if unusual and compelling circumstances render it impracticable to complete the review within the extended review period. Such

further order further extending the review period shall likewise recite with particularity the circumstances which render it impracticable for the reviewing agency to complete its review within the review period as previously extended. If a reviewing agency fails to reject or modify the decision of the administrative law judge within the extended review period, then the decision of the ALJ shall stand affirmed by the reviewing agency by operation of law.

3. DCH may provide by rule that proposed decisions in all or in specified classes of cases before OSAH Hearings will become final without further agency action and without expiration of the 30 day review period otherwise provided for in this subsection.

4. A provider who is aggrieved by the Final Administrative Decision of the DCH Commissioner, or the Commissioner's designated representative, may seek judicial review as authorized by law.

IV. Judicial Review

1. Any provider who has exhausted all administrative remedies within DCH as set forth above and who is aggrieved by the Final Administrative Decision may seek judicial review in accordance with the provisions of O.C.G.A. § 50-13-19.

2. Proceedings for review are instituted by filing a petition within 30 days after the service of the final decision of the agency or, if a rehearing is requested, within 30 days after the decision. The petition may be filed in the Superior Court of Fulton County or in the superior court of the county of residence of the petitioner; or, if the petitioner is a corporation, the appeal may be brought in the Superior Court of Fulton County or in the superior court of the county where the petitioner maintains its principal place of doing business in this state. Copies of the petition shall be served upon the agency and all parties of record. The petition shall state the nature of the petitioner's interest, the fact showing that the petitioner is aggrieved by the decision, and the ground as specified in O.C.G.A. § 5-13-19(h) upon which the petitioner contends that the decision should be reversed or modified. The petition may be amended by leave of court.

3. The filing of the petition for judicial review in superior court does not itself stay enforcement of the agency decision. The agency may grant, or the reviewing court may order, a stay upon appropriate terms for good cause shown.

4. Within 30 days after the service of the petition or within further time allowed by the court, the agency shall transmit to the reviewing court the original or a certified copy of the entire record of the proceeding under review. By stipulation of all parties to the review proceedings, the record may be shortened. A party unreasonably refusing to stipulate to limit the record may be taxed by the court for the additional costs. The court may require or permit subsequent corrections or additions to the record.

5. If, before the date set for hearing, application is made to the court for leave to present additional evidence and it is shown to the satisfaction of the court that the additional evidence is material and there were good reasons for failure to present it in the proceedings before the agency, the court may order that the additional evidence be taken before the agency upon conditions determined by the court. The agency may modify its findings and decision by reason of the additional evidence and shall file that evidence and any modifications, new findings, or decisions with the reviewing court.

6. The review shall be conducted by the court without a jury and shall be confined to the record. In cases of alleged irregularities in procedure before the agency, not shown in the record, proof thereon may be taken in the court. The court, upon request, shall hear oral argument and receive written briefs.

7. The court shall not substitute its judgment for that of the agency as to the weight of the evidence on questions of fact. The court may affirm the decision of the agency or remand the case for further proceedings. The court may reverse or modify the decision if substantial rights of the appellant have been prejudiced because the administrative findings, inferences, conclusions, or decisions are:

(1) In violation of constitutional or statutory provisions;

(2) In excess of the statutory authority of the agency;

(3) Made upon unlawful procedure;

(4) Affected by other error of law;

(5) Clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or

(6) Arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

Note: DCH may obtain assistance with an appeal from a Myers and Stauffer staff member who did not perform the pre-payment and/or post-payment auditing procedures.

C-13. 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. DCH Division of Health IT 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 DCH Division of Health IT financial analyst are responsible for generating reports for DCH's internal management and for submission to CMS.

C-14. Role of Agency Contractors

Current agency contractors have a significant role in Georgia MIP EHR Incentive Program. DCH contracts with MSLC for the purpose of auditing all relevant processes to ensure payment accuracy and compliance with all processes. A list of all contracts is included in the IAPD

C-15. Provider Registration, Verification and Determination Process

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	**July 2011 Update:** 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: • Eligible Professional type (physician, nurse practitioner, certified nurse midwife and dentist). Physician Assistants are not eligible to participate in Georgia • Eligible Hospital type (acute care, critical access and children's hospitals) • Licensure, active Medicaid status and sanctions will be verified • DCH will all verify the correct state code and duplicate payment	
DCH's MMIS interfaceS 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 at CMS, MAPIR will send an electronic email and contact information provided by the R&A to notify the applicant of the state application process and required attestations and documentation.	
If a provider applicant fails CMS registration, applicants will be notified through the R&A.	
Note: DCH will store all of the provider registration data: • Through the portal and MAPIR, DCH wants to ensure provider view capability to provider data received from the R&A. • 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.	

Table 3 - Provider Verification and Determination Processes

Action	System Modification	Provider Attestation
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.		
The EP or EH applicant must enter the portal to confirm the R&A registration information: • Provider Name • Provider Type (based on HITECH listing) • Business Address/Phone • Email and contact information • NPI • CCN (for EHs) • Personal TIN (for EPs) • Payee Legal Entity Name • Payee TIN • Payee Address • Program choice (Medicare/Medicaid, plus Dual for EHs) • State selection (if Medicaid) • Confirmation number	MAPIR	
All provider applicants must respond "Yes" to the following inquiries or the application will be suspended or denied (DCH has to finalize process): • Confirmation of R&A registration information • Confirmation that EP applicant is only pursing payment from Georgia • Confirmation of no current or pending sanctions with Medicare or Medicaid in any state • Confirmation of compliance with HIPAA laws • Confirmation of license to practice (EP) or operate (EH) in Georgia • Attestation that supporting documentation is readily available for review at any time	MAPIR	
Applicant must indicate provider type: • The provider type must meet the HITECH requirements • 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	MAPIR	
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.	MAPIR and CMS R&A	
Hospital based providers: applicant must answer yes/ no question as to location of services If yes, the application will deny with an	MAPIR	**Yes**

Action	System Modification	Provider Attestation
email to the provider and information on the appeals process. If no, an attestation is required. • 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.		
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: • 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) • Applicant must enter all service locations and the encounter volume for needy individuals (CHIP and uninsured) for the numerator. • Applicant must provide total encounter volume information for the denominator (all service locations) • The percentage will be calculated and used to determine the provider's eligibility • If the provider does not meet the eligibility requirements, the application will be denied • Note: EPs practicing predominantly in an FQHC or RHC are not subject to the hospital-based exclusion.	MAPIR	**Yes**
For all other EPs, the applicant must provide the following information: • 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) • Applicant must enter all service locations and the Medicaid encounter volume for the numerator. • Applicant must provide total encounter volume information for the denominator (all service locations) • The percentage will be calculated and used to determine the provider's eligibility • If the provider does not meet the eligibility requirements, the application will be denied • EPs making application as a group practice level will follow the same process but must provide NPIs and associated encounter data for all participants. • 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 providers. • For out-of-state providers, DCH will work with SERCH states to develop processes for verifying patient volume. Applications for	MAPIR	**Yes**

Action	System Modification	Provider Attestation
out-of-state providers may be suspended for review of encounter data.		
For EHs, the applicant must complete the hospital calculation template found in Appendix F. • 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. • If provider does not meet the eligibility requirements, the application will be denied.	MAPIR	**Yes**
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. • 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. • Note: DCH will provide additional information on how we process meaningful use attestations and supportive evidence in the next version of the SMHP.	MAPIR	**Yes**
All provider applicants must provide confirmation of voluntarily assigning the incentive payment to the payee TIN provided in the R&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&A.	MAPIR	**Yes**
The applicant will have an opportunity to confirm the R&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.	MAPIR	**Yes**
When the provider is ready to submit the application, digital signatures will be required for the provider applicant and preparer. • Upon completion, DCH will send the provider applicant confirmation via email along with contact information	MAPIR	**Yes**

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, DCH Division of Health IT 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 was launched in September 5, 2011, MAPIR is 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.

C-16. Provider Payment Process and Frequency

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 from inception of the program.

The frequency of Georgia's EHR Medicaid Incentive payments is **weekly**. 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. • DCH's interface updates the R&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. • If the R&A notifies DCH of an exclusion(s), the application will be 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. • If the R&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.	MAPIR
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

Action	System Modification
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

C-17. 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 has contracted with Myers & Stauffer, a qualified CPA firm to carry out responsibilities for the post payment audits for the Medicaid Incentive Program
- 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, as well as assistance from HP and GA-HITEC.

Role and Plans of the Regional Extension Center

GA-HITEC is federally and state endorsed expert to assist providers in the achievement of Meaningful Use through EHR technology.

C-18. Flex Rule Update

This section to the State Medicaid Health Information Technology Plan (SMHP) addresses anticipated program, system, and audit changes related to the Certified Electronic Health Record Technology (CEHRT) Flexibility rule. Georgia's recent update to the SMHP was submitted to the Centers for Medicare and Medicaid Services (CMS) 0n 10/30/2014.

The Georgia Department of Community Health is committed to complying with federal regulations and guidance from the Centers for Medicare & Medicaid Services (CMS) to effectively administer and oversee the Georgia EHR incentive program. CMS published the final CEHRT Flexibility final rule on August 29, 2014 effective October 1, 2014. The rule provisions allow providers to meet meaningful use (MU) requirements with electronic health records (EHRs) certified to the 2011 or the 2014 Edition criteria, or a combination of both Editions for the 2014 EHR Reporting Period. The rule requires providers to report using 2014 Edition CEHRT for the EHR Reporting Period in 2015, and extends Stage 2 through 2016.

Georgia completed a comprehensive analysis of the final rule to identify information, policy, process and technology impacts to the Georgia Medicaid EHR Incentive Program. The following sections contain a summary of the impacts and Georgia's plan to address the impacts for Program Year 2014.

SMA Policy Changes

The final rule provides parameters defining acceptable reasons that providers were unable to fully implement 2014 Edition CEHRT. Pursuant to these changes, a form has been developed for providers to complete and upload with their application that includes the five reasons for the inability to fully implement. The form includes check boxes as well as a free text box to provide details. Any reason checked or given as free text must be fully explained in the Certification Flexibility Option Form developed.
The state level attestation system and repository (MAPIR) will also include a check off for the five reasons 2014 CEHRT is delayed as allowed in rule and a free text box to provide additional information. These are the reasons that will be coded into the MAPIR.

- Software development delays
- Missing or delayed software updates
- Being able to implement 2014 CEHRT for part of the reporting period (not the full reporting period)

- Unable to train staff, test the updates system, or put new workflows in place due to delay with installation of 2014 CEHRT
- Cannot meet Stage 2 Summary of Care measures due to the recipient of their Summary of Care transmittal being impacted by 2014 CEHRT issues. The sending provider may experience significant difficulty meeting the 10% threshold for electronic transmissions, despite the referring provider's ability to send the electronic document, if the intermediary or the recipient of the transition or referral is experiencing delays in the ability to fully implement 2014 Edition CEHRT.

The following reasons are not sufficient to warrant attestation under the CEHRT Flexibility Rule: financial issues, inability to meet one or more measures, staff turnover and changes, provider waited too long to engage a vendor, refusal to purchase the requisite software updates or providers who fully implemented 2014 Edition CEHRT and can report in 2014.
The prepayment review process will include validation of the verification documentation received from providers. Staff will determine what additional documentation is needed to prove that their delay in implementation of 2014 Edition CEHRT availability is attributable to issues related to software development, certification, implementation, testing, or release of the product by the EHR vendor.

Provider Registration and Attestation

Georgia has reviewed and updated the eligibility verification checklists for Program Year 2014 processing.
DCH has worked collaboratively with Georgia's fiscal agent, Hewlett Packard (HP), and the MAPIR collaborative states, to update the state registration and attestation system requirements for the CEHRT Flexibility Rule. The MAPIR Business Design document has been approved by the MAPIR steering committee consisting of leadership from all participating states. The core code will be tested in early December and released to participating states by the end of December. Georgia will incorporate into the Medicaid Management Information System (MMIS), test and promote into production. The attestation tail will need to be extended through June 30, 2015.

The process to validate the EHR certification is a web service connection in the SLR to the Office of the National Coordinator's Certified Health IT Product List (CHPL). This 'call out' verifies that the certification number is valid. The process continues with manual verification by program staff using the search feature on the Medicaid HiTech website to verify that the CEHRT entered matches the product the provider has identified in their application documentation.
The options for attestation available to the provider will be driven by the certification number they've entered as detailed in the chart below.

Pre Flexibility Rule Scheduled MU Progression	Post Flexibility MU Reporting Options	Provider's Certified EHR Technology		
		2011 CEHRT	2011 & 2014	2014 CEHRT
Not Participating in Program	AIU	Not an option	Not an option	YES
Stage 1 2014 Definition of MU Measures	Stage 1 2013 Definition MU Measures	Yes, Reason Required	Yes, Reason Required	Not an option
	Stage 1 2014 Definition MU Measures	Not an option	Yes, Reason Required	YES
Stage 2 2014 Definition of MU Measures	Stage 1 2013 Definition MU Measures	Yes, Reason Required	Yes, Reason Required	Not an option
	Stage 2 2014 Definition MU Measures	Not an Option	Yes, Reason Required	YES
	Stage 1 2014 Definition MU Measures	Not an option	Yes, Reason Required	Yes, Reason Required

Medicaid EHR Incentive Program Payment Administration

Prepayment validation will continue to ensure that providers meet the requirements prior to approving a payment.
The current appeals process is sufficient to accommodate denials that occur as a result of not meeting requirements to attest under the requirements in the CEHRT Flexibility Rule.

Audit & Program Integrity

Post-payment audit procedures are updated annually prior to commencing the audit for the program year. The annual updates incorporate changes to the audit risk profile. For 2014 this will

reflect Flexibility Rule requirements as well as any other changes due to findings in the prior program year's audits.

