

Minnesota's State Medicaid HIT Plan

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(Version 5.0)

Minnesota Medicaid Electronic Health Record

Incentive Program (MEIP)



Minnesota Department of Human Services

Minnesota's State Medicaid Agency

2017 State HIT Plan
State of Minnesota
Department of Human Services

REVISION HISTORY

Version	Date	Point of Contact	Description of Changes
4.0	3/28/2016	Ruth Knapp	Update "As-Is" to 2015 Add reference to CEHRT flexibility (2014) Add SMHP Addendum for Modified Stage 2 (2015) Add annual audit strategy reference Appendices show screen shots for Modified Stage 2
5.0	2/28/2017	Ruth Knapp	Add SMHP Addendum for 2017 program changes
6.0	07/31/2017	Heather Petermann	Align SMHP goals with IAPD

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Minnesota's State Medicaid HIT Plan

1. EXECUTIVE SUMMARY

The State of Minnesota Department of Human Services (DHS) and Department of Health (MDH) prepared the first State Medicaid Health Information Technology Plan (SMHP) in 2011 with the intent to deploy the Minnesota Electronic Health Record (EHR) Incentive Program (MEIP) and foster a relationship with Minnesota health care providers supporting state wide health information exchanges (HIE). MEIP aims to assist eligible hospitals and health care providers with funding to adopt, implement, upgrade, and meaningfully use an electronic health record system.

The 2007 Minnesota Legislature enacted the country's first e-health mandate to require EHRs and emphasized interoperability and the role of standards. Minnesota Statute §62J.495 (Electronic Health Record Technology) states “[b]y January 1, 2015, all hospitals and health care providers must have in place an interoperable electronic health records system within their hospital system or clinical practice setting. The commissioner of health, in consultation with the MN e-Health Advisory Committee, shall develop a statewide plan to meet this goal, including uniform standards to be used for the interoperable system for sharing and synchronizing patient data across the system. The standards must be compatible with federal efforts.”

The 2009 American Recovery and Reinvestment Act (ARRA) and Health Information Technology for Clinical Health (HITECH) Act provide incentives for eligible professionals (EPs), eligible hospitals (EHs), and critical access hospitals (CAHs) to adopt and meaningfully use certified electronic health records (CEHRTs). The Centers for Medicare and Medicaid Services (CMS) administers the Medicare EHR Incentives Program; states administer the *Medicaid* EHR Incentive Program.

Section 4201 of the HITECH Act provides 90% Federal Financial Participation (FFP) for a state's Medicaid EHR Incentive Program. Matching funds support three State Medicaid Agency (SMA) responsibilities:

- Administer the incentive payments to eligible professionals and hospitals
- Conduct program oversight, including tracking providers' meaningful use
- Pursue initiatives to promote health care quality and the exchange of health care information through certified EHR technology

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States must develop a State Medicaid Health Information Technology Plan (SMHP) to receive FFP for program administration, as well as a separate Health Information Technology Implementation Advance Planning Document (IAPD). The IAPD requests federal matching funds and federal approval to acquire and implement the proposed SMHP services and information systems. Both the SMHP and the IAPD must be updated annually, or when major changes happen within the program. Minnesota has submitted two SMHP addenda for the final rule changes that occurred in 2014 and 2016.

Minnesota's State Level Repository (SLR), or attestation site for MEIP, officially began accepting attestations in October 2012. Since then, about 3,200 unique EPs, EHs, and CAHs have been paid almost \$209 million. Minnesota's physicians have the highest adoption rate of EHRs in the U.S. (100%), according to the Office of the National Coordinator for Health IT (ONC),¹ and Minnesota has a high percentage of EPs returning for meaningful use incentive payments.

Minnesota's State Medicaid Agency (SMA) is the Department of Human Services (DHS), but creation of the SMHP occurs with input from the Office of Health IT (OHIT) in the Department of Health (MDH). A lot of the data in the SMHP comes from surveys administered and analyzed by MDH.

Minnesota has been committed to the implementation of EHRs and their interoperability for years, as shown by a public/private collaboration called the e-Health Initiative and its Advisory Committee, which was created by legislation in 2004. The committee has members representing almost all provider types, government entities, and several payers. The committee coordinates and recommends statewide policy on e-health, develops and acts on statewide e-health priorities, and plans and sponsors the annual e-Health Summit.

The State Medicaid Director's Letter 16-003 of Feb. 29, 2016, allows for the use of HITECH funds for HIE projects that include providers who are not eligible for incentive payments, as long as these projects help EPs or EHs meet meaningful use. MDH has two HIE projects approved related to public health objectives, and DHS is applying for HIE funds to support health information exchange among specific Medicaid providers.

¹ HealthIT.gov Dashboard, Percent of Physicians that have Demonstrated Meaningful Use and/or Adopted, Implemented or Upgraded any EHR; 2015

2. MINNESOTA'S SMHP

Minnesota's SMHP provides an understanding of the DHS will be engaged in for implementing the Minnesota Medicaid EHR Incentive Program (MEIP). The SMHP also identifies state-level action to expedite HIE deployment.

DHS presents the SMHP in five sections, per the CMS template:

- A. *Minnesota's "As Is" HIT Landscape* is a description of MN's HIT and HIE implementation status.
- B. *Minnesota's "To Be" HIT Landscape* presents the five-year goals and objectives for provider participation, IT system architecture, provider interface, and HIE governance and expansion.
- C. *The Implementation Plan* describes the processes to ensure that EPs and EHs meet federal and state requirements for EHR incentive payments.
- D. *The Audit Strategy* is a very high level review of the MEIP audit process.
- E. *Minnesota's HIT Roadmap* describes annual, measureable program targets.

DHS will refine the EHR Incentive Program as:

- Efficiencies are identified
- Policies, rules and laws change
- Provider and state experience increase
- CMS and stakeholder input are incorporated
- CMS publishes changes to different aspects of the incentive program

DHS will inform CMS of anticipated changes to activities, scope, or objectives through annual and as-needed updates to the SMHP and the IAPD. Minnesota is adding an additional HIE project, connecting Medicaid providers to an Encounter Alerting Service, to the FFY 2018 request for funds.

2.1 Changes to Final Rule for Medicaid Incentive Program

The Stage 2 Final Rule was updated in 2012 and then modified in 2014 and 2016. DHS updated the attestation system and screens, and received CMS approval, in time to allow EPs and EHs to attest as soon as the rule became final. The revised screens for the portal are in an appendix of the SMHP.

In 2016, CMS adopted changes to the final rule which included modifications to Stage 2 MU and established baseline requirements for Stage 3. Stage 2 MU is again reportable for a 90 day period, rather than the 365 days that was in the original rule. However, clinical quality measures (CQMs) must be reported for 365 days. Minnesota’s portal began accepting attestations on Jan. 1, 2017, with the new logic implemented. Stage 3 additions were implemented on April 1, 2017, the earliest that CMS allows, after approval of the modified screens. CMS approved the SMHP addendum on Feb. 9, 2017; the document is an appendix to this SMHP.

3. SUMMARY OF MINNESOTA’S EHR PROGRAM

3.1 Minnesota’s “As-Is” Landscape

DHS has been administering the MEIP program since 2012. Individuals and groups involved in Minnesota’s health care landscape have achieved success in advancing the exchange of health information, HIT initiatives, and EHR adoption and meaningful use.

For example, 98% of Minnesota clinics have purchased, installed, and/or are using EHRs. Among hospitals, the rate of partial or complete adoption is 100%. Minnesota’s high adoption rate reflects a strong history of building supportive infrastructure, policy, tools, technology, and stakeholder engagement.

Over the last decade, ongoing efforts in Minnesota have accomplished the following:

- Received a \$45 million State Innovation Model (SIM) grant from the Center for Medicare and Medicaid Innovation (CMMI) to test the Minnesota Accountable Health Model (the Model), which builds on the Integrated Health Partnerships (IHP) program. There are five drivers to the Minnesota Model, and Driver 1 is: “Providers have the ability to exchange clinical data for treatment, care coordination, and quality improvement – HIT/ HIE.” E-health is a critical component of accountable care, in that it supports the safe, accurate and efficient exchange of information among the care team.
- Enacted legislation to promote EHR adoption, including the requirement that all health care providers establish and use e-prescriptions by January 1, 2011, and that all hospitals and health care providers have an interoperable EHR system in place by January 1, 2015. MDH recognizes that some providers were not able to implement EHR systems by January 1, 2015. However, all providers should be working toward the common goals outlined in the mandate.