Outreach, Collaboration, Support

Georgia has been exploring outreach activities related to the release of the CEHRT Flexibility Rule. These efforts include updating the state website to include general information, materials, and links to national resources (such as links to specific pages on the Centers for Medicaid and Medicare Services website), as related to the CEHRT Flexibility Rule. Materials produced by Georgia's Medicaid Electronic Health Record (EHR) Incentive Program outreach team include CEHRT Flexibility Rule Tip sheets, Frequently Asked Questions (FAQ) documents, PowerPoint presentations, and webinars for providers. Webinars on the CEHRT Flexibility Rule have been developed and provided and will continue to be held periodically throughout the 2014 attestation period. Efforts to reach out to providers who have not started 2014 attestations are ongoing.
Additional information is provided to stakeholders routinely and as requested. Meetings with Georgia's Regional Extension Centers (RECs) and Hewlett Packard occur twice monthly with one session devoted entirely to questions and answers. CEHRT Flexibility Rule outreach materials are included at events such as association meetings and provider workshops. Provider workshops will be held across the State providing opportunities for stakeholders to further their understanding of the requirements. Contact with stakeholders is tracked through electronic communication, calls to the contact center; webinar participants are provided answers, in writing, as a follow up to questions received at webinars. Tip sheets and FAQs are updated continually based on feedback from stakeholders in order to better address identified gaps in knowledge.

An in-service training will be assembled with support staff to prepare them for provider inquiries on the rule changes. Updated FAQ documents are available to the call center staff. An escalation process includes referring callers to program staff as needed.

State-Based Performance Measures

Georgia's registration and attestation system, MAPIR, documents the CEHRT used for attestation. Information will be available that identifies Eligible Professionals (EPs)/Eligible Hospitals (EHs) that have delayed implementing 2014 Edition CEHRT attributable to issues related to software development, certification, implementation, testing, or release of the product by the EHR vendor. This information will be available after all payments have been made for the 2014 program year.

Flexibility Rule Changes Effective October 1, 2014		State Checklist - Implementation Status				
Subject	**Change**	**Target Date**	**Not Started**	**In Process**	**Complete**	**Notes**
SMHP/IAPD	Submit SMHP Addendum to CMS	Nov.1, 2014				In Process
	Submit IAPD-U to CMS, if additional FFP needed	NA		x		
General Policy Changes	Review/update policies as it may relate to the Flexibility Rule				x	Complete
	Determine parameters defining acceptable reasons that providers were unable to fully implement 2014 Edition CEHRT				x	Developed a form for providers to complete and upload with their application. Providers will also enter reasons in the MAPIR SLR.
	Determine CEHRT verification process providers will use				x	CHPL and HITECH Website
	Review/update pre-payment verification documentation requirements				x	
Systems/ Infrastructure	Design system changes and develop system requirements				x	Scope for system changes completed. Certification number will drive choices for attesting to meaningful use.
	Develop system changes	Dec 2014		x		Requirements developed.
	Test system changes	April 2015	x			Changes to be implemented at SLR and available for test 3/15.
	Determine if attestation tail period needs extended				x	Will need to extend

						attestation tail
Outreach	Implement outreach strategy for stakeholders				x	
	Provide training for SMA staff/vendors that field phone/email questions from providers				x	
Auditing	Update post-payment audit procedures to incorporate Flexibility Rule		x			Will be done prior to PY 2014 audits
	Review/update audit risk profile(s) to reflect Flexibility Rule		x			

C-19. 2017 Changes

The Centers for Medicare and Medicaid Services (CMS) released a final rule in October 2015 addressing criteria for Stage 3 and Modifications to Meaningful Use (MU) in 2015-2017 for the Electronic Health Record (EHR) Incentive Program. CMS had released Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) final rule which established the groundwork for the Medicare Quality Payment Program (QPP); CMS finalized the QPP in October, 2016, which included modifications to the EHR incentive program. In November, 2016, CMS finalized updated payment rates and policy changes in the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System for calendar year (CY) 2017. These rules also included modifications to the EHR Medicaid Incentive program impacting Program year 2017. The intent of this document, regarded as a State Medicaid HIT Plan (SMHP) Addendum, is to describe the response to these final rules Medicaid program changes and Georgia MAPIR attestation screen changes needed to enable Eligible Professionals (EP) Eligible Hospitals (EH) and Critical Access Hospitals (CAH) to attest to Modified Stage 2 MU for Program Year 2017, including the optional Stage 3 attestation, OPPS, and QPP.

A. 2015 – 2017 Modifications Rule

A.1 Option to Attest to Stage 3

In the Stage 3 rule, to allow all providers to successfully transition to Stage 3 of the EHR Incentive Programs for a full year-long EHR reporting period in 2018, CMS allows flexibility for the EHR Incentive Programs in 2017. A transition period allows providers to establish and test their processes and workflows for Stage 3 of the EHR Incentive Programs prior to 2018.

Stage 3 includes flexibility within certain objectives to allow providers to choose the measures most relevant to their patient population or practice. The Stage 3 objectives with flexible measure options include:

- **Coordination of Care through Patient Engagement** – Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.
- **Health Information Exchange** – Providers must attest to all three measures and must meet the thresholds for at least two measures to meet the objective.
- **Public Health Reporting** – Eligible professionals must report on two measures and eligible hospitals must report on four measures.

To meet Stage 3 requirements, all providers must use technology certified to the 2015 Edition. A provider who has technology certified to a combination of the 2015 Edition and 2014 Edition may potentially attest to the Stage 3 requirements, if the mix of certified technologies would not prohibit them from meeting the Stage 3 measures. However, a provider who has technology certified to the 2014 Edition only may not attest to Stage 3.

Georgia has decided to allow providers this flexibility in 2017

A.2 Program Year 2017 MU Requirements

In 2017, all providers are required to attest to a single set of MU objectives and measures; for both eligible professionals (EPs) and eligible hospitals (EHs) there are 8 objectives.

Specifically, for 2017, CMS proposed providers may either repeat a year at their current stage or move up stage levels. Additionally, for 2017, a provider may not move backward in their progression and providers who participated in Stage 1 in 2016 may choose to attest to the Stage 1 objective and measures, or they may move to Stage 2 or Stage 3 objectives and measures for an EHR reporting period in 2017. Providers who participated in Stage 2 in 2016 may choose to attest to the Stage 2 objectives and measures or move to Stage 3 objectives and measures for an EHR reporting period in 2017. However, under no circumstances may providers return to Stage 1

	Regulation and EHR Program Requirements	SMHP Addendum Updates (Can use checkmark or enter date when requirement has been addressed)				
		Program	System	Policy	Audit	Notes
A						
1	**Option to attest to Stage 3 in 2017**	✓	Available Est. 12/1/17	✓	✓	Modified-MU2 and MU3 administrative tools, application review rubrics and MAPIR database updates are planned for implementation as of 12/1/17.

	Regulation and EHR Program Requirements	SMHP Addendum Updates (Can use checkmark or enter date when requirement has been addressed)				
		Program	System	Policy	Audit	Notes
2	**Program Year 2017 MU Requirements**	✓	Available Est. 12/1/17	✓	✓	External Education and Outreach to communicate the PY2017 changes will be ongoing through regular emails to our program participant list, website updates, targeted outreach, webinars and User Guide updates. Audit plan revisions to accommodate PY2017 rule and process changes, including audit risk factors and new MU requirements, will occur in a future update to our audit strategy.

B. OPPS Rule

B.1 90-day EHR Reporting Period

In the CY 2017 OPPS/ASC proposed rule (81 FR 45753), CMS proposed to change the definition of "EHR Reporting Period" in 2016 for returning participants from the full CY 2016 to any continuous 90-day period within CY 2016. This would mean that all EPs, eligible hospitals and CAHs may attest to meaningful use for an EHR reporting period of any continuous 90-day period from January 1, 2016 through December 31, 2016.

As of this date, CMS requires a full year reporting period for CQMs.

B.2 Modifications to Measure Calculation Timeframe

There are changes to the measure calculations policy, which specifies that actions included the numerator must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs. If the reporting period is any continuous 90-day period, the action must occur between January 1 and December 31, 2017, but does not have to occur within the 90-day period.

CEHRTS are built to calculate numerators according to the rules; it would be difficult to verify pre-verification; may want to focus on post-payment audits.

	Regulation and EHR Program Requirements	SMHP Addendum Updates (Can use checkmark or enter date when requirement has been addressed)				
		Program	System	Policy	Audit	Notes
B	**OPPS Rule**					

	Regulation and EHR Program Requirements	SMHP Addendum Updates (Can use checkmark or enter date when requirement has been addressed)				
		Program	System	Policy	Audit	Notes
1	**90-day EHR reporting period**	✓	Available Est. 12/1/17	✓	✓	MAPIR has configurable settings for EHR Reporting Periods per Program Year, but no separate system inputs for CQM reporting periods. Therefore, MAPIR 6.0 contains an enhancement that will prevent providers subject to the Full Year CQM reporting period requirement from submitting a PY2017 application before 1/1/18. A possible complication is that providers may switch practices, and not have a full year of CQM data with the practice they are attesting with. The practice that the provider left may not be willing to share CQM data, especially since they are not receiving an incentive payment. Georgia will allow providers who were not at their attesting practice for a full year to use abbreviated CQM data solely from the attesting practice. This will be reviewed and documented pre-payment when the date ranges on the CQM and MU reports are compared to the attested date ranges. This will also be reviewed post-payment on attestations selected for audit.
2	**Modification to measure calculation timeframe**	✓	Available Est. 12/1/17	✓	✓	For all MU measures, unless otherwise specified, actions included in the numerator must occur within the EHR reporting period if that period is a full calendar year, or if it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs. For example, if the EHR reporting period is any continuous 90-day period within CY 2017, the action must occur between 1/1 and 12/31/2017, but does not have to occur within the 90-day EHR reporting period timeframe. External Education and Outreach to communicate this change to measure calculation timeframes in PY2017 will be ongoing through regular emails to our program participant list, website updates, webinars and User Guide updates. The pre-payment validation process will include reviewing the MU reports to ensure the dates on the reports align with the attested MU time periods. In circumstances when providers want to expand their numerator to include the calendar year, as opposed to just the EHR reporting period, then additional documentation will be requested, such as a dated list of the encounters in the numerator and denominator. This documentation will be reviewed for reasonableness. If this provider is selected for post payment audit, then this documentation will be reviewed again and additional supporting materials will be requested if deemed necessary.

C. Medicare Quality Payment Program (QPP)

This section details the effect of the Medicare QPP on the Medicaid EHR Incentive Program.

C.1 Updates to definition of Meaningful EHR user

(1) Subject to paragraph (3) of this definition, an EP, eligible hospital or CAH that, for an EHR reporting period for a payment year or payment adjustment year, demonstrates in accordance with § 495.40 meaningful use of certified EHR technology by meeting the applicable objectives and associated measures under §§ 495.20, 495.22, and 495.24, supporting information exchange and the prevention of health information blocking and engaging in activities related to supporting providers with the performance of CEHRT, and successfully reporting the clinical quality measures selected by CMS to CMS or the States, as applicable, in the form and manner specified by CMS or the States, as applicable; and

(2)(i) Except as specified in paragraph (2)(ii) of this definition, a Medicaid EP or Medicaid eligible hospital, that meets the requirements of paragraph (1) of this definition and any additional criteria for meaningful use imposed by the State and approved by CMS under §§ 495.316 and 495.332.

(ii) An eligible hospital or CAH is deemed to be a meaningful EHR user for purposes of receiving an incentive payment under subpart D of this part, if the hospital participates in both the Medicare and Medicaid EHR incentive programs, and the hospital meets the requirements of paragraph (1) of this definition.

(3) To be considered a meaningful EHR user, at least 50 percent of an EP's patient encounters during an EHR reporting period for a payment year (or, in the case of a payment adjustment year, during an applicable EHR reporting period for such payment adjustment year) must occur at a practice/location or practices/locations equipped with certified EHR technology.

A MU provider demonstrates the use of CEHRT by meeting the objectives and measures; supporting information exchange, etc. These requirements are reviewed with pre-verification.

C.2 Updates to definition of Meaningful EHR user – SPPC and Health Information Exchange and Prevention of Information Blocking

The final rule further updated the definition of Meaningful User to include Supporting Health Care Providers with the Performance of CEHRT (SPPC). Provider will need to attest that they engage in activities related to SPPC, HIE and prevention of information Blocking.

Georgia completed a comprehensive analysis of the all the rules to identify information, policy, process and technology impacts to the Georgia Medicaid EHR Incentive Program. The following sections contain a summary of the impacts and Georgia's plan to address the impacts.

	Regulation and EHR Program Requirements	SMHP Addendum Updates (Can use checkmark or enter date when requirement has been addressed)				
		Program	System	Policy	Audit	Notes
C						
1	**Updates to definition of Meaningful EHR User**	✓	Available Est. 12/1/17	✓	✓	MAPIR 6.0 screen changes will accommodate these additional requirements by asking providers yes/no questions about their compliance. Education and outreach will be ongoing to let providers know of the new questions. Providers' responses to these questions will be captured and recorded as part of their attestation. The question responses will be reviewed manually as part of pre-payment verification procedures. When responses indicate compliance, no additional steps will be taken. Provider outreach will occur as necessary when required responses indicate non-compliance. Payment will not be made unless it is deemed that the requirements have been reasonably satisfied and there is sufficient explanation and/or documentation.
2	**Demonstration, via attestation, of updated Meaningful EHR user definition.**	✓	Available Est. 12/1/17	✓	✓	

System Changes

GA's team has been actively participating in the MAPIR collaborative effort on the roll out of the new changes. The impacts summarized in the tables above, as well as the plan to address the impacts for Program Year 2017, are in alignment with the Core MAPIR specifications that have been designed and implemented in MAPIR version 6.0. A walkthrough of PY2017 screen changes and system updates was conducted with the MAPIR Collaborative and CMS on 1/18/2017. CMS has approved the screens and the workflow. Georgia does not plan to make any state specific changes to the MAPIR core screens and as such is not resubmitting the screens

The next step is for HPE to present us with the Business Design Document (BDD) which details each requirement, what MAPIR must do, how we will test each requirement. These documents are generally 200+ pages because of the detail. The collaborative makes comments and then approves the BDD. HPE is programming while waiting for the approval but may have to make changes based on the review. After HPE finishes all the coding we have a two week User Acceptance Testing (UAT) period. Many of the states including Georgia participate. The core code is released to the states a week after UAT ends. The core code is scheduled to be released to the states mid-may 2017

Once released, GA's HPE custom staff must implement the core code into our MMIS. HPE and Program staff have to work out what we want for any items that are state configurable. The testing is the most time consuming as HPE has to go through the entire process of completing applications for both EP and EH for every payment year. Testing needs to be coordinated with other subsystems such as financial and Georgia MMIS. Our

HPE team usually needs three months from the release of the core code to promoting it to production. This results in a December 1st go-live date.

Georgia is not requesting a tail extension period beyond March 31, 2018 for Program Year 2017 applications. With the planned deployment of MAPIR 6.0 on 12/1/17, this will afford 120 days of access to the updated attestation system before the submission deadline, which program history and past experience has demonstrated is a sufficient time period for providers and preparers to start and submit their applications

Timelines

System implementation

1. MAPIR solution core release – May, 2017
2. Integration into GA MMIS - July, 2017
3. Georgia Testing – Oct 2017
4. Go-live – December 2017

Please note that MAPIR screen shots for these changes were submitted by the collaborative and approved by CMS. Due to the large size of files containing the screen shots we have not included them in the SMHP as CMS already has them.

Audit & Program Integrity

Post-payment audit procedures are updated annually prior to commencing the audit for the program year. The audit guide will be updated for any changes made to the post payment audit procedures to incorporate the Stage 3 reporting requirements and any additional risk criteria identified for audit selection. The revised audit guide will be submitted for approval to CMS separately from this SMHP addendum. The planned post payment audit procedures for Stage 3 will be similar to the Modified Stage 2 post payment audit procedures. The percentage-based measures, yes/no measures and excluded measures will be analyzed in the same manner as under the Modified Stage 2 requirements. A change in the post payment audit procedures for the security risk analysis (SRA) will include ensuring the SRA was completed during calendar year (2017) rather than prior to the provider's date of attestation.

Outreach, Collaboration, Support

Georgia has been exploring outreach activities related to the release of the new. These efforts include updating the state website to include general information, materials, and links to national resources (such as links to specific pages on the Centers for Medicaid and Medicare Services website. Materials produced by Georgia's Medicaid Electronic Health Record (EHR) Incentive Program outreach team include Tip sheets, Frequently Asked Questions (FAQ) documents, PowerPoint presentations, and webinars for providers. Webinars will be developed and provided and will continue to be held periodically throughout the 2017/2018 attestation period.

Additional information is provided to stakeholders routinely and as requested. Meetings with Georgia's Regional Extension Centers (RECs) and Hewlett Packard occur twice monthly with one session devoted entirely to questions and answers. The new Rule outreach materials are included at events such as association meetings and provider workshops. Provider workshops will be held across the State providing opportunities for stakeholders to further their understanding of the requirements. Contact with stakeholders is tracked through electronic communication, calls to the contact center; webinar participants are provided answers, in writing, as a follow up to questions received at webinars. GA has been informing providers of the rule changes via website updates, webinars, boot camps, direct mailings, onsite visits, fairs, bus tours, and the like. Tip sheets and FAQs are updated continually based on feedback from stakeholders in order to better address identified gaps in knowledge. An in-service training will be assembled with support staff to prepare them for provider inquiries on the rule changes. Updated FAQ documents are available to the call center staff. An escalation process includes referring callers to program staff as needed.

State-Based Performance Measures

Georgia's registration and attestation system, MAPIR, documents the MU rules used for attestation. Georgia plans to monitor the exclusions exercised by the provider and provide additional technical assistance to providers if needed.

CMS Approval

On June 13th 2017 CMS approved our request to extend Georgia's tail period for PY 2017 EP MU applicants from 03/31/2018 to 04/30/2018.

Section D: The State's Audit Strategy

This section of the SMHP provides a description of DCH's methods to avoid making improper payments within the Medicaid EHR Incentive Payment Program, including program monitoring, post-payment auditing strategies, preventing and detecting fraud and abuse, federal claiming and federal reporting.

The Georgia Medicaid Incentive Payment Program Audit Guide is attached as Appendix G to this document. The purpose of this Audit Guide is to set forth the process and procedures designed jointly by the Georgia Department of Community Health (DCH), DCH's Office of the Inspector General (OIG) and Program Integrity Unit, and MSLC LC, an independent auditing firm, for conducting pre-payment reviews and performing post-payment audit functions of the Medicaid EHR Incentive Program administered by the DCH Division of Health IT.

To the extent feasible, DCH is using the following resources when conducting the pre-payment reviews and post-payment audits:

- EH and EP data obtained from the Registration and Attestation System;
- Provider enrollment data and sanction information stored in the Georgia MMIS;
- Medicaid claims and encounter data in the Georgia MMIS;
- MAPIR to verify provider eligibility in MMIS, sanctions and licensure, capture provider type, hospital-based status, declaration of adoption, implementation or upgrades of certified EHR technology; submission of a CHPL number; and patient volume data;
- MAPIR for EP and EH attestations regarding patient volume calculations, EH incentive payment calculation, hospital-based status, and the adoption, implementation or upgrade of certified EHR technology;
- CHIP discount factors
- Hospital cost reports, Disproportionate Share Hospital (DSH) surveys and other data sources for comparisons with EH patient volume and incentive payment calculations;
- Databases developed by MSLC using MMIS data: Patient Volume Database, the Prequalified Database, Eligible Professionals Database; Eligible Hospital Database; and FQHC/RHC Database;
- Listings of presently certified, commercially available certified EHR technology and their websites;
- The website for the Certified Health Information Technology Product List (CHPL) maintained by the ONC;
- Data regarding providers originating from the GA-HITEC
- Data from the administrative and audit modules of EP and EH operated certified EHR technology when appropriate;
- Internal auditing resources to the extent that such resources can review information or data on an automated basis through the analysis of existing, currently available or pre-requested data series; and
- Payment information stored in MAPIR that tracks the EPs and EHs who successfully apply for and obtain Medicaid incentive payments from Georgia.

Suspected fraud or abuse may be detected at any point during an audit or review process. By conducting extensive pre-payment verification activities, DCH is striving to minimize fraud and abuse and to reduce the potential for payment errors.

The Medicaid Fraud Control Unit, the DCH OIG, the Program Integrity Unit and MSLC are closely aligned in their post-payment activities. DCH's Program Integrity Unit is responsible for the initiation of the recovery of mis-payments, suspension of future payments, the termination of agreements with providers, or other

action(s) that may be necessary while the Medicaid Fraud Control Unit investigates the potential fraud. Depending upon the outcome of the investigations by the Program Integrity Unit and the Medicaid Fraud Control Unit, recoupment of mis-payments may take place and will be tracked in MMIS and MAPIR.

Updated Section E: October 1, 2012

Section E: The State's Health IT Roadmap

This section of the SMHP provides an overview of the State's plans related to the promotion and implementation of Health IT as a means to improving care coordination, improving health outcomes and reducing the overall cost of care.

Three-Year Strategic Plan

This Georgia Three-Year Strategic Plan ("Strategic Plan"), July 2017 through June 2020, addresses the use of health IT and health information exchange within Georgia and the potential impact such technologies have to lower costs for Medicaid and the Children's Health Insurance Program (CHIP), while maintaining and improving quality of care for program members. Implementation of the projects outlined in this Strategic Plan are expected to have a positive effect in raising community health status and reducing long term health risks for Georgia Medicaid members. Also, each project within the Strategic Plan includes broad Georgia health care stakeholder input and engagement and are set in the context of broader state innovation in expectation of achieving a sustainable statewide HIE network while significantly improving health system performance. The steps outlined with the Strategic Plan require that key public and private stakeholders and CMS work together to explore opportunities where health IT initiatives can accelerate community-based health system improvements to produce better results for Georgia Medicaid and CHIP members.

The following sections detail specific problems affecting Medicaid and CHIP services delivery and member management, solutions identified through use of health IT and HIE strategies, specific health IT projects supporting the identified strategies, and expected outcomes resulting from regular provider adoption and utilization of health IT and HIE technology implementations.

E-1A. Current Health IT Environment (As-Is)

Georgia Health IT Environment: Strengths

- Georgia has strong public and private stakeholder investment and commitment in health IT and health information exchange.
- Georgia is a strong leader in EHR adoption, at about 74% statewide (as of 2016).
- Multiple community and regional HIEs exist in Georgia that are the components for creating a "network of networks" for the statewide HIE.
- MITA aligned HIT initiatives
- Georgia is planning a new modular Medicaid Management Information System which provides an updated foundation to aid Georgia DCH in more effectively establishing an interoperable IT architecture and related strategies to build and implement necessary health information technologies that support the goals and objectives for improved health care delivery throughout Georgia.
- The Georgia Broadband initiative is expanding high-speed Internet access throughout areas of rural Georgia that will enable providers in less populated parts of the state to connect to the statewide HIE. It is still a challenge in some rural parts of the state,
- On June 29, 2012 DCH launched *GeorgiaDirect*, Directed Exchange secure messaging. Directed Exchange specifies a simple, secure, scalable, standards-based way for participants to send encrypted health information directly to known, trusted recipients over the Internet. *GeorgiaDirect* is currently

being enhanced to be available to all Georgia Medicaid providers giving each the opportunity to securely and electronically exchange patient health data for purposes of treatment.

Georgia Health IT Environment: Challenges

- Critical technical infrastructure and interfaces are needed to enable providers to connect to a statewide HIE network and achieve meaningful use.
- While Georgia's EHR adoption rate is increasing, the number is still relevantly low and it is not known how many providers are meaningful users of certified EHR.
- Certain provider types, such as behavioral health, substance abuse and long-term care providers, are not eligible for federal EHR incentive programs but need to be supported to be linked to the HIE and participate in the exchange of patient information.
- Providers must manually enter clinical data multiple times in multiple systems.
- Patients' care and referrals are supported by manual processes.
- Critical clinical data cannot be shared across all providers statewide and is not available at the point of care delivery.
- Non-standard interfaces and data create interoperability issues.
- Healthcare outcomes are difficult to measure given the limitations of current technology.

E-1B. Problem Statement

This section presents five key challenges outlining a variety of health care and health related issues facing Georgia Medicaid.

1. Member Access to Care – The Declining Number of Medicaid Providers in Georgia and Fewer of Those Accepting New Patients

A. Georgia stands among the lowest ranked states for the number of primary care physicians per 10,000 persons. [2]

- As of 2010, Georgia ranked 44th in the nation for active PCPs with 74.0 per 100,000 and was 18.2 percent lower than the all-state median of 90.5 physicians per 100,000.
- Georgia experienced a decline in PCPs and growth in specialists. The specialties experiencing the greatest declines over the last decade are General Surgery and Obstetrics/Gynecology (OB/GYN).
- Rural areas have seen a slightly greater decline in physician availability for pediatrics, internal medicine, and family medicine.

B. Physician supply issues and impacts on Georgia Medicaid[3]

- Medicaid members represent approximately 18.8 percent of the total Georgia population.

- Georgia's Medicaid program provides health care for approximately 1.8 million low-income children, pregnant women and people who are aging, blind and disabled.
- As of 2008, more than 65 percent of Georgia physicians were accepting new Medicaid patients and approximately 74 percent are currently serving Medicaid patients.
- An estimated 202,327 of the approximate 1.6 million covered lives are PeachCare for Kids ® CHIP members.
- Today, more than thirty-three (33%) percent of Georgia's physicians are not accepting new Medicaid patients and the percentage continues to increase.

2. Splintered Coordination of Care

A. Providers have fragmented view of patient health history[4]

There is splintered coordination of care amongst health professionals, Georgia Medicaid and other state agencies (including Behavioral Health and Public Health departments). Currently, no mechanism or process exists for coordination of care at the state system level. Also, there is no comprehensive care management system to track and coordinate care of members with chronic conditions. Additionally, transitioning children members from acute to residential facilities is a complicated and lengthy process that is not sensitive to the needed level of care.

B. Data capture and workflow impacts[5]

Practices for referrals, utilization of services, and coordination of care are not streamlined. Despite mandated immunization reporting requirement in Georgia, inadequate reporting exists due to inefficient data capture and transmission processing and workflow disruption.

C. Limited number of Patient-Centered Medical Homes[6]

Patient-Centered Medical Homes allow for access to primary care, adoption of evidence-based care protocols, adoption of health information technology, improved coordination across specialists and transitions in care, broader use of nurses and care coordinators, and more effective care and treatment of high complex and chronic conditions. Less than 40 NCQA recognized PCMHs currently exist in Georgia.

D. Performance measures and feedback is not readily available to Medicaid providers[7]

The current Georgia Medicaid system lacks ability to electronically monitor care quality and present providers with performance feedback contained within a mechanism to furnish providers with performance improvement opportunities.

3. Georgia Medicaid's Costs and Administrative Burdens are Considerable

A. Significant need for spending controls.

Like most Medicaid programs across the country, Georgia Medicaid is facing fiscal pressures and, as a result, is under tremendous pressure to explore options to deliver services in a more efficient manner and to control spending growth – all while maintaining quality of care and all within the context of potential physician shortages.[8] Total Fee-for-Service (FFS) per person per month (PMPM) costs are projected to rise.

B. Georgia Medicaid lacks a uniform provider credentialing process[9]

Both DCH and CMOs are duplicating efforts related to provider credentialing and prior authorization processes. The process is not streamlined, is cumbersome, varies among the CMOs and is very slow.

4. Georgia Medicaid Member Health Status and Outcomes

A. Georgia ranks near the bottom among states for child health and wellness[10]

The 2011 Commonwealth Fund State Scorecard on Child Health Performance System ranked Georgia 43 out of 50 states when reviewing multiple health indicators, including access, affordability, prevention, and potential to lead health lives. Georgia ranked second highest (49th) in the percentage of children aged 10 to 17 who are overweight or obese and third-highest (48th) in the percentage of children aged 2 to 17 who need mental health treatment/counseling and actually received such needed care. The State also ranked 47th in the percentage of children with special health care needs under aged 17 whose families received all needed family support services. Finally, Georgia ranked 42nd in infant mortality, defined as deaths per 1000 live births.