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- Established a comprehensive public-private collaboration, *The Minnesota e-Health Initiative*, to enable and coordinate statewide HIE, act on statewide e-health priorities, and incorporate stakeholder interests from across a wide variety of settings, disciplines, and perspectives.
- Developed a statewide implementation plan for meeting Minnesota’s 2015 interoperable EHR mandate, including practical guidance to providers.
- Established a statewide governance structure and HIE oversight process, which requires entities providing health information exchange services for clinical meaningful use transactions, to apply for a certification of authority either as a Health Information Organization or a Health Data Intermediary (Minnesota Statutes §§ 62J.498 through 62J.4982). There are three health information organizations (HIOs) and 15 health data intermediaries (HDIs).
- Providers now routinely use clinical decision support tools, like physician alerts, within their EHR systems to support improved quality and patient outcomes.
- Communities across the state are forming collaboratives to better coordinate care and use information to help improve health care outcomes and population health through the secure exchange of clinical information.
- MDH has begun an HIE project to increase the agency’s ability to accept and process electronic data from Medicaid providers to the MN Immunization Information Connection (MIIC) and the MN Electronic Disease Surveillance System (MEDSS), which is electronic lab reporting.

As both the SMA, and a large purchaser of health care services in Minnesota, DHS plays a crucial role in planning, shaping, and implementing the initiatives that encourage and support HIE, HIT and EHR adoption. DHS coordinates with MDH’s OHIT on public health reporting of meaningful use, including immunization registration and electronic lab results reporting; and is a member of the MN e-Health Initiative Advisory Committee and is engaged in its workgroups, focusing on issues of EHR adoption and meaningful use; HIE; standards and interoperability; privacy and security.

- DHS received a Demonstration Grant for Testing Experience and Functional Tools (TEFT) in Community-Based Long-Term Services and Supports in 2014. The goal of the project is to demonstrate the benefit of a personal health record (PHR) for people enrolled in community-based services and supports. The PHR contains both their acute health care and long-term services and supports information.

3.2 Minnesota's "To-Be" Landscape

This plan supports the following five-year goals:

- Continue to administer the MEIP program and maximize return of eligible providers for meaningful use stage 3
- Support on-going meaningful use activities through 2021.
- Further the adoption of EHR technology throughout the full continuum of care, including long-term care and behavioral health.
- Create an Encounter Alert Service for Medicaid providers to be able to consistently receive timely admissions, discharge and transfer (ADT) information about their Medicaid clients.
- Complete Minnesota Department of Health projects (MIIC and MN ELR) designed to support Medicaid providers in meeting the public health portions of meaningful use.

DHS contracts with CGI Technology Solutions to moderate the web-based application for registration, eligibility, attestation, and reporting of MU requirements. Payment requests, calculations, and issuance are a collaborative effort between CGI and DHS Financial Operations Division. This partnership enabled Minnesota to begin accepting attestations and sending payments before the end of 2012, and to implement changes to the rules by the earliest possible implementation date in all cases.

3.3 Implementation Plan for MEIP

The implementation plan has been improved in an iterative process that incorporates CMS' and Minnesota stakeholders' feedback. The plan has evolved as advanced strategies and policies for program administration are developed.

3.3.1 Payment Years

Year one payments are for eligible providers and eligible hospitals that adopt, implement, or upgrade (AIU) EHR technology and hospitals who have not been paid by Medicare. EPs are paid over six years. As allowed in the final rule, the SMA elected to issue hospital EHR incentive payments over three years, with 50% of the total incentive payment being paid in year one, 40% in year two, and the remaining 10% in year three. This payment approach rewards hospitals for AIU and supports ongoing efforts to meet and maintain MU standards.

In payment year two, MEIP participants must meet Modified Stage 2 or Stage 3 MU requirements, including the following measures:

- Capture health information electronically in a coded format.

- Use health information to track key clinical conditions.
- Communicate health information for care coordination purposes.
- Report clinical quality measures and public health information.

For year two MU payments, the SMA worked with HIT/E stakeholder groups to support the MU reporting requirements for clinical quality measures (CQM) and additional measured objectives. It is now possible to upload CQMs electronically. This effort also encompasses the future needs for MU stage three, which must be reported beginning in program year 2018.

3.3.2 Estimated Participation

There were several challenges in estimating EP and EH program participation. A primary limiting factor in estimating participation was that DHS cannot accurately predict Medicaid patient volume for providers or hospitals. A conservative estimate of a 10% participation rate of Medicaid enrolled providers (approximately 2,600 eligible providers) was established at the beginning of the program in 2012. As of program year 2016, we have well exceeded our goal, with 3,188 unique providers and 126 hospitals having received at least one payment through the incentive program. With 2016 being the final year to begin participation in the program, Minnesota has altered our efforts to focus on returning provider participation rates.

Returning provider percentages (as of June 2017):

- EP AIU to MU return percentage over 70%
- EP year 2 to year 3 return percentage over 80%
- EP year 3 to year 4 return percentage over 80%
- EH year 1 to year 2 return percentage over 80%
- EH year 2 to year 3 return percentage over 80%

3.3.3 Administrative Responsibilities

DHS continues to:

- Administer incentive payments to eligible professionals and hospitals.
- Conduct program oversight, including tracking MU.
- Pursue initiatives to promote health care quality and the exchange of health care information through certified EHR technology (CEHRT).
- Facilitate the enrollment and attestation process

- Integrate the EHR incentive payment process within existing business processes; the DHS Medicaid Management Information System (MMIS) claims payment system pays incentive program payments.
- Develop electronic tools and resources to support medical homes and Accountable Care Organizations (ACO) including functions such as analysis of clinical information to determine risk adjustment, evaluation of outcomes and provider feedback.
- Field a strong project team and administrative structure.
- Leverage existing HIT and HIE infrastructure to facilitate program improvement and stakeholder communications, and build new relationships to expand efforts.
- Manage a website and communication plan to promote the EHR incentives program, HIT initiatives and provide updates on state and federal developments.
- Establish policies and procedures for enrollment, attestation, payment and audit.
- Maintain an advanced web application to link with the National Level Repository (NLR).
- Administer an appeals process consistent with EHR final rules to assure that provider concerns are promptly addressed.

3.4 Audit Strategy

DHS built on its existing audit program and automated MMIS system checks to assure that MEIP is efficiently administered, verifying that payments are made only to providers who are eligible and meet program requirements.

Pre-payment review includes 100% verification of the applicants' licensure, EHR certification numbers, and MU information. The EP review includes cross-checking all EPs against the federal and state debarment, suspension, Office of Inspector General (OIG), and Master Death lists. Hospital review uses Medicare cost reports, MMIS claims information, and proof of CEHRT purchase. Post-payment audit controls include risk assessments and randomly sampled post-payment audits for each EP risk category. These audits focus on provider eligibility requirements, payment calculations, monitoring and verification, overpayments, disputes and appeals, and the detection and prevention of fraud, waste and abuse. Meaningful use reviews for dual eligible and Medicaid only EHs are performed by CMS.

3.5 Minnesota's HIT Roadmap

Minnesota's HIT Roadmap shows how the EHR Incentive Program aligns with current federal and state health care e-initiatives. The EHR annual measures are achievable because the state and providers have a strong start towards meeting them.

Minnesota will achieve its five-year goals through:

- Maximizing eligible hospitals' and providers' participation in AIU and meaningful use through EHR incentives.
- Contracting with a qualified vendor (CGI) for full support of EHR incentives through all stages of MU and attestation requirements.
- Encouraging providers who are not eligible for the incentive program, including long term care and behavioral health providers, to effectively use EHRs.
- Working with the e-Health Advisory Committee to improve health information exchange in Minnesota.

4. THE STATE'S "AS-IS" HIT LANDSCAPE (SECTION A of CMS Template)

4.1 Minnesota's Medicaid Program

In State fiscal year 2015, DHS provided comprehensive medical assistance to approximately 1.2 million individuals under Title XIX of the Social Security Act through the Minnesota Medicaid Program (Medical Assistance).²

4.2 Response to CMS Questions

This section provides Minnesota's response to 15 questions about the "As-Is" HIT landscape.

4.2.1 Data on Current EHR Adoption

What is the current extent of EHR adoption? How recent is this data? Does [the data] provide specificity about the types of EHRs in use by the State's providers? Is [the data]

² "Enrollment by Major Program and State Fiscal Year", DHS SAS Portal, Dec. 2016

specific to Medicaid or is it an assessment of overall statewide use of EHRs? Does the SMA have data or estimates on eligible providers broken out by types of providers? Does the SMA have data on EHR adoption by types of provider (e.g., children’s hospitals, acute care hospitals, pediatricians, nurse practitioners)?

Minnesota has one of the highest percentages in the country of physicians who have adopted and are meaningfully using electronic health records.³ Electronic health record adoption in the state of Minnesota’s clinics has seen a steady growth from 87% in 2013 to 98% in 2016. High adoption rates are seen in clinics, hospitals, and nursing homes.

The status of EHR adoption by different provider types is captured by surveys performed by various groups and with varying frequency. The data is an assessment of overall statewide use, and is not specific to Medicaid. MDH surveys physicians annually, and the Minnesota Hospital Association surveys hospitals once a year. Other provider types, such as behavioral health, long term care, or chiropractic providers, are surveyed more sporadically.

The following tables show the status of Minnesota provider use of EHRs according to the dates referenced in the tables.

Table 4.2.1A: Adoption of Electronic Health Records (EHR) and Health Information Technology (HIT)⁴

Key Indicator	Percent	N	Year
Clinics with EHRs	97%	1,232/1,257	2016
Hospitals with EHRs	100%	145/145	2016
Local health department with public health EHRs	97%	69/71	2015
Clinical labs with laboratory information systems	97%	133/137	2012
Nursing homes with EHRs	95%	254/266	2016
Chiropractic offices with EHRs	25%	69/277	2011

Minnesota’s high EHR adoption rate reflects the state’s strong history of building the infrastructure, policy, tools, technology, and stakeholder involvement needed to promote HIE,

³ <http://dashboard.healthit.gov/quickstats/pages/FIG-Health-Care-Professionals-EHR-Incentive-Programs.php>, March 2016

⁴ <http://www.health.state.mn.us/e-health/assessment/docs/briefehealth.pdf>

HIT and EHR. Details on Minnesota EHR use among hospitals and professionals are provided here.

Ambulatory Clinic EHR Adoption

The 2015 Minnesota HIT Ambulatory Clinic Survey found that 97% of respondents had installed EHRs. Of the 35 clinics without an EHR, 21 said they plan to implement within the next five years, and 14 indicated they had no plans to implement an EHR. Ambulatory clinics were defined as primary care and specialty clinics, including urgent care, one-stop, radiology, and behavioral health clinics with a primary care physician on staff.

Table 4.2.1B: EHR Adoption and Implementation Status, 2015 (N=1257)

System Status	Percent (#) of Clinics
EHR installed and in all/some clinic areas	98% (1,232)
Clinic does not have EHR	2% (25)
Total	100% (1,257)

Source: MDH, OHIT, 2016 MN HIT Ambulatory Clinic Survey

Of the clinics with an EHR, 99% (1,244 of 1,257) reported using Computerized Physician Order Entry (CPOE) systems and 90% of specialty care clinics with EHRs used medication guides/alerts. All seven of the measured clinical decision support (CDS) tools were routinely used by half or more of primary care clinics with EHRs, but most of these tools are routinely used by less than half of specialty care clinics. Furthermore, there was evidence that providers in clinics used multiple tools, with 82% of primary care and 47% of specialty clinics reporting that their providers used three or more of the seven CDS tools measured.

Table 4.2.1C: Ambulatory Clinics and Meaningful Use Objectives

Percent Achieving Selected MU Objectives
<p>Clinical Decision Support: 90% of primary care and 77% of specialty care clinics with EHRs used medication guides/alerts. All seven of the measured CDS tools were routinely used by more primary clinics than specialty care clinics. Compared to urban clinics, rural clinics more routinely use chronic disease care plans, patient-specific reminders, and preventive care services due.</p> <p>Health Information Exchange: 69% of clinics exchanged health information with unaffiliated hospitals or clinics.</p> <p>Provide patient with health information: 88% of clinics with EHRs provided patients with the option to view their patient health information online</p> <p>Electronic Prescribing: 88% of all Minnesota clinics e-prescribed for most non-controlled substance prescriptions, either using their EHR or another electronic method. Primary care clinics used e-prescribing at a higher rate (90%) than specialty care EHR clinics (86%). There was also a difference in e-prescribing between urban (86%) and rural (96%) clinics.</p> <p>Summary of Care: 92% of clinics with EHRs were able to generate an electronic summary of care record from their EHR for patients who require a referral to another provider, or transition from one setting of care to another. 41% of clinics provided an electronic summary care record to that facility for 50% or more of patients who transitioned, an increase from 33% in 2015.</p>

Source: MDH, OHIT, 2016 MN HIT Ambulatory Clinic Survey

The survey also asked clinics to what degree they were electronically exchanging clinic and patient data with specific providers. Sixty-nine percent of clinics routinely exchange data with hospitals and clinics not affiliated with their system, which is down from 2015, but still up overall from 2014. Primary care clinics exchanged health information with unaffiliated hospitals and/or clinics at a higher rate (80%) than specialty care clinics (56%). Less than half of clinics with EHRs (45%) received automated alerts from hospitals when a patient was admitted, discharged or transferred.

Table 4.2.1D: Clinics Electronically Exchanging Clinical and Patient Data with Specific Providers

Clinics	Percent
Clinics exchanging within their system (2013)	53%
Hospitals exchanging within their system (2013)	58%
Clinics with unaffiliated hospitals/clinics (2016)	69%
Hospitals with unaffiliated hospitals/clinics (2013)	36%

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Clinics	Percent
Other settings (nursing homes, behavioral health, post-acute care) (2015)	32%

Ambulatory Clinics: EHR Type

Seventy-five percent of clinics reported using one of the six most common EHR Systems. Forty-nine percent use Epic systems.

Table 4.2.1E: Most common EHR systems used in Ambulatory Clinics (N=1,257)

Type of System	Percent (#) of Clinics
Epic	51% (641)
eClinicalWorks	9% (112)
Allscripts	5% (69)
NextGen	5% (64)
Cerner	4% (53)
Greenway	4% (48)
Other	21% (270)

Source: MDH, OHIT, 2016 MN HIT Ambulatory Clinic Survey

The ambulatory clinic survey further reported that:

- Most clinics utilized data from the EHR for internal quality improvement efforts. 94% of clinics with EHRs shared data with providers, 87% used EHR data to set goals around clinical guidelines, 87% created benchmarks or developed priorities, and 69% supported professional development activities. Furthermore, 91% of clinics with EHRs used only their EHR to collect and submit quality measures to outside organizations.
- 88% of all Minnesota clinics e-prescribed for most non-controlled substance prescriptions. E-prescribing rates for controlled substances were much lower. 83% of clinics created these prescriptions electronically and then faxed or otherwise manually delivered to the pharmacy or patient. Minnesota allows electronic prescribing of controlled substances, but 45% of clinics indicated that their greatest challenge is that

they don't have the security and technology requirements to e-prescribe controlled substances.

EHR Adoption by Hospitals

According to data from the 2015 American Hospital Association (AHA) survey, all 146 hospitals in Minnesota have adopted EHRs. Minnesota has 133 acute care hospitals, four federal hospitals and nine behavioral health hospitals. Three different EHR systems are used by 77% of the hospitals. (The report of the results is written by the MDH Office of Health Information Technology (OHIT) and is cited below.)

4.2.1F. Most Common EHRs in Hospitals

Type of System	Percent (#) of Hospitals	Number of Hospitals
Epic	53%	77
Meditech	14%	20
Cerner	10%	15
Other	23%	34
Total		146

Source: MDH, OHIT: *Minnesota Hospital E-Health Report, 2015*

Most acute care hospitals have fully implemented the most common electronic clinical documentation functionalities, including patient demographics (99%) and nursing notes (93%). They have also implemented results-viewing tools, such as laboratory reports (97%), radiology reports (96%), and radiology images (95%).

Table 4.2.1G: Computerized Provider Order Entry (CPOE) Implemented, 2015

Electronic Clinical Documentation	Percent Implemented
Laboratory Tests	89%
Nursing Orders	88%
Radiology Tests	88%
Consultation Requests	84%
Medications	89%

Percent Fully Implemented at Acute Care Hospitals (N=129)

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Clinical Decision Support (CDS) Tools Implemented, 2015	Percent Implemented
Drug allergy alerts	91%
Drug-drug interaction alerts	89%
Drug-lab interaction alerts	78%
Clinical reminders	78%
Drug dosing support	77%
Clinical guidelines	76%

Percent Fully Implemented at Acute Care Hospitals (N=129)

Electronic Exchange: Data also shows that hospitals are more likely to exchange patient data electronically with hospitals and clinics inside their system. Critical access hospitals (CAHs) had significantly less exchange activity than non-CAHs.