The cost implications for the State resulting from the health status is profound – resulting in more than $200 million in annual health care expenditures for Georgia children affected by asthma alone.

B. Georgia's mediocre immunization rates for children aged 19-35 months[11]

In 2011, the United Health Foundation ranked Georgia 14th nationally for children aged 19-25 months who have received a recommended series of immunizations based on data collected from the National Immunization Survey[12]. States were ranked according to the average percentage of children ages 19-35 months who have received individual vaccinations: four or more doses of DTP, three or more doses of poliovirus vaccine, one or more dose(s) of any measles-containing vaccine, and three or more doses of HepB vaccine.

According to the Centers for Disease Control and Prevention National Immunization Survey (sample size of about 30,000 children), Georgia's vaccine dose dispensing ranks the state 19th for DTP vaccine, 8th for Poliovirus vaccine, 32nd for measles vaccine, and 43rd for HepB vaccine.

C. Patient non-compliance[13]

This is a critical issue which has financial consequences for providers. It is hard to capture and win over the Medicaid population due to multiple factors, such as reading level and mobility. Medicaid members do not have a financial stake so they are not incented to comply with treatment plans. There are no penalties when members do not keep appointments or do not comply with treatment protocols.

D. Communication channels not aligned to ways Medicaid members receive information[14]

DCH underutilizes communication methods accessed most by Medicaid members. In survey of 4,000 members, 78 percent indicated they receive their primary information through mobile phone and 95 percent of members indicated their primary contact was the Smart phone.

E. Community outreach and education methods are limited and ineffective[15]

Continuous member outreach and education needs to occur for various programs. Other states have been reaching out to communities about what managed care is, the various programs, etc. This is especially important with the high turnover in the member population.

E-2. Medicaid Health IT Strategy

Looking forward into the next 3 years, DCH seeks to improve the quality of care for its members, create operational efficiencies while reducing costs and administrative burden for its providers and the agency, and present providers with key performance metrics in order to improve delivery of care. The Medicaid Health IT Strategy outlined below shows the path for:

1. Projects roadmap for products and services development and deployment
2. Participating public and private stakeholders (including payer participation)
3. Implementation approach and timeline
4. Provider and stakeholder engagement
5. The goals Medicaid will achieve as a result of health IT products and services deployment

1. Health IT Project Roadmap

DCH and its Divisions of Health IT and Medicaid have identified five (5) key project that once developed and deployed will demonstrate support to achieve the three-part aim of lower health care related costs, better health outcomes and improved delivery of care to Medicaid members. These initiatives are aligned to the Governor's health and efficiency related goals and are in keeping with efforts to move the state toward meeting the SMHP vision and goals.

Project 1: Georgia Medicaid EHR Incentive Payment program
Project 2: Georgia Statewide Health Information Exchange Network growth to include connectivity with state agencies, commercial payers, large Medicaid health systems, patient and other wellness partners to support population health initiatives.
Project 3: Medicaid Member Portal
Project 4: Population Health Management and Health Informatics: Enterprise Data Solution
Project 5: Foster Care Virtual Health Record

See Section E-3 for detailed project descriptions.

2. Participating Stakeholders

The following is a list of participating stakeholders and their role

- DCH – Georgia Medicaid and facilitator of the GaHIN
- DCH, DPH, DBHDD, DJJ, and DFCS – state agencies as initial entities for integration with the Georgia statewide HIE network
- HP – Development partner for Medicaid Member Portal, Pophealth
- Medicaid providers – Authorized users
- Medicaid members – Authorized users
- Georgia Health Information Network, Inc. (GaHIN) Board of Directors – representing virtually all health care stakeholders throughout Georgia, including many federal agencies, patients/consumers, pharmacy, long-term care, hospitals, physicians, behavioral health, health informatics, legal and privacy, technology, financial sustainability, clinical services, Public Health, corrections and juvenile justice, rural and urban health care settings, payers, employers, and state government.
- HITECH

- Regional HIEs
- Payers: BCBS-GA, CIGNA, and anticipated but limited Medicaid managed care organization (CMO) participation

Vendor	Total Group Members	% of Market
Aetna	465,000	11%
BCBS*	1,753,750	42%
CIGNA	558,209	13%
UHC	1,439,198	34%
Total	4,216,157	100%

3. Provider and Stakeholder Engagement

Georgia is executing a multi-prong approach to provider engagement. The following outlines activities underway:

- Georgia is currently enhancing the MMIS Web Portal to engage Medicaid providers, drive awareness of the many benefits and uses of Direct and enable easy enrollment for *GeorgiaDirect* services.
- Leverage the GHIE, Inc. Board of Directors, Committees and Workgroup participants.
- DCH hired a marketing vendor to develop both traditional and digital marketing and outreach campaigns using online promotions and print collateral
- DCH partnered with researchers from Georgia Tech's Institute for People and Technology to conduct research and gather community input on the goals, motivations, and concerns of Georgia healthcare professionals regarding health information technology (IT). The initiative informed a customer-centric approach to DCH and its partners' programs in support of health IT, including electronic health records (EHRs), meaningful use, and health information exchange.
- DCH holds regular quarterly town hall events and attends many professional association conferences and meetings promoting the use and benefit of *GeorgiaDirect*
- DCH has designed an organizational strategy leveraging the local and regional HIEs to expand their network and reach many providers for the purpose of establishing statewide interoperability.
- DCH is developing a value-based contract with the GA-HITEC to capitalize upon their success with promotion and conversion of providers to adopt EHR technology. The GA-HITEC will provide HIE specific outreach, enrollment and education services. The GA-HITEC will also be responsible for promoting and cross-selling health IT related services as they become available on the statewide network.

4. Implementation Approach

The Department of Community Health's Division of Health Information Technology (Health IT) facilitates various aspects of Georgia's Health IT infrastructure that make it possible for providers and patients to better manage their care through secure use and exchange of health information.
Focus areas are:

4.1 Administer the Medicaid EHR Incentive Program (MIP): This program has resulted in an investment of over $260 million for acquiring EHRs by Georgia Providers. This activity will continue until 2022 and HIT staff will:

a. Interpret new CMS rules and guidance

b. Implement policy, system, procedures
c. Conduct provider audits and
d. Offer provider and member outreach and technical assistance.

4.2 Advance Health Information Exchange (HIE):

DCH and GaHIN, Inc launched GeorgiaDirect, direct secured messaging in July 2012. To date there are over 3000 providers registered to use this service to electronically exchange CCD's (Continuity of Care Documents) and other clinical information. In August 2013, Medicaid became the first member (node) to go-live on the GaHIN query-based exchange making available 1.8 million Medicaid member claims' information available on the network. This activity requires HIT staff to:

a. Interpret new CMS and ONC rules and guidance around Health information Exchange
b. Ensure that CMS requirements for funding of the GaHIN are met and reported in a timely fashion
c. Work with Medicaid stakeholders to ensure that GaHIN capabilities are benefitting Medicaid
d. Participate in technical and business roll out of additional value-add services for GaHIN.

4.3 Public Health:

Because of a shared responsibility to provide health care services to populations across the state, including a focus on indigent and underserved populations, there is a natural partnership between DCH and the Department of Public Health (DPH). DCH and DPH have identified a series of collaborative opportunities but are most focused on improving the cost and quality of care by enabling provider access to technology and supporting Meaningful Use. Over the last three years, the DCH-DPH collaboration has led to many successes and identified many new opportunities for future collaboration. This activity requires HIT staff to collaborate on several efforts including:

a. Immunization Registry - Enhancements to DPH's immunization registry, GRITS, including system upgrades
b. Lab Information Systems: Modifications to DPH Laboratory Information Systems to enable receipt of electronic orders and transmission of results.

4.4 Clinical Quality Measurement (CQM/PopHealth):

The implementation of electronic health records for Medicaid providers, furthers the capability to perform clinical quality measurement. In the past, we have been limited in our CQM strategy due to the limitation of clinical data in the claims. We are currently in the process of implementing an initial phase of electronic CQMs for providers who participate in the MIP program. This activity includes:

a. Identification of CQMs to be monitored
b. Reporting requirements
c. Provider education.

5. Strategic Medicaid Health IT Goals and Objectives

The following are 2014 goals issued by the Governor's Office and related to health and health care improvement throughout Georgia.

- Reduce childhood obesity in Georgia
- Increase access to health services throughout the state
- Increase consumer choice and personal responsibility in health care
- Improve access to treatment and community options for those with disabilities
- Increase availability of state services through innovative technology solutions
- Enlist community support and public-private partnerships to leverage available resources

Keeping in line with these overarching health-related goals, the following section outlines specific Medicaid Health IT goals and objectives. These goals and objectives employ use of health information technology to build a healthy Georgia by increasing member access to care, presenting opportunities for improved provider coordination of patient care, and encouraging Georgia Medicaid members to engage in and adopt more active and healthy lifestyles. These are initial goals and objectives and DCH will further refine them as the health IT market evolves, technology advances, and the needs of Georgia Medicaid providers and members change over time. Updates will be reflected in future iterations of the SMHP.

GOAL 1: Improve Medicaid member access to comprehensive, patient-centered, coordination of quality health care

Objective 1: Promote and increase the usage of digital tools to bridge the information gap as Medicaid members obtain and maintain access to their personalized health information ultimately driving usability and increasing utilization.

Strategies and Tactics

- Establish appropriate and usable consumer-facing applications within the Medicaid Management Information System (MMIS).

- Present Medicaid members with access to their personal health information in the form of a Personal Health Record (PHR), including opportunities to self-report health data where appropriate, obtain treatment plans, and preventative health and wellness guidelines as a means for patient engagement,

  Use health IT to drive awareness and encourage improvement in member health and wellness outcomes.
- Facilitate provider effectiveness and efficiency at the point of care by providing clinically relevant claims data.

Objective 2: Improve care coordination by enabling providers to access accurate, reliable, and timely patient data and the point of care.

Strategies and Tactics

- Make *GeorgiaDirect* widely available for providers and promote use cases for specific types of providers and practices demonstrating the tool's effectiveness in their daily workflows (e.g. behavioral health, exchange between long-term care facilities and referring hospitals, and established referral networks.)

- Utilize established and expanding statewide interoperability for the purpose of increasing care coordination among multiple physical health, mental health, and substance use clinics. Employ the statewide HIE network to link providers with information across sites and settings and to make essential information available at the point of care.

- Align technology with proven strategies to improve transition in care from pre-admission through discharge planning and transition out of hospital or between settings.

- Make clinical data readily available to those authorized to access it in QBE for case management services – making clinical information available to all authorized parties including the patient, from the point of service via the HIE network. The standardized and protected information is immediately available for clinical decisions.

- Present a complete record for each member, including EHR and PHR, standardized clinical protocols, and standardized business rules definitions pertaining to service coverage.

Objective 3: Improve patient safety, reduce medication errors and duplication of care

Strategies and Tactics

- Use HIE integrated EHR in relevant residential and long-term care settings where the age and frailty of Medicaid patients with a high volume of medication use and complexity of drug interactions and side effects increases the risk of medication errors in these settings.

- Make use of health IT to prevent care that may be duplicative, counter-productive, and potentially harmful to all Medicaid populations.

GOAL 2: Increase Georgia Medicaid Provider Adoption and Utilization of Health Information Technology

Objective 1: Develop and execute a strategic vision to significantly increase health IT adoption and use by Georgia Medicaid providers to achieve substantial interoperability between electronic health records via the statewide HIE .

Strategies and Tactics

Employ change management principles to drive provider adoption of health information technologies.
(1) Drive awareness and education through use of marketing and outreach tactics targeting providers, patients and other stakeholders.

(2) Motivate Georgia Medicaid providers by promoting value propositions that resonate with them – present the benefits of health IT for their business and the many opportunities to achieve Meaningful Use (e.g. communicate with public health agencies, generate lists of patients who need care and use them to reach out to those patients, and apply clinical decision support at the point of care.)

(3) Use GA-HITEC to present Georgia Medicaid providers with the path to health IT adoption and ways to achieve Meaningful Use

- Fund EHR Specialist Program focused on the GA-HITEC encouraging Georgia Medicaid providers to use certified EHRs and foster participation in the statewide HIE.
- Leverage existing outreach relationships and healthcare stakeholder networks to promote use of certified EHRs and the statewide HIE network in order to achieve Meaningful Use.

Objective 2: Promote Medicaid EHR Incentive Payments program to Georgia Medicaid providers

Strategies and Tactics

GA-HITEC, and HP, are organized as follows:

- To ensure that Medicaid providers are fully informed about the financial incentives available under the incentive program;
- To encourage Medicaid providers to become meaningful users of certified EHR technology;
- 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.
- Explain data exchange standards apply to all who participate in the exchange of information who wish to receive federal funds for implementing new system as well as exchange any information with external agencies.

Objective 3: Develop the Georgia HIE network to quickly enable secure statewide interoperability, produce an organizational strategy to support sustainability for both statewide and regional HIE networks, and establish a mechanism to distribute key services that providers need and want

Strategies and Tactics

- Establish the Georgia statewide HIE network as the mechanism responsible for the electronic movement of health related information for and between state agencies as needed for treatment and health-related services.

- Develop and execute HIE network organizational strategy that leverages local and regional health information exchanges in existence and provide a means of making the set of core and value-added services available to benefit the entirety of the Georgia healthcare ecosystem. Utilize the regional HIE networks as a conduit for health information interchange, including immunization and disease registries for the HIE Participant subscribers.

- On-board health-related state and federal agencies, managed care organizations, and other payers

- Execute established plans for key areas of HIE network solution integration:
    - Medicaid
    - Public Health (GRITS immunizations, registries, syndromic surveillance, labs)
    - Payer collaboration (eligibility, referrals, screening alerts)
    - Other federal programs (federal bridge: NwHIN, Department of Defense, Veteran's Health Administration, Centers for Disease Control, etc.)