Table 4.2.1H: Hospitals' Electronic Exchange Activity by Type of Organization

Exchange Activity	CAH (N=76)	Non-CAH (N=53)
Affiliated clinics	78%	92%
Affiliated hospitals	72	91
MDH	62	89
Unaffiliated clinics	64	81
Unaffiliated hospitals	64	81
External labs	55	81
Local public health departments	46	68
Nursing homes	26	47

Source: MDH, OHIT: *Minnesota Hospital E-Health Report, 2015*

As shown in Table 4.2.1I, many hospitals listed barriers to exchanging health information. Many hospitals reported challenges to implementing an EHR that meets meaningful use requirements.

Table 4.2.11: Issue Hospitals Face when Exchanging Health Information, 2015

Reasons Meeting Health Information Exchange (HIE) Criteria is Difficult	Percent of Hospitals
Experience greater challenges exchanging across different vendor platforms	71%
Difficult to locate the address of the provider to send the information	51
Other providers have an EHR but lack capability to receive the info	47
Other providers do not have an EHR or electronic system able to receive the info	44
Recipients do not find the info useful	25
Cumbersome workflow to send the information from our EHR system	22
Additional costs to send/receive data outside their system	13
Difficult to match or identify the correct patient between systems	10
Lack capability to electronically receive patient health info from outside providers or other sources	8
Lack capability to electronically send patient health info to outside providers or other sources	4

Source: MDH, OHIT: *Minnesota Hospital E-Health Report, 2015*

Other Provider Types and Related Information

Specialty Care Clinics are catching up to primary care clinics in the implementation of EHRs, but they still lag behind. For primary care clinics, 99% are using EHRs, and 96% of specialty

care clinics have implemented EHR systems as of 2016⁵.

- There is near universal use of CPOE among all clinics.
- Primary care providers exchanged health information with unaffiliated hospitals and clinics at a significantly higher rate (80%) than specialty care providers (56%)
- There was an increase in the number of clinics that use telemedicine compared to 2015. In 2016, 69% of primary care clinics and 39% of specialty care clinics used telemedicine.

Clinic(s) for the purpose of this study means any location where primary or specialty care ambulatory services are provided for a fee by one or more physicians in Minnesota.

Nursing homes: There are 377 nursing homes in Minnesota. A 2016 MDH survey of nursing homes produced 266 responses, and found 95% having an EHR installed and in use, a substantial increase from 69% in 2011. Regarding use of automated alerts, 22% of respondents reported receiving admission, discharge, or transfer messages (ADT)s, and 12% reported sending ADTs⁶.

E-prescribing among pharmacies and physicians:

- Approximately 95% of Minnesota's active pharmacies have e-prescribing, up from 80% in 2010.⁷
- Primary care EHR clinics used e-prescribing at a higher rate (90%) than specialty care EHR clinics (88%). Rates for e-prescribing of a controlled substance were much lower at 4%.

⁵ Minnesota Department of Health, Office of Health Information Technology; Clinics: Adoption and Use of EHRs and Exchange of Health Information, 2016 (<http://www.health.state.mn.us/e-health/assessment/docs/reportclinic2016.pdf>)

⁶ Minnesota Department of Health, Office of Health Information Technology, E-health Assessments; Nursing Home Report, 2016 (<http://www.health.state.mn.us/e-health/assessment/docs/2016-nh-report-final.pdf>)

⁷ Minnesota Department of Health, Office of Health Information Technology, *Electronic Prescribing in Minnesota*, 2013

- Minnesota ranks 24th in the nation for e-prescribing controlled substances. 75% of pharmacies, are enabled to e-prescribe these drugs. The US average is 81% of pharmacies (Surescripts®, 2015).⁸

4.2.2 Broadband Issues

To what extent does broadband internet access pose a challenge a HIT/E in the State’s rural areas? Did the state receive any broadband grants?

Broadband Access

Minnesota’s health care providers have achieved some capacity for and access to broadband services necessary for HIE, to transmit radiologic images and access available services. For Minnesota’s rural providers, broadband capacity must also support tele-health services. Broadband access for most of the state is “adequate,” meaning there are limited **unserved** areas. However, there remain pockets that have limited bandwidth or are **underserved**. Whether the current bandwidth capacity (“adequate level” of greater than 10 Mbps) is enough for more extensive health information exchange, telehealth, and efficient access for patient portals remains an open question. A recent ambulatory clinic HIT assessment survey did not indicate that broadband is a major barrier.

Connect Minnesota maintains maps of broadband service inventory online at <http://mn.gov/deed/programs-services/broadband/maps-tests/>. The mapping does not target health care provider capacity; however, it does identify gaps in service geographic availability that will inform health care broadband planning efforts in the future. In July 2016, 86.7% of Minnesota households had access to terrestrial fixed broadband service of at least 10 Mbps download and 6 Mbps upload (excluding mobile and satellite services).⁹

Broadband Grants

Minnesota received two broadband grants. *The Greater Minnesota Telehealth Broadband Initiative (GMTBI)* received funding from Federal Communications Commission Rural Health Care Pilot funds. The GMTBI was a consortium of five health care networks representing approximately 146 health care facilities. The goal of GMTBI was to build upon established vision of a strong integrated rural telehealth care delivery system supported by a telecommunications infrastructure that will ultimately allow any patient in any community in

⁸ <http://surescripts.com/news-center/national-progress-report-2015/>

⁹ http://mn.gov/deed/assets/historic-targeted-speed-tiers_tcm1045-190761.pdf

Minnesota and bordering states to connect to any provider in Minnesota and beyond.

The pilot program has ended and most of the participating sites are transitioning to the [Federal Communication Commission \(FCC\) Health Care Connect Program](#) administered by the Universal Service Administrative Company (USAC). The broadband goals were met and the foundation for greater telehealth linkages has been formed although not realized yet. The relationships established over the past six years will most likely help connect providers for telehealth. The *Department of Agriculture's Rural Utilities Service* and the *National Telecommunications and Information Administration* (NTIA) provided approximately \$102 million in broadband stimulus funding to five Minnesota projects.

4.2.3 FQHC HIT/ EHR Funding

Does the State have Federally Qualified Health Center networks that have received or are receiving HIT/EHR funding from the Health Resources Services Administration (HRSA)? Please describe.

Two FQHC networks received HIT/EHR funding from the Health Resources Services Administration (HRSA):

The Neighborhood Health Care Network (NHCN), supporting 16 community health clinics in the Minneapolis and Saint Paul metropolitan area with 48 clinic locations, received \$832,768 in Round 1 of the Community Health Center 2009 HIT awards. As of January 2012 the NHCN is now doing business as the Federally Qualified Health Center Urban Health Network (FUHN). FUHN is now an organization of ten FQHCs working in partnership with DHS on Medicaid health care reform efforts, including FUHN's participation as an Integrated Health Partnership (IHP). This project will allow the Network's FQHCs to further enhance health care provided to Medical Assistance patients.

The Northern Minnesota Network has expanded its service area and number of members. Now having five members that are either FQHCs or Migrant Health Centers, they provide care through 29 clinical sites in urban or rural, medically underserved areas of Minnesota, Wisconsin, Illinois, and eastern North Dakota. They received awards totaling \$2.98 million in Round 1 and Round 2. Northern Minnesota Network (NMN) is a 501(c)(3) Health Center Controlled Network (HCCN) providing health information technology systems, resources, and support. For the last 10 years, they have been helping safety net providers improve delivery of health care for patients in communities of all sizes through Health Information Technology (HIT) tools and resources. Since 2012 MEIP has paid incentive funds to 1,387 treating providers who are associated with 80 different FQHCs, TUFs, or RHCs.

4.2.4 VA and TUF EHRs

Does the State have US Department of Veterans Affairs offices or tribal and urban facilities (TUF) that are operating EHRs? Please describe.

US Department of Veterans Affairs (VA)

The US Department of Veterans Affairs (VA) has two medical centers and fourteen Community Based Outpatient Clinics (CBOCs) in Minnesota, all of which utilize the Veterans Health Information Systems and Technology Architecture (VistA) EHR system. In addition, veterans have access to a personal health record (PHR) called My HealtheVet. By 2017, the VA will have an architecture and framework that supports interoperability, care coordination, meaningful use and partnership (source: Veterans Health Administration: The Department of Veterans Affairs EHR; November 13, 2013).

The Minnesota e-Health Advisory Committee recognized the importance of creating an interoperable EHR network infrastructure with federal care delivery organizations and involved them in its workgroups and activities for several years. The VA participated on the *Minnesota e-Health Initiative Exchange and MU Workgroup* to ensure that the VA and its populations are considered in statewide implementation, and that research and relationships at the VA state and federal level support an interoperable health care network.

Indian Health Service (IHS)

Cass Lake IHS Hospital, Red Lake IHS Hospital, and the White Earth Health Center all use the Resource and Patient Management System (RPMS). RPMS links all departments within each facility (dental, medical, lab, ER, pharmacy, inpatient). IHS representatives participated in the *MN e-Health Initiative's Exchange and MU Workgroup* to help coordinate related activities.

4.2.5 HIT/ E Stakeholders

What stakeholders are engaged in any existing HIT/E activities and how would the extent of their involvement be characterized?

A large number of stakeholders are involved in the Minnesota HIT/E activities, especially through the MN e-Health Initiative and its advisory committee. DHS has a long-standing relationship with MN e-Health and its workgroups.

The Minnesota e-Health Initiative

The Minnesota e-Health Initiative is a public-private collaboration established in 2004 to accelerate the adoption and effective use of HIT to improve healthcare quality, increase

patient safety, reduce healthcare costs, and enable individuals and communities to make the best possible health decisions.¹⁰

The initiative:

- Coordinates and recommends statewide policy on e-Health
- Develops and acts on statewide e-Health priorities
- Reflects the health community’s strong commitment to work in a coordinated, systematic and focused way

The legislatively-chartered Minnesota e-Health Advisory Committee is composed of 25 members representing a broad range of stakeholders.

Table 4.2.5A: MN e-Health Stakeholders

Stakeholder	Groups
Providers	<ul style="list-style-type: none"> • Laboratories • Pharamcists • Pharmacies • Health plans • Large and small hospitals • Local public health nurses • Physicians • Long term care • HIT vendors • Clinic managers • FQHCs
Consumers, Academics, Purchasers, QIOs	<ul style="list-style-type: none"> • Consumers • Academics/informatics • Health care purchasers and employers • Quality improvement organizations • Training/education/health professional schools

¹⁰ See e-Health website at: <http://www.health.state.mn.us/e-health/>

2017 State HIT Plan
State of Minnesota
Department of Human Services

Stakeholder	Groups
Minnesota State Agencies, Exchanges, and Collaborative	<ul style="list-style-type: none"> • Department of Commerce • Department of Health (MDH) • Department of Human Services (DHS = SMA) • Department of Administration

Minnesota e-Health Advisory Committee Support of e-Health

The Advisory Committee supports the statewide implementation plan for interoperable EHR systems in many ways, including coordination of efforts and policy/resource development, as shown below.

- Adoption and effective use of interoperable EHR systems;
- Identification of specific standards for sharing patient data across EHR systems and across the continuum of care
- Adoption and implementation of electronic prescribing statewide.
- Coordinating with national HIT activities.
- Coordinating statewide responses to proposed federal health information technology regulations and guidelines.
- Ensuring strong privacy protections and implementation of electronic prescribing policies.
- Assessing the status of EHR adoption, effective use and interoperability in private and public settings.

The MN e-Health Initiative’s work is carried out through the workgroups which involve dozens of individuals in the health care community. Workgroups change or are dissolved as their work is completed.

Table 4.2.5B: Minnesota e-Health Initiative Workgroups (2016-2017)

Workgroup	Charges include ¹¹
Health Information	<ul style="list-style-type: none"> • Having identified 12 key barriers to HIE, the group will offer input into

¹¹ Each group’s charge includes several elements; this table does not include the group’s full charge.

2017 State HIT Plan
State of Minnesota
Department of Human Services

Workgroup	Charges include¹¹
Exchange	<p>policy work toward establishing statewide HIE</p> <ul style="list-style-type: none"> • Summary report of recommended <i>Expectations for Statewide HIE Capabilities in Minnesota</i> that align with federal and state initiatives
Privacy and Security Workgroup	<ul style="list-style-type: none"> • Advise on privacy/security related to MN Accountable Health Model • Advise on plans for education and dissemination of tools
Workforce Activity	<ul style="list-style-type: none"> • Develop a list of skills required for health informatics • Develop guidelines for workforce training
Consumer Engagement	<ul style="list-style-type: none"> • Believing that engaged consumers are healthier, define consumer engagement • Define an active e-health consumer • Develop a baseline metric on what e-health information providers give their clients

The Minnesota e-Health Initiative provides feedback on state and federal definitions, criteria and/or proposed regulations relating to e-health. The feedback is provided in the form of a public coordinated response in which members of the e-health initiative, workgroups, and the public participate.

The Administrative Uniformity Committee

The Administrative Uniformity Committee (AUC) is a voluntary, broad-based group representing Minnesota health care public and private payers, hospitals, health care providers, and state agencies, working to standardize, streamline, and simplify health care administrative processes. The AUC plays a key role in the development and implementation of Minnesota’s Uniform Companion Guides (“Guides”) pursuant to Minnesota Statutes, section 62J.536. The Guides provide uniform, detailed specifications for electronically exchanging eligibility requests and responses, claims, acknowledgments, and remittance advices in Minnesota. The AUC is also active in addressing other administrative simplification issues and in making recommendations to national standards settings groups as part of federal health care reform.

4.2.6 SMA HIT/E Relationships

Does the SMA have HIT/E relationships with other entities? If so, what is the nature (governance, fiscal, geographic scope, etc.) of these activities?

DHS has HIT/E relationships with numerous Minnesota entities. The nature of these activities includes:

- DHS and the Office of Health IT (OHIT) within the Minnesota Department of Health (MDH) work together to create the SMHP. Both departments share responsibility for implementing Minnesota’s SIM grant award.

- DHS and the MN e-Health Initiative have worked closely for over ten years promoting HIE and EHR. The manager of Health Data Quality at DHS serves as the DHS representative on the MN e-Health Advisory Committee. Other Medicaid staff serve on the committee and its work groups.
- The SMA joined MN HIE as a founding partner and served on the MN HIE State Steering Committee.
- DHS will continue its collaboration and coordination with other stakeholders as MEIP planning and implementation proceeds and SMHP elements evolve.
- DHS worked closely with REACH, Minnesota’s REC, until it closed in 2016.

4.2.7 Health Information Exchanges (HIEs)

Specifically, if there are health information organizations in the State, what is their governance structure and is the SMA involved? How extensive is their geographic reach and scope of participation?

Rather than one state-mandated and supported health information exchange, Minnesota has a market-based approach to HIE. The Minnesota Department of Health (MDH) certifies health information organizations (HIOs) and health data intermediaries (HDIs). Currently there are three HIOs and 16 HDIs, with others applying for certification. An HDI is defined as “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” as defined in Minnesota statutes.

The three HIOs are Allina Health Systems, Koble-MN, Southern Prairie Community Care.

The current list (2017) of state-certified HDIs is found here: <http://www.health.state.mn.us/e-health/hie/certified/index.html>

4.2.8 MMIS and MITA

Please describe the role of the MMIS in the SMA’s current HIT/E environment. Has the State coordinated their HIT Plan with their MITA transition plans and if so, briefly describe how.

Minnesota Medicaid Management Information System (MMIS) Role

MMIS is undergoing a phased approach to MITA implementation, which includes migrating many of the mainframe processing components to a new architecture based on the MITA framework. These changes will continue to facilitate HIT/E advancement in the state.

Minnesota anticipates modifying MMIS to support future HIE transactions and to position the state to better measure and monitor Medicaid recipients' health outcomes.

Minnesota is also testing an enterprise service bus (ESB) to coordinate exchange of health information utilizing this universal translator so that systems can connect to each other. This process works to connect the varied systems within the Minnesota Medicaid system to take information out from MMIS to other systems (SSIS, PRISM, MAXIS, etc.) that may be out of date. The ESB in this scenario will act as a data translator or data hub. Medicaid beneficiaries who are on long term support from the state may use this technology to be able to have information shared between DHS and their case workers using a personal health record (PHR). Minnesota has successfully used this technology to allow MMIS to exchange information with a state HDI.

Minnesota currently processes all Medicaid Managed Care Organization encounter data through its MMIS system, and aggregates the encounters along with fee-for-service (FFS) claims, and eligibility data into an enterprise datawarehouse. This comprehensive data source enables analytics for functions such as attribution to providers, and applications such as:

- **Health Information Request (HIR) Tool:** HIR allows providers to search up to three years of claims history for inpatient and emergency department history and up to one year of drug utilization history on Medicaid recipient.
- **Integrated Health Partnership Partner Portal:** Providers participating in the Medicaid Accountable Care Initiative receive regular population and patient level reports, as well as secure demographic, care management and utilization files that can be used to augment or supplement their own population health registries or clinical data repositories.