- Cultivate HIE network relationship with largest health plans serving Georgians, including those supporting the Georgia State Health Benefit Plan, and establish connectivity.

GOAL 3: Population Health Management

Objective 1: Improve Quality Monitoring and Program Improvement

Strategies and Tactics

- Collect timely and meaningful feedback from clinical data sets so that provider organizations and insurers can encourage provider performance improvement.

- Facilitate evidence-based clinical decision support systems for the purpose of preventative care screening, management of chronic diseases, and tracking and monitoring of immunizations, tests and other orders relevant to specific patient populations such as pediatrics.

- Utilize the HIE network to present providers with program outcomes and performance standards based on comparison of members served by program with peers not served. Present data outcomes in a dashboard showing the provider whether the members are receiving better care, satisfaction, and improving or declining health trends.

- Produce evidence-based health profile that alert providers to a client's potential need for coordinated services or special programs

- Use QBE as foundation to expand data sharing with additional agencies and health care entities and build benchmarking tools to evaluate quality of care among peers.

Objective 2: Use of non-traditional health care services to improve care and reduce costs

Strategies and Tactics

- Explore use of telehealth technologies and programs to drive substantial benefits as alternatives to traditional care models, resulting in significant savings (Ex. Veterans Health Administration 2006-2007 study showed home telehealth program reduced bed days of care by 25%, reduction in number of admissions by 20%, and a mean satisfaction score rating of 86%. The resulting net cost per patient per year was only $1,600 compared to $13,121 for home-based primary care and $77,745 for nursing home care rate average).

Objective 3: Use Administrative Data to Improve Provider Efficiency and Effectiveness

Strategies and Tactics

- Use of a single common portal to all payers/purchasers that may increase the adoption of HIT and reduce the administrative burden of providers.

- Use data extracted from claims, diagnoses, and procedures to both measure and support coordination of care, health maintenance, disease management, medication compliance, targeted quality improvement, and improved patient safety.

Objective 4: Coordination with Public Health Efforts to Ensure Accurate and Efficient Population Tracking and Monitoring

Strategies and Tactics

- Utilize the statewide HIE network to eliminate redundant Public Health reporting. DPH will receive immediate notification via HIE which sends information to Public Health that is timely and consistent. Public Health will be able to improve response time for health and bio-terrorism alerts.

- Establish integration and interoperability between Medicaid and public health agencies for safety and monitoring of the population as a whole and for Medicaid policy development.

GOAL 4: Patient Engagement: Empower Medicaid Members to Track Wellness and Improve Individual and Family Health Outcomes

Objective 1: Produce functionality within the Medicaid Management Information System (MMIS) for Medicaid members and their families to track the progress of their health outcomes and empower them to take steps toward better health. Ultimately this functionality will be duplicated within the statewide HIE network for all Georgia consumers to utilize.

Strategies and Tactics

- Employ a personal health record and health risk assessment for patient engagement purposes including opportunities for patient generated data, the ability to track and monitor progress and/or resolution of acute health conditions, the management of chronic disease processes, and compliance with medications, immunizations, and other relevant orders.

- Integrate health related web and mobile applications and widgets for tracking, monitoring progress and/or resolution of acute health conditions, the management of chronic disease processes, and compliance with medications, immunizations, and other relevant purposes.

- Implement an initial set of health and wellness content presented generally or based upon a limited personalization engine.

- Make available functionality for members to use secure electronic messaging to communicate with providers regarding relevant health information.

- Enhance the user experience by optimizing the member portal for mobile-enabled devices such as tablets and Smartphones for a more convenient user experience.

- Craft strategic, compelling and meaningful messaging promoting the use of health IT tools (enhanced Medicaid Member Portal) to educate and bring awareness to the Medicaid population that Members user experience

E-3. Five Health IT/HIE Initiatives That Will Improve Georgia Medicaid Delivery of Care to Members While Reducing Costs

The initiatives listed below present an approach using health IT tools and the services expected to be available from the Georgia HIE network Georgia to continually improve cost, quality and population health outcomes for Georgia Medicaid and CHIP members.

Project 1: Medicaid Electronic Health Record (EHR) Incentive Payment Program

The Georgia Medicaid EHR Incentive Payment program is part of the 13-state collaborative. The Medical Assistance Provider Incentive Repository (MAPIR) is a web-based tool that supports the administration of the federal Electronic Health Record (EHR) Incentive Payment Program. The Georgia program launched in September 2011 and to date, DCH has issued over $217 million in incentive payments to over 4,000 Georgia providers. The program continues to be refined and enhanced to issue Year 2 and Year 3 Meaningful Use payments. The Collaborative is currently working on the changes necessary for the stage 2 regulations

As a means to expand the program, drive awareness and reach additional providers, DCH is contracting with the GA-HITEC to initiate a new program further encouraging adoption, implementation, upgrade and meaningful use of certified EHR technology targeting eligible Medicaid specialist providers. As the priority for Regional Extension Centers through the ONC contracts is to provide assistance to primary care providers, support of a similar level to Physician Specialists and Subspecialists (PSS) (includes dentists) was lacking.

Provider adoption of the health IT, specifically EHR technology is the fundamental necessity to achieve the three-part aim of lower health care costs, improved quality and better health care outcomes.

PROJECT 1: CORRELATION TO GEORGIA MEDICAID

The first step in building a cohesive interoperable health exchange system is digitizing the patient information at the provider offices. The Medicaid Incentives Payment program targets eligible hospitals and professionals who meet specific criteria, including Medicaid patient volume thresholds to receive funds to adopt, implement or upgrade the EHR systems and to become meaningful user of the certified technology. This project manages the application process, verifies provider attestations, issues appropriate incentive payments to approved providers, and conducts audits as necessary.

Project 2: Georgia Statewide Health Informational Exchange Network

The Georgia Statewide HIE Network is being developed and rolled out in a phased approach.

Phase 1: GeorgiaDirect (Directed Exchange Secure Messaging)

DESCRIPTION

Establish secure messaging using Direct Project protocols. Enable quick, low cost mechanism for Medicaid providers to securely exchange patient data with other authorized health professionals for purpose of treatment. Currently, Georgia is developing this capability as part of the ONC Challenge Grant – targeting 3 clinics and hospitals in Rome, Georgia. Newly diagnosed breast cancer patients in this community will have the opportunity to bi-directionality and securely exchange patient health information with their oncologist and receive near real-time results. The results of this initiatives will be leveraged as a basis to explore bi-directional communication between Medicaid providers and members for purposes of treatment.

Phase 2A: PatientFinder (Query-Based Exchange)

DESCRIPTION

Providers also need the ability to find information when they are delivering unplanned care. For example, when someone arrives at the emergency department with sudden chest pain, a physician will probably want to look up the patient's cardiac history. PatientFinder is the working title for the query-based exchange functionality allowing authorized providers to query patient information via their EHRs or via a web portal. This functionality will provide more efficient care need mechanisms to find key patient information such as medications, recent radiology images, and problem lists so that emergency department visits do not turn into costly, unnecessary inpatient stays.

Through the adoption of certified EHR technology and the development of the statewide HIE, the ability to augment administrative data with timely clinical data will be of enormous value to Georgia Medicaid and other state agencies. In particular, such data will support activities related to care management, care coordination, and quality improvement. In addition to facilitating connectivity and supporting Meaningful Use objectives, Query-based Exchange will provide critical services to meet the requirements of Stage 2 Meaningful Use where bi-directional exchange is necessary. The QBE will access information necessary to successfully implement a predictive matching index via the Enterprise Patient Matching Index and Record Locator Service. These features will enable the provider to perform a patient lookup in order to pull information from other providers without the workflow overhead associated with push only transactions.

Among other features within Query-Based Exchange are:

- Provider Directory
- Integration of existing HIEs
- Enterprise 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.

Phase 2B: Statewide HIE Solution Integration Services

DESCRIPTION

Solution integration services are critical to both the development and sustainability of the statewide HIE network but also to delivery of health care and related services provided to members by Medicaid and other state agencies (e.g. Foster Care). Georgia is currently in an active procurement for a vendor to produce Query-Based Exchange who will also work with identified stakeholders and statewide agencies to implement services and interfaces as needed to establish tightly integrated interoperability. The projects listed below in table will be implemented as part of the Query-Based Exchange deployment and pilot program.

Project Name	Brief Description and Purpose
HIE/Public Health	Establish a secure clinical data reporting mechanism using a standard and anonymized format as is necessary for the routing of such data between public health entities and HIE participants, disease surveillance reporting to Public Health and CDC. Includes assessment and enhancements as needed for data exchange with and between HIE participants (providers) for access to GRITS, SENDSS, and DPH labs. **GRITS: Exchange of Immunization Data** Establish functionality and standards for exchange of immunization data, that includes the processing of immunization data, reporting, and transmission of immunization records to the HIE for distribution to the appropriate registry. **Lab Exchange** The State Lab in Georgia performs clinical laboratory services for hospitals and providers throughout the state. They perform all newborn screening and STD tests in the state and many other tests as well. The current process is manual and this project will simplify the process of lab ordering and lab results delivery. **SENDSS: State Electronic Notifiable Disease Surveillance System** All reportable conditions and diseases in the state of Georgia are required by statute to be reported to SendSS. SendSS maintains connections to about 50 hospitals and laboratories across Georgia for Syndromic Surveillance data and Electronic Lab Reporting. This project will further streamline this connectivity and make the reporting more timely.
State System Interoperability	Deploy a mechanism to enable interoperability with Georgia's integrated Eligibility system, MMIS, and other health plan data repositories in accordance with applicable law and as permitted by DCH policy, including but not limited to claims and clinical information from claims (Example: medications, diagnoses, hospital stays).
MMIS/HIE Integration	Integrate MMIS into HIE for purposes of a bi-directional interface – MMIS claims need to be available in HIE and relevant HIE data into MMIS.
Personal Health Records (PHR) and Georgia HIE	Enable capabilities for available EHR/EMRs to interface with available PHRs.

Phase 3: Value-Added Services (Advanced Exchange)

DESCRIPTION

The table below outlines specific initiatives integrating systems and added services to the Georgia statewide HIE network to improve data access and support Georgia Medicaid

Project Name	Brief Description and Purpose
Interstate Exchange	Deploy capabilities to support interstate HIE exchange aligned to specific instances and use cases where such exchange occurs and as determined by DCH.
Georgia HIE Provider/Participant Portal – Electronic Health Record Capabilities	Deploy functionality that provides electronic health record capabilities via a web-based portal and mobile application for those providers who do not own or have access to such capabilities or who wish to migrate to the hosted solution.
Vocabulary Translation Services	Enable functionality to perform translations between various medical vocabularies in clinical records to allow for incorporation of information between clinical systems that utilize differing vocabularies, including LOINC encoding and mapping and encoding services for all Meaningful Use standards.
Quality Reporting and Analytics	Enable the capability for providers and hospitals to report quality measures to CMS and/or DCH and other appropriate state agencies via the Georgia HIE.
Transformation Services	Deploy functionality to enable transformation of clinical and administrative data between different document formats (ex: HL7v2 or v3 or EDI to XML), including data parsing and validation, routing messages, canonical data model support, metadata, receiving, and retrieving data.
Radiology and Imaging	Deploy functionality providing HIE-integrated radiology/imaging services that facilitate the ordering of radiological studies to the appropriate and designated locations and providers.
Business Intelligence (BI) Services	Enable functionality to access business intelligence services and information in order to analyze HIE utilization, system uptake, and other reporting and analytics as determined by DCH and its partners.
Data Analysis	Activate tools and services to support data analysis and analytics based on specific HIE-related features and programs or goals.
Event Reporting	Enable functionality to record and analyze data on adverse and near-miss events reported by HIE participants. Examples of reportable events include falls, process-of-care errors, medication errors, and transfusion errors.
NCQA/HEDIS Reporting	Enable features to facilitate the collection of data through the HIE to support NCQA and HEDIS reporting requirements and which are consistent with authorities and state and federal laws.

Building and Sustaining the Georgia HIE

A combination of Federal Funding, State Matching Funds, Grants, and Payer Investments appears to be the best approach for building the Georgia HIE infrastructure. The financial sustainability model being constructed by GA HIE is based on the principle that entities participating in the Georgia HIE (i.e., providers, payers, state government, labs, pharmacies, and others) should contribute to financing the ongoing operations and sustainability of the system. Membership fees are currently being address may be based on participant type as explained below:

- Hospitals – sliding fee scale based on various factors such as bed size and on total annual revenue
- Provider Practice Fees – sliding fee scale based on number of providers in the group
- Pharmacies – fee based on whether pharmacy is independent or a chain (fee for chain pharmacies is determined by number of locations)
- Labs – fee based on whether lab is independent or affiliated (one fee per group for affiliated labs)
- Other Facilities (Nursing, Long-term Care, etc.) – fee based on number of beds
- State Government Agencies – a per agency charge will be assessed initially
- Payers – fee based on number of covered lives

PROJECT 2: CORRELATION TO GEORGIA MEDICAID
(All phases of the statewide HIE network)

Medicaid providers and DCH will benefit significantly by having timely access to up to data clinical information based upon continuously enhanced HIE services (*GeorgiaDirect*, *PatientFinder* (working title for Query-Based Exchange), and eventually advanced exchange services). Georgia Medicaid and other state agencies will benefit from access to near real-time clinical information at the point of service and have the ability to better coordinate care as a result of relevant and reliable information. These integrated systems and services via the statewide HIE, make more efficient the correlation of health and claims data, enable a single “front door” for provider directory information, and give Medicaid providers the ability to directly report public health information via the statewide HIE. Finally, the statewide HIE network services also facilitate patient management of their own health information.

Project 3: Medicaid Member Portal

Description

Medicaid members have online access to the Georgia Medicaid Management Information System (GAMMIS), a web based portal for both Medicaid and PeachCare for Kids public medical assistance plans. Members can register securely on-line to obtain access to self-service tools and resources like finding a provider, reviewing claims data, obtaining eligibility status and requesting a new benefits cards if lost or stolen. To date, from the 1.8 million members covered under Medicaid, approximately 25,000 members have electronic access to the existing Medicaid portal. As a result, the Department of Community Health, Health Information Technology Division has the opportunity to be the catalyst to affect change by introducing new enhancements to existing systems and fostering partnerships that may elevate awareness, prevention, save money and potentially save lives within the Medicaid system.