Medicaid Information Technology Architecture (MITA) Coordination

DHS adopted an Enterprise Architecture effort that supports the use of MITA as part of the architectural approach. DHS incorporated MITA specifically in projects such as 5010 and ICD-10. DHS used MITA to implement electronic funds transfer information for eligible hospitals on remittance advices and processing claim line-level third party liability (TPL). DHS will follow the MITA approach for all HITECH efforts.

4.2.9 Activities to Facilitate HIE/EHR Adoption

What State activities are currently underway or in the planning phase to facilitate HIE and EHR adoption? What role does the SMA play? Who else is currently involved? For example, how are the regional extensions centers (RECs) assisting Medicaid eligible

providers to implement EHR systems and achieved MU?

In addition to administration of incentive payments from the MEIP program, and the work of the e-health Advisory Committee as led by MDH, Minnesota had numerous HIE activities underway throughout the SIM grant. Community collaborative grants were awarded to help care team members from clinical, community, and social service settings use health information technology to better meet the health needs of patients. E-health roadmaps and recommendations¹² for providers from long-term care, behavioral health, social services and public health settings were established, and a privacy and security toolkit¹³ was created to help guide providers through the complexity of consent, sharing agreements, and other issues that can be barriers to exchange.

Although Minnesota’s Regional Extension Assistance Center for HIT ended in 2016, one of its key program partners, Stratis Health, remains an active collaborator in supporting providers and providing technical assistance related to health IT. DHS meets quarterly with Stratis to discuss and coordinate relevant activity.

Minnesota HIE Expansion

In 2016, DHS and MDH submitted an Implementation Advance Planning Document (IAPD) for the use of HITECH funds to support MEIP and to begin two projects to onboard providers to the immunization and electronic lab results registries which are maintained by MDH. Minnesota expects these projects to be complete within five years and to enable Medicaid providers to meet public health MU objectives. MDH expects that certified HDIs will be communicating with the two registries.

In addition, in 2016 DHS began requirements gathering work to support the expansion of the HIE. This work will utilize 90/10 funding and part of the state SIM grant to aid in this expansion. The initial phase of this work is projected to be completed in late 2017.

Current work plans include development of an Encounter Alerting Service (EAS) to provide timely notifications to Medicaid providers of admissions, discharges and transfers of their patients. This activity is primarily intended to address gaps in the current HIE infrastructure that are preventing Medicaid provider’s ability to consistently access these high-value transactions needed for effective care coordination. The EAS is expected to improve patient

¹² <http://www.health.state.mn.us/e-health/roadmap/index.html>

¹³ <http://www.gpmlaw.com/Practices/Health-Law/Foundations-in-Privacy-Toolkit>

outcomes for Medicaid members, allowing more of the patient's care team members to communicate security with each other and remain updated to the latest developments of the patient's health activity. The EAS also serves as a pilot in creating shared service infrastructure that enables connections between and among the existing HIOs, HDIs, and providers otherwise not connected to either. The EAS will focus first on establishing this fundamental service for the Medicaid population and will be a part, but is being designed such that it could in the future be leveraged more broadly.

4.2.10 SMA Relationship to State HIT Coordinator, HIE Cooperative and REC

Explain the SMA's relationship to the State HIT Coordinator and how the activities planned under the ONC funded HIE cooperative agreement and the Regional Extension Centers (and Local Extension Centers, if applicable) would help support the administration of the EHR Incentive Program?

DHS has a strong relationship with the State Office of Health Information Technology (OHIT, at MDH), and had an ongoing relationship with both the ONC-funded cooperative agreement (MDH's initiative known as MN e-Health Connect), and the Regional Extension Center, known as REACH. For example, each month staff from DHS and OHIT (MDH) collaborated with other REACH partners to share information, identify key concerns, and analyze issues via phone calls organized by REACH. Participants discussed and analyzed issues regarding EHR adoption, provider enrollment and other HITECH provider issues. The MN e-Health Connect and REACH are not functioning anymore. However, the collaboration between DHS and OHIT at MDH strengthened under the state's SIM efforts which required joint planning and implementation of e-health activities to support accountable care and continues to date through weekly project calls. DHS is also contributing to the development of the HIE strategic and operational planning through its ongoing engagement with the MN e-Health Initiative and the HIE Study Steering Committee.

4.2.11 Other SMA Activities

What other activities does the SMA currently have underway that will likely influence the direction of the EHR Incentive Program? Please describe.

Major SMA activities influencing MEIP are:

- Continued collaboration in state HIE/EHR activities, including work with the MN e-Health Initiative, HIT Coordinator, and other stakeholders
- RFP for funding an Encounter Alert System (EAS) for Medicaid providers who are part of care delivery and payment reform in Minnesota

- Responding to recent and new legislation
- Continued development of MMIS within the MITA framework

4.2.12 Recent Law/Regulatory Changes

Have there been any recent changes (of a significant degree) to State laws or regulations that might affect the implementation of the EHR Incentive Program? Please describe.

MDH has established an HIO oversight mechanism. To be a certified HIE service provider in Minnesota, applicants must demonstrate that they can meet Minnesota's interoperability requirements, follow national standards, participate in statewide shared HIE services, and exchange patient data securely and seamlessly to provide high quality, coordinated care. (More information on the MN HIE Oversight Law can be found at <http://www.health.state.mn.us/e-health/hie/docs/hieoversightlaw.pdf>).

4.2.13 Crossing State Borders for HIT/E and Service Access

Are there any HIT/E activities that cross state borders? Is there significant crossing of state lines for accessing health care services by Medicaid beneficiaries? Please describe.

HIT/E Activities across Borders

Minnesota has been involved in several activities that cross state lines, including UM HIE and the Nationwide Health Information Network Trial Implementations (NHIN). Currently several border state HIEs are Minnesota certified HDIs including Wisconsin's Statewide Health Information Network (WISHIN) and South Dakota Health Link. Koble, one of Minnesota's certified Health Information Organizations, also supports the North Dakota and Iowa HIEs.

Crossing State Borders for Service Access

In State fiscal year 2016 (July 1 2015 through June 30, 2016), less than 2% of Minnesota Medicaid services were rendered by border state providers in Iowa, Wisconsin, North Dakota, and South Dakota. Although this is a small percentage, cooperation between the states is important to Minnesota Medicaid clients. The greatest share of these encounters is in North Dakota, where Moorhead, Minnesota residents obtain health care services in Fargo, North Dakota. In rural southwest Minnesota, the closest major health care center is in Sioux Falls, South Dakota. With the majority of Minnesota's population in the Minneapolis/St. Paul area, residents often seek health care in nearby Wisconsin facilities. Minnesota and its border states share encounter data about Medicaid clients to support attestation for the incentive program.

4.2.14 State Immunization and Public Health Surveillance Databases

What is the current interoperability status of the State Immunization registry and Public Health Surveillance reporting database(s)?

In 2015, MDH's Office of Health Information Technology (OHIT) completed an informatics assessment to measure the interoperability status of 21 programs that accept clinical, individual-level health data, including the immunization registry and the disease surveillance system. The results of this assessment have been used by some programs to address issues that were previously not documented or understood well enough to effectively address. It also helped identify potential candidates to become (public health) specialized registries for meaningful use.

In addition, the assessment highlighted the need for an agency-level strategic plan for interoperability and the coordination of activities to support interoperability across the agency and with external stakeholders. In 2016, MDH implemented a project to develop an agency vision and document details and plans to address the challenges related to achieving interoperability. Future activities may include creating an agency-wide interoperability program to provide consistent leadership and direction for all MDH programs, the design and plan for enhancement of a gateway infrastructure, in particular the shared services included in the gateway, and eventually the implementation of the gateway infrastructure including the costs associated with connecting MDH meaningful use programs to the gateway. All of these future activities are dependent upon the identification of resources to implement.

Currently, to support Medicaid providers to report public health data for meaningful use, Minnesota has an approved HIE project to increase the capacity of two MDH programs to onboard providers to submit immunizations and lab data electronically. Beginning in FFY 17, this project is expected to be completed in FFY 2021, and will include future requests for enhancing the capacity of other public health registries such as electronic case reporting (eCR).