The purpose of the enhanced Medicaid Member Portal is to encourage widespread adoption of healthier practices that deliver better health care using Health Information Technologies. It will also provide the member a robust and meaningful user experience. Enhancements to the portal will be designed to empower and equip members with tools and resources to manage their health and better utilize the healthcare system. This initiative will also pose as opportunity to explore the development of implementing an integrated member portal between Georgia Medicaid and CMOs. This partnership will create a more streamlined approach to access to health information and reduce costs. With the rapid development of technology, innovation and a data-driven push for patient/consumer engagement, emphasis has been centered on empowering patients to take ownership of their health care needs. Therefore any existing delivery or coordination of care challenges can be aided by leveraging this technology.

Research shows that consumers are beginning to take ownership of their health and therefore healthcare related information online are becoming a critical part of their fact finding experience. Consumers are becoming more aware and better educated about their conditions, possible treatments and preventive measures. Online health browsing using cell phones, tablets and other smart devices are becoming more prevalent among younger populations. Topics like symptoms and conditions, side effects, treatments, medications, prevention and general health related information are at the top of the list.

It is a strategic goal of the Division of Health IT and Georgia Medicaid to:

- Promote the member portal as the catalyst for which engaged Georgia Medicaid members can obtain and maintain access to their personal health information ultimately driving usability and increasing utilization.

- Solidify the Georgia Medicaid Member Portal as the standard by which Medicaid members encounter a full-bodied user experience where information is readily accessible, easy to read, navigate and understand.

- Redevelop the functionality of the portal through incorporating a cleaner homepage, clearer fonts, straightforward menu options and providing an accurate and up to date list of participating providers and specialists. Making such changes to the existing portal shall compel members to use the site on a consistent basis and making it apart of their everyday lifestyle.

Objectives of this project:

- To engage the consumer by educating, communicating and delivering electronic access to personal health records and online resources to improve health outcomes

- To deliver interactive technology and increase utilization of online access to records, notifications, resources and services

- To educate consumers on opportunities to obtain and maintain electronic access to their personal health record

- To communicate ways consumers can improve health outcomes by establishing partnerships with their healthcare providers

- To empower consumers to make better informative decisions to improve their health care

The scope of this project is to enhance the Medicaid Member Portal via 5 components:

1. Functionality
2. Wellness content and Digital Tools
3. Data Driven User Experience via Self-reporting opportunities
4. Privacy and Security
5. Usability and design

Justification of the project:
This project will support Georgia Medicaid's member population and promises to deliver features and functionalities that will evoke a robust user experience. Justification for this project includes:

- Meeting and exceeding member expectations in the area of health initiatives
- Expanding the resources offered to members as means to attract and retain member portal users
- Improving ability to control health care costs
- Increasing opportunities to positively influence member's health behavior
- Providing personalization and targeted messaging based upon individualized programs and self-reported data for healthier outcomes
- Providing members the ability to control their health, healthcare and lifestyle decisions
- Streamling access to personalized healthcare data

Feature Enhancements Include:

Secure online messaging	Automated alerts and reminders (SMS, E-mail)
Lab results	Risk factor comparisons
Symptom tracker	Health education library
Prevention services	Health tracker
Appointment scheduler	Prescription renewal, medication list
Health e-journal	Nutrition education, tracker, journal
Fitness education	Family history journal
Contraindication lists	Document sharing (Scan & Upload)
Self-care tools	Images (X-ray etc.) – scan & upload
Health Risk Assessments	Audit tracker
Progress charts	Visit summary
Social media outlet	Health e-Calendar
Health and wellness content and videos	Immunizations List
Insurance benefits	Doctors notes
App store	Biometric reporting (BMI etc.)

PROJECT 3: CORRELATION TO GEORGIA MEDICAID

This is a DCH initiative and is the link to bridging the information gap of access to shared data from Medicaid to its member population. Looking forward, Medicaid members will be notified about new up-and-coming technologies that will be afforded to them in the near future. By crafting strategic, compelling and meaningful messages that speak to the needs of our members, that through the use of technology, may make what seemed cold and distant more real and significant. Keeping Georgia Medicaid members and their caregivers at the center of this initiative, we can focus on promoting (in plain language) the value and benefits of digital enhancements to their portal, bring awareness of privacy and security of their data, and educate them on how to access, read, and understand their healthcare record.

Therefore, fostering a deeper collaboration between the Division of Health IT and Georgia Medicaid can create awareness, gain buy-in and build momentum in solidifying the sustainability of a comprehensive and robust GAMMIS Member Portal system. This project has a very strategic value to GA Medicaid, because it will also serve as a model for future initiatives to improve health outcomes and reduce cost. By expanding access to healthcare through deeper digital patient engagement, healthier behaviors and outcomes and reduced costs associated with health care can be realized.

Project 5: Virtual Health Record for Foster Care and Other Population-Based Service Coordination

DESCRIPTION

In July 2012, DCH announced that the Foster Care and Adoptive Assistance program will transition from Fee-for-Service (FFS) to Managed Care (CMO) services by January 1, 2014. A joint task force has been convened and is comprised of the Georgia Department of Community Health (DCH), the Georgia Department of Public Health (DPH), the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), and the Georgia Department of Family and Child Services (DFCS). The Foster Care and Adoptive Assistance Joint Task Force is advisory in nature and its goal is to provide input into the transition of the foster care and adoptive assistance populations to one of the Care Management Organizations (CMOs) currently participating in Georgia Families, a full-risk managed care program for certain Medicaid populations and PeachCare for Kids®.

Children in foster care are among the highest priority to the state of Georgia due to the complex relationship involved in their care and customer and the extraordinary instability of their lives and health status. The delivery of care and other services to foster care children in Georgia occurs in many different settings – physicians' offices, hospitals, behavioral health and residential facilities, within the juvenile justice and corrections systems, foster care home and temporary respite centers. The foster care population is very transient with children moving in and out of Georgia DFCS and other state systems. These two factors alone generate various data source silos which often contain duplicative information, require manual data entry and are likely to store incomplete data sets. These short-lived care and service provider scenarios create environmental instability and limits access to physical and behavior health care – mostly due to the lack of information. Without medical and behavioral health histories, providers must treat foster children with either no information or limited information that is provided by either the child or relative if available. Other service providers within the DFCS system also face challenges in delivering coordinated services necessary for proper treatment and care of foster children.

As a result, there is a critical need for timeliness and standardization of data to transmit relevant information to health care providers and other foster care service providers in a clinically useful form. As part of the transition to managed care, DCH with its partners will develop a virtual health record (VHR) specifically for managing the health information of children in foster care. The VHR will utilize the Georgia Query-Based Exchange service of the Georgia statewide HIE network (available in 2013) interoperable with various state agency data sources and programs serving foster care children in Georgia. This solution will avoid duplication of effort, provide data sharing capability, and enable providers to receive data from the electronic health records systems. Specific functionality will allow authorized clinicians and other authorized individuals to access various data sources connected to the statewide HIE network and query for relevant health information for the purpose of treatment and relevant specialized services. Data integration and queried results will adhere to all federal and state health information related privacy and security laws and regulations, including those policies with the Georgia Statewide HIE Network Privacy and Security Policy Framework. The VHR will be capable of presenting queried health information to a variety of end-use applications to efficiently meet a variety of information needs for the total care team. The information will be gathered, tailored to and compatible with the needs of case workers, foster care service providers, legal parents, health care providers, and the foster child, upon emancipation or reaching maturity.

The rationale for developing a VHR for the foster care population is to enhance the coordination of care and access to services, improve health outcomes, develop and utilize meaningful and complete medical

records; and for state agencies to meet full compliance with regulatory reporting requirements. At the outset of the project, a measurement framework will be established to baseline the current system and compare it to the new system and measure overall effectiveness and draws conclusions about user satisfaction with product performance. Finally, this data integration project will be the basis for establishing new models integrating behavioral health, children's dental health, substance abuse, and long-term services and support for Georgia Foster Care.

PROJECT 5: CORRELATION TO GEORGIA MEDICAID

This is a DCH initiative and is integral to the movement of this vulnerable population from a fee for service model to the managed care environment. There is currently lots of data about these Medicaid members but it is all in silo systems. It is imperative that this data integration project be completed prior to changing the healthcare delivery model for this population to ensure that the transition is not only smooth but the care is greatly enhanced.

This project has a very strategic value to GA Medicaid, because it will also serve as a model for future initiatives to improve health outcomes and reduce cost. GA Medicaid will also learn and improve a measurement framework which is in alignment with the federal initiative on outcome and performance improvement.

Health IT Overarching Goals - FY17 and Beyond

Medicaid EHR Incentive Program

- Increase the number of Eligible Professionals transitioning from AIU (Payment Year 1) to MU (Stage 3) by 33% from 2017 to 2020.

Health Information Exchange

- Promote advanced statewide interoperable activities including care plan exchange, medication management, medical image exchange, medical event notifications, lab results delivery, public health registries and CMO transition of care initiatives among hospitals, providers, state agencies and regional HIEs.

Population Health Management

- Pilot an electronic Clinical Quality Measure system to ensure all Georgia Medicaid providers report actionable clinical information; ultimately improving the quality of care within the health care delivery system.

Innovation and beyond

- Pilot a personal health record system to demonstrate and improve managed care efforts and timely delivery of clinical and non-clinical information among Medicaid long-term services and supports waiver programs.
- Engage strategic public-private health IT partnerships to pursue initiatives in telehealth/telemedicine, Health Level Seven (HL7) eLTSS data standards, patient engagement including Medicaid member portal enhancements, clinical data warehousing, and future innovative Health IT activities.

E-4. Benchmarks and Expected Outcomes

Product of Achieving Georgia Medicaid Health IT/HIE Goals

FY18 Goals
Drive awareness by reaching 3,000 Georgia Medicaid providers between October 2017– Sept 2018 **Transition 960 Georgia Medicaid providers from consideration phase to conversion phase (signed agreements with GaHIN connected members in FY 2018)** GaHIN will also connect 200 non-eligible providers who electronically share data with eligible Georgia Medicaid providers across the Georgia Statewide Health Information Network. These non-Eligible Providers may include: • Behavioral health providers, • Substance abuse treatment providers, • Long-term care providers (including nursing facilities), • Home health providers, • Pharmacies, • Laboratories, • Correctional health providers, • Emergency medical service providers, • Public health providers, and • Other Medicaid providers, including community-based Medicaid providers **Transition 5 key Georgia Medicaid providers from conversion phase to advocacy phase between October 2017– Sept 2018**

RESULTS OF INITIATIVES – EXPECTED OUTCOMES

- Enhances appropriate use of services by Medicaid members
- Improves clinical decision-making at the point of care
- Achieves long-term sustainable savings in services
- Improves health care outcomes for members
- Simplifies Medicaid administrative process like Prior Authorizations
- Provides a longitudinal clinical record for the Medicaid foster care kids

Appendix A: Abbreviations and Glossary of Terms

Abbreviations

Abbreviations	Defined
ABD	Aged, Blind, and Disabled Medicaid
AHA	American Hospital Association
AIU	Adopt, Implement, Upgrade
ARRA	American Recovery and Reinvestment Act of 2009
CAH	Critical Access Hospital
CCN	CMS Certification Number
CDC	Center for Disease Control
CDR	Clinical Data Repository
CGHE	Central Georgia Health Exchange
CHIP	Children's Health Insurance Plan
CHL	Chatham HealthLink
CHPL	Certified HIT Product List
CLIA	Clinical Laboratory Improvement Act
CMO	Care Management Organizations
CMS	Centers or Medicare and Medicaid Services
CPRS	Computerized Patient Record System
CY	Calendar Year
DCH	Department of Community Health
DHIT	Division of Health IT
DJJ	Department of Juvenile Justice
DoD	Department of Defense
DPH	Department of Public Health
EH	Eligible Hospital
EHR	Electronic Health Record
EP	Eligible Professional
FFP	Federal Financial Participation
FFS	Fee-For-Service
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GAPHC	Georgia Association of Primary Health Care
GBDRIS	Georgia Birth Defects Reporting and Information System
GCC	Georgia Cancer Coalition
GFHP	Georgia Farmworker Health Program
GHIE, Inc.	Georgia Health Information Exchange, Inc.
GRAcHIE	Georgia Academic Community Health Information Exchange
GRITS	Georgia Registry of Immunization Transactions and Services
GTA	Georgia Technology Authority
HCRIS	Healthcare Cost Report Information System
HIE	Health Information Exchange

HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HL7	Health Language Seven
HP	Hewlett-Packard Enterprise Services
HRSA	Health Resources and Services Administration
I-APD	Implementation Advance Planning Document
ICD	International Classification of Diseases
ID	Identification
IT	Information Technology
LIM	Low Income Medicaid
MAPIR	Medical Assistance Payment Incentive Repository
MIP	Medicaid EHR Incentive Program
MITA	Medicaid Information Technology Architecture
MMCO	Medicaid Managed Care Organization
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
NLR	National Level Repository
NPI	National Provider Identifier
NwHIN	Nationwide Health Information Network
OIG	Office of Inspector General
ONC	Office of National Coordinator for Health Information Technology
PCMH	Patient Centered Medical Home
PHR	Patient Health Record
QBE	Query Based Exchange
R&A	CMS Registration and Attestation System
REC	Regional Extension Center
RHC	Rural Health Clinic
RHIO	Regional Health Information Organization
RSM	Right From the Start Medicaid
SCHIP	State Children's Health Insurance Program
SDE	State Designated Entity
SendSS	State Electronic Notifiable Disease Surveillance System
SLA	Service Level Agreements
SMA	State Medicaid Agency
SMHP	State Medicaid Health Information Technology Plan
SORH	State Office of Rural Health
TANF	Temporary Assistance for Needy Families
TIN	Tax Identification Number
UAT	User Acceptance Testing
UDS	Uniform Data System
UNHSI	Universal Newborn Hearing, Screening and Intervention
VA	Veteran Affairs
VHA	Veteran's Health Administration

WISP	Wireless Internet Service Provider
WSC	Western States Consortium

Glossary

American Recovery and Reinvestment Act of 2009 (ARRA): A $787.2 billion stimulus measure, enacted into law in February 2009, that provides financial assistance to states and cities, funding for infrastructure projects and the expansion of Medicaid and health information technology among other provisions.

American National Standards Institute (ANSI): The U.S. standards organization that establishes procedures for the development and coordination of voluntary national standards.

Architecture: The structure of an information system and how its pieces communicate and work together.

Centers for Medicare and Medicaid Services (CMS): A federal agency within the United States Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards.

Certificate Authority(ies) (CA): The entity(ies) that issues digital (X.509v3) certificates to entities and individuals for the purposes of conducting secure information exchange in a PKI framework. A CA is the issuing CA with respect to the certificates it issues and is the subject CA with respect to the CA certificate issued to it. CAs may be organized in a hierarchy in which an organization's CA issues certificates to other CAs operated by subordinate organizations, such as a branch, division, or department within a larger organization.

Clinical Data Repository (CDR): A real-time database that consolidates data from a variety of clinical sources to present a unified view of a single patient.

Consumer-Mediated Exchange: Connects patient personal health records with health information exchanges.

Continuity of Care Document (CCD): Summarizes a consumer's medical status in a standard format for the purpose of information exchange. The CCD promotes interoperability between participating systems such as Personal Health Record Systems (PHRs), Electronic Health Record Systems (EHRs), Practice Management Applications, and other systems.

Cross-enterprise Document Sharing (XDS): A system defined by IHE for sharing clinical documents between institutions. XDS re-uses ebXML registry methodology to provide a centralized method of indexing documents.

Data Use and Reciprocal Support Agreement (DURSA): A comprehensive, multi-party trust legal agreement and is based upon a set of policy assumptions that bridge varying state and federal laws and regulations, as well as various policies. This legal contract, signed by all entities currently exchanging information via the Nationwide Health Information Network (NHIN) Exchange, provides a framework of trust assurance to support health information exchange across the NHIN.

Data Warehouse (DW): Data warehouse is a repository of an organization's electronically stored data. It is designed to facilitate reporting and analysis.
Decryption: The process used to "unscramble" information so that a "scrambled" or jumbled message becomes understandable.

Digital Imaging and Communications in Medicine (DICOM): A standard for handling, storing, printing, and transmitting information in medical imaging.

Direct Address: Used to identify an endpoint (a Sender or Receiver) when information is exchanged. The Direct Address has two parts, a Health End Point Name and a Health Domain Name, for example, drbob@samplehispname.org.

Directed Exchange: A secure point-to-point electronic delivery of health data between health care participants using Direct Project protocols.

Electronic Health Record (EHR): An electronic health record of an individual's health-related information that includes patient demographics and clinical health information, such as medical history and problem lists; and has the capacity to provide clinical decision support; to support physician order entry; to capture and query information relating to health care quality; to exchange health information; and to integrate such information from other sources.

Electronic Medical Record (EMR): An electronic record of health-related information regarding an individual that conforms to nationally recognized interoperability standards and that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.

Encryption: Translation of data into a code in order to keep the information secure from anyone but the intended recipient.

Enterprise Architecture: A strategic resource that aligns business and technology, leverages shared assets, builds internal and external partnerships, and optimizes the value of information technology services.

Enterprise Master Patient Index (EMPI): Is an index that includes all patients whose records are maintained in the enterprise record system.

Electronic Business using eXtensible Markup Language (ebXML): A family of XML based standards whose mission is to provide an open, XML-based infrastructure that enables the global use of electronic business information in an interoperable, secure, and consistent manner by all trading partners.

Electronic data interchange X12 (EDI X12): The structured transmission of data between organizations by electronic means. It is used to transfer electronic documents or business data from one computer system to another computer system, i.e. from one trading partner to another trading partner without human intervention.

Electronic Prescribing (eRX): Computer technology in which physicians use handheld or personal computer devices to review drug and formulary coverage and transmit prescriptions to a pharmacy, electronic health record system or printer.

Eligible Hospital (EH): Acute care (excluding long term care facilities), critical access hospitals and children's hospitals.
Eligible Professional (EP): Non-hospital-based physicians who receive reimbursement through Medicare FFS program or a contractual relationship with a qualifying MA organization. Eligible professionals are widely considered to be physicians whose practices are less than 90% inpatient and ER.

Federated Model: A model in which health information is retained by each participating health care provider and is exchanged with other members as needed. Features a decentralized approach to storing and accessing health information. The health information consists of a collection of clinical data repositories which are located remotely.

Federally Qualified Health Center (FQHC): A type of provider organization as defined by Medicare and Medicaid that provides health care to the medically underserved; generally includes community health centers, migrant health centers, and other similar entities.

GRITS (Georgia Registry of Immunization Transaction and Services): A registry designed to collect and maintain accurate, complete and current vaccination records to promote effective and cost-efficient disease prevention and control.

Health Alert Network (HAN): The CDC's network that provides information about urgent health events to state and local public health practitioners, clinicians, and public health laboratories.

Healthcare Information Technology Standards Panel (HITSP): Created by the Office of the National Coordinator for Health Information Technology (ONC) to promote interoperability in health care by harmonizing health information technology standards.

Health Data Intermediary (HDI): An entity that provides the infrastructure to connect computer systems or other electronic devices used by health care providers, laboratories, pharmacies, health plans, third-party administrators or pharmacy benefit managers to facilitate the secure transmission of health information, including pharmaceutical electronic data intermediaries. Term does not include health care providers engaged in direct health information exchange.

Health Domain Name: The delivery location for messages to an individual Direct HISP, the HISP portion of a Direct Project Address.

Health End Point: The delivery location for messages to an individual Direct user, the user portion of a Direct Project Address.

Health Information Exchange (HIE): The electronic transmission of health-related information across organizations according to nationally recognized standards.

Health Information Organization (HIO): An organization that oversees, governs, and facilitates the exchange of health-related information among organizations according to nationally recognized standards.

Health Information Service Provider (HISP): An organization that provides services on the Internet to facilitate use of Direct. The entity that is responsible for delivering health information as messages between

senders and receivers over the Internet. A vendor that provides Direct messaging services. A HISP ensures that your Direct messages are delivered securely to the correct recipient.

Health Information Technology (HIT): The combination of technology and connectivity required to meaningfully use and exchange electronic health information, including EHRs. The application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.

Health Information Technology for Economic and Clinical Health (HITECH) Act: It is a section in ARRA ("an act within an act") that provides approximately $34 billion in federal funding aimed at promoting the adoption and use of health information technology and furthering the electronic exchange of health information across health systems.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): A federal law intended to improve portability of health insurance and simplify health care administration; HIPAA sets standards for the electronic exchange of claims-related information and for ensuring the security and privacy of all individually identifiable health information.

HIPAA Privacy Rule: Regulates the use and disclosure of Protected Health Information (PHI) held by "covered entities" (generally, health care clearinghouses, employer sponsored health plans, health insurers, and medical service providers that engage in certain transactions.)

Health Record Bank: A community organization that provides a safe, secure location to automatically store health records where the patient is in charge of all personal, private health information.

Health Level 7 (HL7): 1. An ANSI accredited organization that develops international standards for health care. HL7 standards specify a number of flexible standards, guidelines, and methodologies by which various healthcare systems can communicate with each other. An interface standard for exchanging and transferring health data between computer systems.

Hybrid Federated: Incorporates some centralized core services such as clinician and patient directories, secure routing of messages and files, and user identity verification and authorization to access. A cross between centralized and decentralized architecture. A hybrid model provides the interface engine for which organizational entities in the HIE communicate. The hybrid model stores key record identifiers and requests for the information that is distributed across the network. The record locator key is used to gather and transfer medical information to the requesting healthcare provider. Incorporates some centralized core services such as clinician and patient directories, secure routing of messages and files, and user identity verification and authorization to access.

Integrating the Healthcare Enterprise (IHE): An initiative by healthcare professionals and industry to improve the way computer systems in healthcare share information.

Interface: A means of interaction between two devices or systems that handle data. Equipment or programs designed to communicate information from one system of computing devices or programs to another.

Interoperability: The ability of two or more systems or components to exchange information and to use the information that has been exchanged. Typically, interoperability is understood to have three components: technical, semantic, and process. The ability of systems or components to exchange health

information and to use the information that has been exchanged accurately, securely, and verifiably, when and where needed.

Logical Observation Identifiers Names and Codes (**LOINC):** A database and universal standard for identifying medical laboratory observations. Universal code names and identifiers to medical terminology related to the EHR and assists in the electronic exchange and gathering of clinical results (such as laboratory tests, clinical observations, outcomes management and research).

Master Patient Index (MPI): A central index of patient records used for the purpose of matching records from different sources and accurately relating that data to the same patient. An MPI usually does not have medical data contained with it and may or may not point to medical data found elsewhere.

Meaningful Use: Under the HITECH Act, an eligible professional or eligible hospital is considered a meaningful EHR user if the EP or EH uses certified EHR technology in a manner consistent with criteria established by federal rules, including e-prescribing through an EHR, and the exchange of information for the purposes of quality improvement, such as care coordination.

Medicaid Information Technology Architecture (MITA): A national framework to support systems development and health care management for the Medicaid enterprise.

Medicaid Management Information System (MMIS): MMIS consists of an integrated group of procedures and computer processing operations (subsystems) developed at the general design level to meet principal objectives, including Medicaid program control and administrative costs; service to recipients, providers, and inquiries; operations of claims control and computer capabilities; and management reporting for planning and control.

National Council for Prescription Drug Programs (NCPDP): ANSI-accredited, standards development organization with over 1575 members representing virtually every sector of the pharmacy services industry.

National Level Repository (NLR): A nationwide data repository maintained by CMS to provide support for the electronic administration of incentive disbursements to eligible providers and eligible hospitals under the Medicaid and Medicare incentive programs.

National Provider Identifier (NPI): A 10-digit, intelligence free numeric identifier that replaces all other health care provider identifiers. A system for classifying all providers of health care services, supplies, and equipment covered under HIPAA.

Nationwide Health Information Network (NwHIN): Technologies, standards, laws, policies, programs and practices that enable health information to be shared among health decision makers, including consumers and patients, to promote improvements in health and health care. A federal initiative to develop a set of standards, services, and policies that enable the secure exchange of health information over the Internet for sharing among health decision makers, including consumers and patients, to promote improvements in health and health care.

Office of the National Coordinator for Health Information Technology (ONC): An agency within HHS that oversees and encourages the development of a national, interoperable health information technology system to improve the quality and efficiency of health care.

Open Source: Practices in production and development of software that promote access to the end product's source code. Open source products are usually developed collaboratively with the software freely distributed to anyone willing to abide by the rules of its use and distribution. Systems whose human-readable ("source") code is always freely available to anyone who is interested in downloading it.

Participating Providers: For the purposes of this document are providers who have signed all required agreements to participate in the Georgia statewide HIE.

Participation Agreements: For the purposes of this document are those agreements that the governance entity for the statewide HIE determines are required as a condition for participation by providers.

Patient-Centered Medical Home Model (PCMH): An approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Patient Record Locator: The electronic means by which patient files are located to assist patients and clinicians to find test results, medical history, prescription data, and other health information.

Personal Health Record (PHR): An electronic application through which individuals can maintain and manage their health information (and that of others for whom they are authorized) in a private, secure, and confidential manner. Electronic tools that offer a comprehensive view of personal health information, including information patients generate themselves, information from doctors (diagnoses and test results), and information from pharmacies and insurance companies, which allow patients to access, use, share, and coordinate their personal health information.

Practice Management System (PMS): That portion of the medical office record which contains financial, demographic and non-medical information about patients. The software used by physicians for scheduling, registration, billing and receivables management. Many EMR vendors also offer practice management systems that are fully integrated with the clinical EHR software.

Protected Health Information (PHI): Health information transmitted or maintained in any form that can reasonably be used to identify an individual.

Provider Portal: The point of access for all participating providers in the statewide HIE. Point of access to a disparate computer system (e.g., at hospital) or the internet.

Query-Based Exchange: The functionality to send and query patient information.

Record Locator Service (RLS): An index containing patient demographic information and the location of a patient's medical records. It generally does not contain clinical information. Participating entities decide whether or not to put record locations into the RLS. Designed to take a query in the form of demographic details and return only the location of the matching records. An electronic index of patient identifying information that directs providers in a health information exchange to the location of patient health records held by providers and other data sources.

Regional Extension Center (GA-HITEC) and administrative workflow, and to comply with privacy and security requirements. Each REC is required to focus its efforts on individual or small group practices and providers in public and critical access hospitals, community health centers, and other safety net providers.

Regional Health Information Organization (RHIO): A multi-stakeholder organization that enables the exchange and use of health information in a secure manner for the purpose of promoting the improvement of health quality, safety and efficiency. A health information organization that brings together health care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in that community.

Software as a service (SaaS): A software delivery model in which software and associated data are centrally hosted on the cloud.

Scalability: The ability to add users and increase the capabilities of an application without having to make significant changes to the application software or the system on which it runs.

SendSS (State Electronic Notifiable Disease Surveillance System): A web-based reporting system designed to collect information pertaining to notifiable diseases in Georgia.

Service Level Agreement: A contract between a service provider and a user that specifies the level of service expected during a contract term. Service level agreements determine how performance will be measured and, in the event of underperformance, how the penalties will be calculated and paid.

Service Oriented Architecture (SOA): A building-block approach to application development which emphasizes the reuse of software components that are built to perform individual functions and which interact with each other through clearly-defined interfaces. A set of principles and methodologies for designing and developing software in the form of interoperable services.

Shared Directory: A service that enables the searching and matching of data to facilitate the routing of information to providers, patients, and locations.