Immunizations Reporting: The Minnesota Immunization Information Connection (MIIC),¹⁴ managed by MDH, is Minnesota's statewide immunization information system (IIS). While MIIC's enrollment rate is high, the program is unable to handle all of the requests for electronic data submission and, more recently, bi-directional exchange. The bi-directional exchange capability is a requirement for Stage 3 meaningful use and MIIC is now live with

¹⁴ <http://www.health.state.mn.us/divs/idepc/immunize/registry/index.html>

the capability to support that type of exchange. Support will be needed to upgrade the current data reporting connections to bi-directional exchange. Current data indicate that 87% of 804 primary care providers' sites (public and private providers, including those participating in Minnesota Vaccines for Children program) are enrolled in MIIC. Approximately 76% of these sites submit data regularly. While the enrollment rate is high in the immunization registry, Minnesota is striving to achieve the federal goal of 95%.

Electronic Lab Reporting: The Minnesota Electronic Disease Surveillance System (MEDSS) has been operational since 2009, and has expanded to include several new program areas including HIV, Zika, emerging infections, and Family Home Visiting. However, MDH is struggling to increase the number of labs reporting ELR. Under 40% of lab reports are submitted electronically to MEDSS and the queue of hospitals waiting to onboard is quite large. An analysis of MEDSS conducted by an external consultant in 2015, determined additional staffing resources were needed to expedite and increase the amount of ELR submissions. In fact, Minnesota is one of the last states in the country in terms of making progress onboarding hospitals labs to submit ELR data.

Electronic Case Reporting: MEDSS will also be used for electronic case reporting (eCR) data. MDH will need additional resources to plan for how it will manage this new public health reporting option. Minnesota has representation on the national planning and (pilot) implementation efforts for this work, The Digital Bridge, including a health care system and the electronic health record vendor used by most hospitals and clinics in the state. These resources will be utilized during any MDH planning activities.

4.2.15 HIT-related Grant Awards

If the State was awarded an HIT-related grant, such as a Transformation Grant or a CHIPRA HIT grant, please include a brief description.

In 2007, Minnesota was awarded a CMS Transformation Grant. A MITA demonstration project, the grant built several re-usable services onto MN-ITS (Minnesota Information Transfer System) to set the stage for future initiatives within a service-oriented architecture (SOA).

In 2012, Minnesota was awarded a \$45 million State Innovation Model (SIM) testing grant to advance Minnesota's accountable health model. The grant supported some activities including HIT, e-health, and data analytics, as well as practice transformation and development of community partnerships to support accountable care. In response to many of the lessons learned through SIM, Minnesota state staff began planning in 2016 for the activities that would build on the SIM successes, and address persisting gaps for Medicaid

providers after the SIM project ended. This planning was what prompted the identification of the need for the EAS project.

In 2013, Minnesota was awarded a four-year TEFT grant (Testing Experience and Functional Tools) with a budget of \$4,000,000 over four years, and an initial six month planning phase budget of up to \$500,000. TEFT's deliverables include:

- Demonstrate use of an untethered personal health record (PHR) system with beneficiaries of community-based long term services and supports (CB-LTSS);
- Identify, evaluate, and test an electronic long term services and supports (e-LTSS) standard with the ONC standards and interoperability (S&I) framework process;
- Field test a beneficiary experience survey within multiple CB-LTSS programs for validity and reliability; and
- Field test a modified set of continuity assessment record and evaluation (CARE) functional assessment measures for use with beneficiaries of CB-LTSS programs.

5. THE STATE'S "TO-BE" HIT LANDSCAPE (SECTION B)

While some of Minnesota's previous 'to-be goals', such e-prescribing and use of interoperable EHRs are now part of its current landscape, several overarching goals remain relevant. The specific strategies and activities supporting those goals are refined to reflect progress or changes over time. Additionally, new goals have been identified and are incorporated into this plan.

Minnesota continues to emphasize integrated care delivery models in its Medicaid program that are patient centered and team-based in order to achieve improved patient health outcomes, and avoid unnecessary costs. Examples of these include Integrated Health Partnerships and Health Care Homes, Behavioral Health Homes, and Certified Community Behavioral Centers. These reforms require a strong HIT landscape that includes widespread use of effective care coordination tools and exchange of relevant health information.

5.1 HIT/E "To-Be Goals"

- Continue to administer Minnesota's EHR incentives program and support ongoing meaningful use activities through 2021
- Improve coordination of care, quality of care, and health outcomes and decrease health care costs in Minnesota through health information exchange and meaningful use of EHRs. Evaluate progress using process and outcome-based indicators.

- Align support for providers participating in care delivery and payment reform initiatives. Broader goals for 2018 and the future involve the following initiatives:
 - Request for Proposal (RFP) process to acquire a third party vendor to assist with the creation and integration of encounter alert messaging, direct secure messaging (DSM) and a comprehensive provider directory for Medicaid providers.
 - Priority will be given to the implementation of an encounter alert messaging system/network to advise providers within the system of encounters with other networked EPs of admissions, discharges, transfers (ADT).
 - Integration of a DSM to allow EPs to communicate between each other regardless of software or provider network.
 - Creation of a comprehensive provider directory to allow providers to locate and contact each other regarding continuity of patient care for Medicaid recipients
- Expand the Minnesota Immunization Information Connections (MIIC) system's capacity to support meaningful-use transactions and other HIE activities.

5.2 Response to CMS Questions

5.2.1 HIT/E Goals and Objectives

Looking forward to the next five years, what specific HIT/E goals and objectives does the SMA expect to achieve? Be as specific as possible (e.g. the percentage of eligible providers adopting and meaningfully using certified EHR technology, the extent of access to HIE, etc).

DHS supports five specific goals through MEIP administration and activities

- **Achieve 80% return of meaningfully using eligible providers and eligible hospitals by end of program year 2017.**
DHS works to encourage EPs and EHs to become meaningful users of their EHRs, and to continue that process throughout the life of the incentive program. For EHs, that is only three years (83 of MN's 126 registered hospitals have completed the program), but for EPs, it is six years. MEIP has developed action items to encourage continued meaningful use of EHRs after the incentive program ends.
- **Support ongoing meaningful use criteria through 2021.**
DHS's goal is to support the electronic reporting of meaningful use transactions through

all current and future stages of MU as defined through future rulemaking.

<using IHP framework>

<monitor through assessment survey key areas of MU>

<explore how can use CQM data for analytics and VBP>

- **Complete Minnesota Department of Health projects (MIIC and MN ELR) designed to support Medicaid providers in meeting the public health portion of meaningful use.**

See Section 4.2.14 (p. 34) for explanation of MDH projects. MEIP continues to support the ongoing formation of these registries through funding designed to help build these public health registries for use by Minnesota Medicaid providers. Completion of these projects will facilitate meeting the requirements for meaningful use.

- **Further the adoption of EHR technology throughout the full continuum of care, including long-term care and behavioral health.**

DHS is seeking to increase EHR use among all Medicaid providers, with or without federally-financed EHR incentives, because of the critical need for the HIE to have comprehensive patient data. The primary effort is adding the broader range of care settings regardless of available incentives.

For example, DHS's Direct Care and Treatment (DCT, formerly State Operated Services (SOS) provides campus and community-based programs serving people with mental illness, developmental disabilities, chemical dependency, and traumatic brain injury, and continues deploying an EHR. Licensed practitioners and other DCT health care professionals' document patient assessments, including the history and physical, psychiatric, nursing, social work, and others, into the EHR. DCT continues to deploy new modules even though it does not qualify for incentives, and closely follows federal guidelines on EHR development, deployment and use.

DHS also has aided county public health entities as they initiate EHR adoption initiatives to determine how data can be prepopulated into their EHR from the State's Social Service Information System (SSIS).

- **Establish an Encounter Altering Service (EAS) to accelerate the ability of providers serving Medicaid beneficiaries to share necessary transition of care information**

DHS is seeking to increase the exchange of information between Medicaid providers. To that end, we are currently requesting funding through our HITECH IAPD to develop an encounter alert service which will allow Medicaid providers to be informed of any admissions, discharges, or transfers (ADT) of patients within healthcare systems in the state. DHS plans to leverage existing e-health connections already established, but

expand capabilities of providers not currently able to receive these automated notifications. DHS will also leverage relationships with Integrated Health Partnerships to initially connect Medicaid facilities as senders of ADTs, but continue onboarding and connecting other applicable subscribers including behavioral health, long term and post acute care facilities.