Simple Object Access Protocol (SOAP): A protocol specification for exchanging structured information in the implementation of Web Services in computer networks.

Secure Sockets Layer (SSL): A network protocols that provide communication security over the Internet**.**

State Designated Entity (SDE): A not-for-profit organization with broad stakeholder representation on its governing board designated by the state as eligible to receive awards under the Cooperative Agreement.

State Health Benefit Plan (SHBP): Provides health insurance coverage to state employees, school system employees, retirees and their dependents.

State Health Information Exchange Cooperative Agreement Program: Funds states' efforts to rapidly build capacity for exchanging health information across the health care system both within and across states.

Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT): A systematically organized computer process able collection of medical terms providing codes, terms, synonyms and definitions covering diseases, findings, procedures, microorganisms, substances, etc.

Telehealth: The use of telecommunications technologies and electronic information to support long-distance clinical health care, patient and professional health-related education, or public health and health administration. Technologies used in telehealth include videoconferencing, the Internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

Telemedicine: An application of clinical medicine where medical information is transferred through interactive audiovisual media for the purpose of consulting, and sometimes remote medical procedures or examinations.

Transport Layer Security (TLS): A network protocol, successor to Secure Sockets Layer (SSL), that provide communication security over the Internet**.**

Workforce Development: Funding to develop programs and curricula to prepare a skilled workforce for the deployment of HIT and statewide HIE.

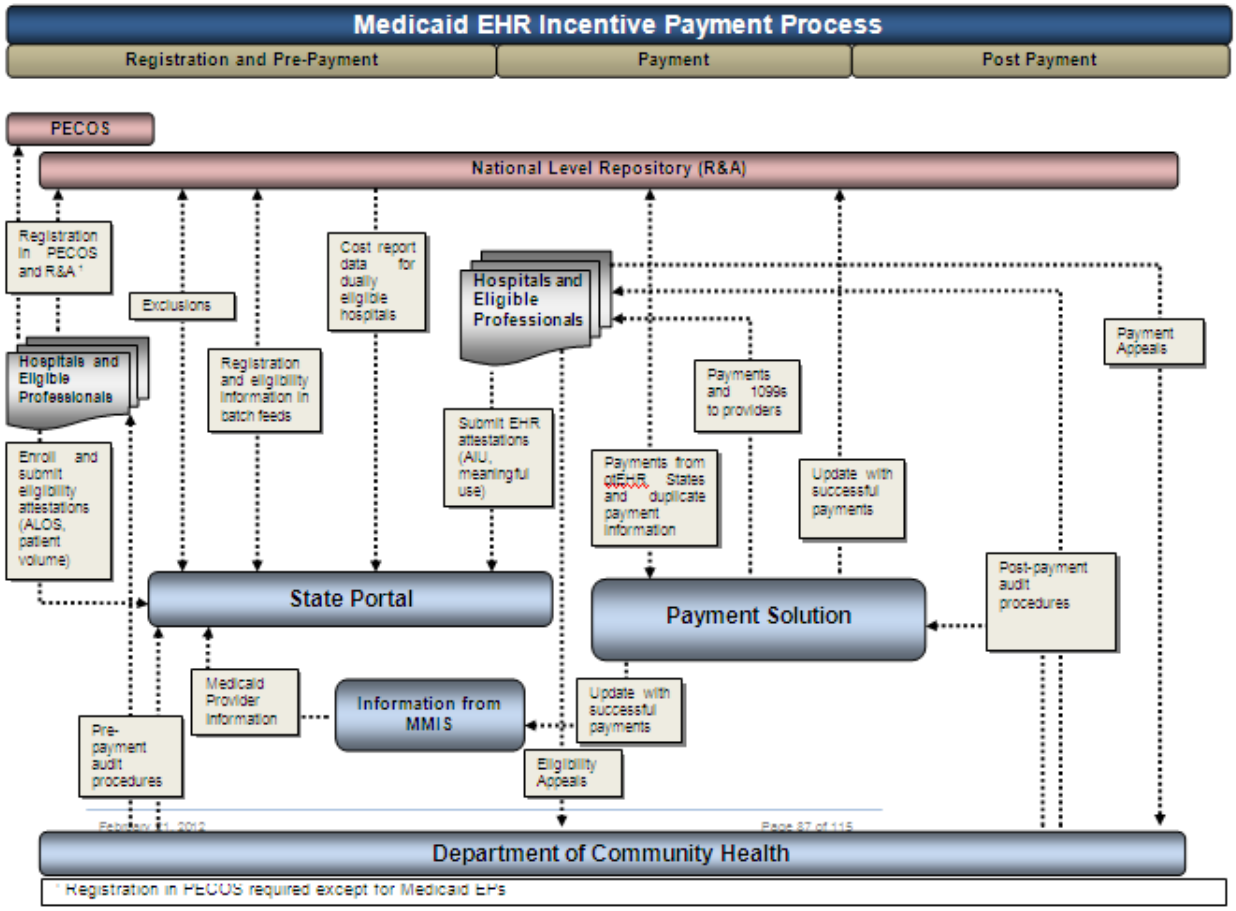
Appendix D: Provider Communication and Outreach Plan

Georgia's Division of Health IT is currently engaged with Hewlett-Packard Enterprise Services (HPE) and the Georgia Health Information Technology Extension Center (GA-HITEC) to further the adoption of EHRs and Meaningful Use throughout Georgia. Each partner works collaboratively, including making presentations during meetings, conferences and other special events, and speaking with the GaHIN board.

Medicaid EHR Incentive Program – Communications Outreach At-A-Glance	
The Market	**The Marketing Tools for External & Internal Communications**
Providers (Eligible Professionals and Eligible Hospitals)	Marketing (banner messages, digital campaigns, print ads), special events (monthly webinars and workshops), collateral for Medicaid providers (postcards, toolkits, fact sheets, FAQs)
Partners – GA-HITEC and HPE	Collaborative efforts (including onboarding public health districts into the Medicaid EHR Incentive Program), marketing strategies, speaking engagements, meetings/special events, and more
Media – Health Care/IT/Consumer	Press kits, ongoing press releases, briefings, story pitches and PSAs
GA State Organizations	Intranets, eNewsletters, special legislative briefing packages/presentations
Federal Organizations	Email briefings

Appendix E: Medicaid EHR Incentive Payment Process

The following diagram depicts the Georgia Medicaid EHR Incentive Payment Program process, including pre and post audit procedures.



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.

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 Template									
Calculation Components:									
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									
Calculation Example:									
Step 1:	Determine the average annual growth rate in discharges over 3-year period preceding first calculation year								
	Data Sources:	Total discharges from hospital cost reports, worksheet S-3, Part I, Column 15, Lines 12, 14, 14.0x							
		(Include acute inpatient subprovider units, such as rehabilitation and psychiatric subprovider units)							
	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!						
3-year average (growth rate)			**#DIV/0!**						
Step 2:	Determine total discharge-related amount for each of 4 years								
	Data Sources:	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!				
Year 4: (Year 3 + Growth Rate)			#DIV/0!	$200	#DIV/0!				
Step 3:	Determine overall EHR amount								
	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	$0	1	$2,000,000					
Year 2	$2,000,000	#DIV/0!	0.75	#DIV/0!					
Year 3	$2,000,000	#DIV/0!	0.5	#DIV/0!					
Year 4	$2,000,000	#DIV/0!	0.25	#DIV/0!					
TOTAL				**#DIV/0!**					
Step 4:	Determine Medicaid Share								
	Data Sources:	Hospital cost report, worksheets S-3, S-10, and C							

	(include acute inpatient subprovider units, such as rehabilitation and psychiatric subprovider units)								
Total Medicaid Days (w/s S-3 part I, col. 5, line 12, and if applicable, 14, 14.0x)									
Total Medicaid HMO days (w/s S-3 part I, col. 5, line 2)									
Total Medicaid and HMO Medicaid days						0			
Total Hospital Charges (w/s C part I, col. 8, line 103)									
Charity Care Charges or Other Uncompensated Care Charges (w/s S-10, line 30)									
Total Hospital Charges Excluding Charity Care Charges					$0				
Non-charity percentage					#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!			
Medicaid Share						**#DIV/0!**			
(Total Medicaid and HMO Medicaid days) divided by Total Non-charity Hospital Days									
Step 5:	Determine Aggregate EHR incentive amount								
	Calculation:	Aggregate Incentive Amount = Overall EHR Amount * Medicaid Share							
Overall EHR			#DIV/0!						

Amount									
Medicaid Share			#DIV/0!						
Aggregate EHR Incentive Amount			**#DIV/0!**						
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.									

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 Example								
Calculation Components:								
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									
Calculation Example:									
Step 1:	Determine the average annual growth rate in discharges over 3-year period preceding first calculation year								
	Data Sources:	Total discharges from hospital cost reports, worksheet S-3, Part I, Column 15, Lines 12, 14, 14.0x							
		(Include acute inpatient subprovider units, such as rehabilitation and psychiatric subprovider units)							
	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%						
3-year average (growth rate)			**2.50%**						
Step 2:	Determine total discharge-related amount for each of 4 years								
	Data Sources:	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				
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				
Step 3:	Determine overall EHR amount								
	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					
TOTAL				**$15,439,693**					
Step 4:	Determine Medicaid Share								
	Data	Hospital cost report, worksheets S-3, S-10,							

	Sources:	and C							
	(include acute inpatient subprovider units, such as rehabilitation and psychiatric subprovider units)								
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				
Charity Care Charges or Other Uncompensated Care Charges (w/s S-10, line 30) [1]					$150,000,000				
Total Hospital Charges Excluding Charity Care Charges					$1,050,000,000				
Non-charity percentage					87.50%				
(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)					110,000				
Total Non-charity Hospital Days						96,250			
Medicaid Share						**22.86%**			
(Total Medicaid and HMO Medicaid days) divided by Total Non-charity Hospital Days									
Step 5:	Determine Aggregate EHR incentive amount								
	Calculation:	Aggregate Incentive Amount = Overall EHR Amount * Medicaid Share							

Overall EHR Amount			$15,439,693						
Medicaid Share			22.86%						
Aggregate EHR Incentive Amount			**$3,529,072.78**						

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.

Appendix G: Georgia Medicaid EHR Incentive Payment Program Audit Guide

Note: *Attached as a separate document.*

Appendix H: Inventory of Georgia Public Health Registries

Georgia Public Health Registries

Program Name	Brief Description	What identifiers are used?	Where is Data Housed?
Georgia Comprehensive Cancer Registry	Collects cancer incidence data on all GA residents whether they are diagnosed and or treated in or out of GA; main purpose is to measure the burden of cancer among GA residents including children	First name, last name, date of birth, Race, Ethnicity, SSN, county of residence, and date of cancer diagnosis	Database resides with a Contractor, but this data is sent to and kept on site by DPH as well
Georgia Registry of Immunization Transactions and Services (GRITS)	Provides an interactive user interface for authorized users to enter, query, and update client immunization records	DOB, race, gender, full name, mother's maiden name, County of administration, and contact information	DPH
Georgia Newborn Screening Program	Program screens newborns for various genetic disorders and endocrine conditions	# of screens performed and number of positive screens; Names are reported to DPH if there is a positive screen	DPH
Universal Newborn Hearing Screening and Intervention (UNHSI)	Program that screens newborns for hearing conditions, and provides referrals for early treatment	# of screens performed and number of positive screens; Names are reported to DPH if there is a positive screen	DPH
Georgia Birth Defects Reporting and Information System (GBDRIS)	Designed to provide information on incidence, prevalence, trends and epidemiology of birth defects and to facilitate referrals to our early intervention system, Children 1st	Child name, physician name, child DOB, defect/diagnosis	DPH
Vital Records	Centralized database that stores all Births that occurred in Georgia as well as Births that occurred in other states to Georgia residents	Birth records include child's name, DOB, address, race, sex, and medical record number	DPH
Childhood Lead Poisoning Prevention Program	Keeps a registry of children tested for blood lead levels	Child name, DOB, address at the time of the test, test result and test type, race, sex and ethnicity (if available)	DPH

Program Name	Brief Description	What identifiers are used?	Where is Data Housed?
State Trauma Registry	It collects specific trauma injury data from our designated trauma centers which includes 2 pediatric centers	DOB and race	DPH/Vendor
OASIS	Department's data warehouse	Data received is technically not unique to OASIS, as it is technically extracted from various other systems; However, the data received for birth and death does contain name, address, and various demographic profile information (race, age, sex, etc.)	DPH
Georgia Violent Death Reporting System	Collects information on all violent death (homicide, suicide, undetermined death, and legal intervention)	First name, last name, date of birth, race, ethnicity, sex, SSN, county of injury, date of death	DPH
State Electronic Notifiable Disease Surveillance System (SendSS)	Tracks 70+ health conditions that are reportable or notifiable by law in Georgia	Name, address, DOB, race, ethnicity, phone number, medical record number (if applicable), and clinical/laboratory information	DPH

End Notes

[1] Source: Georgia Pharmacy Association.
[2] "State of Georgia Department of Community Health Medicaid and PeachCare for Kids® Design Strategy Report." Navigant, p. 4-.6
[3] Ibid. 4-8 and 4-9.
[4] Ibid. 4-40 through 4-41.
[5] Ibid., p. 4-40.
[6] Ibid., p. 4-43.
[7] "State of Georgia Department of Community Health Medicaid and PeachCare for Kids® Design Strategy Report." Navigant, p. 4-39.
[8] Ibid. 4-16 and 4-17.
[9] Ibid.
[10] "Strategies for Medicaid & CHIP Redesign: Ensuring a Healthier Future for Georgia's Children.", p. 3.
[11] America's Health Rankings, United Health Foundation. Online: http://www.americashealthrankings.org/ALL/Immunize/2011
[12] Children in the Q1/2010-Q4/2010 National Immunization Survey were born from January 2007 through July 2009.
[13] "State of Georgia Department of Community Health Medicaid and PeachCare for Kids® Design Strategy Report." Navigant, p. 4-38.
[14] Ibid., p. 4-43.
[15] Ibid., p. 4-44.