5.2.2 SMA IT System Architecture in Five Years

General system architecture: What will the SMA's IT system architecture (potentially including the MMIS) look like in five years to support achieving the SMA's long term goals and objectives? Internet portals? Enterprise Service Bus? Master Patient Index? Record Locator Service?

As of 2017 Minnesota has large systems modernization projects in development, and these will improve the ability of the State to establish a Medicaid only HIE. A high-level description of each of the projects follows.

- METS (Minnesota Eligibility Technology System) is Minnesota's single portal for health care coverage and determining eligibility for Medicaid or subsidies for health insurance premiums. This system is in production but requires many fixes to be optimal.
- ISDS (Integrated Service Delivery System) establishes an integrated, people-centered human services delivery system. This integrated system encompasses several major business processes: eligibility, assessment, enrollment, and case management. County and tribal agencies are critical partners in this project.
- MMIS (Medicaid Management Information System) modernization will replace aging technology and modernize payment and provider management for all health care and long-term care.
- Direct Care and Treatment (DCT) Modernization will upgrade all the modules of the EHR that DCT uses. Because many DCT clients are also Medicaid clients, the ability to share health information moves Minnesota toward the triple aim.

Shared Master Index

The Shared Master Index (SMI) is a web-based system developed by DHS to assist counties, tribes, and DHS to coordinate client services across state and county systems. The SMI interacts with other state and service entity systems, creating a cross-reference data base and a common client identifier to assist workers in tracking clients across systems. The SMI provides a common database for client demographic data and a comprehensive view of client data and program participation across program areas.

DHS continues to align its current technical architecture with MITA and has worked for

several years on the MITA Systems Modernization Process, which will yield new goals and an updated strategic plan. The MMIS performs claims processing and related support transactions, and the MN-ITS application is expanding to offer enrolled providers a front-end interface to MMIS. The data warehouse supports internal end-user applications and data analytics. New Medicaid web-based applications continue Minnesota's overall vision for e-government. Examples include:

- The Minnesota Electronic Health Record Incentive Program (MEIP) registration, attestation and payment application
- The Minnesota Eligibility Technology System (METS), described above.
- MnChoices, a web-based application, integrates assessment and support planning for Minnesotans who need long term services and supports.

5.2.3 Medicaid Providers Interface with SMA IT

How will Medicaid providers interface with the SMA IT system as it relates to the EHR Incentive Program (registration, reporting of MU data, etc.)?

DHS purchased an existing web-based application for registration, attestation, and reporting of MU requirements and eligibility payment requests, calculations, and payment issuance. Each change to rules that impact MEIP are seamlessly reflected in the application. Help desk support is available for Medicaid providers who have questions.

5.2.4 HIE Governance Structures in Five Years

Given what is known about HIE governance structures currently in place, what should be in place by five years from now in order to achieve the SMA's HIT/E goals and objectives? While we do not expect the SMA to know the specific organizations that will be involved, etc., we would appreciate a discussion of this in the context of what is missing today that would need to be in place five years from now to ensure EHR adoption and meaningful use of EHR technologies.

Currently, MDH's OHIT certifies HDIs and HIOs in Minnesota, using a public presentation process where the ultimate approval decision is made by a group of health care and IT professionals. Initially, HIE providers must complete a certification process to have the authority to operate in Minnesota. All documentation submitted as part of the HIE Service

Provider's application for certification will be posted on the MN e-Health webpage¹⁵ on public hearings for HIE for viewing before proceeding through the certification process. Each HIE Service Provider must complete an annual recertification process to maintain the authority to operate in Minnesota. All documentation for the recertification process will be available for public review on the MN e-Health webpage.

The Minnesota e-Health Initiative Advisory Committee has a subcommittee addressing the complexities of health information exchange in the state. For more information, see Section 5.2.1. Within five years, DHS expects the Health Information Exchange to produce the following for Medicaid clients:

- Increased efficiency and quality outcomes
- Improved ability to avoid adverse events
- Timely access to information from your patients' other providers
- Routine availability of admission, discharge and transfer alerts
- Routine availability of summary of care documents

Both MDH and DHS are planning and implementing HIE projects that will be fully implemented within five years. At a minimum, DHS will have a functioning Encounter Alerting Service that will enable consistent and timely access for Medicaid providers to admissions, discharges, and transfer notices. MDH will be successfully electronically onboarding Medicaid providers to the immunization registry and the electronic lab reporting registry, as well as to e-case reporting (eCR.) All of these projects are included in the updated MEIP Implementation Advance Planning Documents.

5.2.5 Specific SMA Steps in Next Year to Encourage EHR Adoption

What specific steps is the SMA planning to take in the next 12 months to encourage provider adoption of certified EHR technology?

Minnesota's requirement that all providers adopt interoperable health records became effective in January 2015, but there is no penalty for noncompliance. However, practitioners and hospitals in Minnesota have one of the highest rates of adoption and use of EHRs of any state in the U.S.

To further the use of CEHRT, MEIP presents at and supports the e-Health Summit in June of each year. Additionally, DHS has an EHR Incentive Program website and listserv. DHS also

¹⁵ <http://www.health.state.mn.us/divs/hpsc/ohit/publichearings.html>

hosts webinars and offers computer-based training for Medicaid providers and presents at events sponsored by the state's provider associations. DHS will continue to participate on the Minnesota e-Health Advisory Committee and associated workgroups to leverage existing stakeholder groups, promote HIE activity.

Because 2016 is the last year that EPs and EHs can begin the Medicaid incentive program, the MEIP team contacted providers who appear to qualify for the incentive program but who have not yet attested. Program activity in 2017 and 2018 will focus on providers who can return to the program, auditing and exploring opportunities to leverage existing eCQM processes and data in support of value-based purchasing initiatives.

5.2.6 FQHCs with HRSA HIT/EHR Funding

If the State has FQHCs with HRSA HIT/EHR funding, how will those resources and experiences be leveraged by the SMA to encourage EHR adoption?

In 2010, the Office of the National Coordinator for Health Information Technology (ONC) established 62 Regional Extension Centers (RECs) tasked to provide electronic health record technical assistance primarily to healthcare providers in individual and small practices, as well as to practices that increase access to health care for medically underserved communities, uninsured and underinsured individuals. On February 2013, the ONC reported 100% of Minnesota's 16 HRSA funded FQHCs and look-alike organizations worked with RECs.¹⁶ This includes 167 providers in the state that participated with REACH, Minnesota's REC. Since 2012, MEIP has paid incentive funds to 1,387 treating providers who are associated with 80 different Federally Qualified Health Centers (FQHC), Tribal or Urban Facilities (TUF), or Rural Health Clinics (RHC).

5.2.7 Provider Technical Assistance

How will the SMA assess and/or provide technical assistance to Medicaid providers around adoption and meaningful use of certified EHR technology?

DHS employs MEIP staff who are subject matter experts on the Medicaid Incentive Program, including all rules and policies about payments for AIU or MU. However, MEIP staff do not recommend specific CEHRT to providers, and they do not provide technical assistance on

¹⁶ ONC Data Brief No. 8, Feb. 2013, "Supporting Health Information Technology Adoption in Federally Qualified Health Centers"

implementation of EHRs. Minnesota's EHR Incentives website provides up-to-date technical assistance and program information, including a hospital calculation spreadsheet template along with a completed example to help hospitals prepare their final attestation requirements. DHS provider training presenters urge participants to sign up for listserv updates and to submit questions via the site's e-mail box. In addition, the site's multiple resource links include the CMS EHR official website.

MEIP staff provide EHR presentations to professional organizations, such as the Minnesota Hospital Association, Minnesota Medical Association, Minnesota chapter of the Healthcare Financial Management Association, managed care organizations, tribal health directors, and others. With each new final rule, MEIP staff present webinars for EPs and EHs, explaining the details of the changes. Business Services staff (MEIP's contractor that staffs the SLR) are available to answer questions from 7 a.m. to 7 p.m. Central time, Monday through Friday.

MDH's OHIT has a Meaningful Use Coordinator who provides technical assistance about the public health MU objectives.

Lastly, DHS is a member of Minnesota's e-Health Advisory Committee, which encompasses a broad range of stakeholder voices and multiple workgroups focused on common goals regarding HITECH and Minnesota's broader HIT/E goals. DHS utilizes this group for feedback and help in identifying unmet needs in the stakeholder community and developing effective solutions from all HITECH entities.

5.2.8 Unique Populations

How will the SMA assure that populations with unique needs, such as children, are appropriately addressed by the EHR Incentive Program?

Minnesota's two children's hospitals and clinics systems participate in the EHR incentives program.

DHS is examining ways to increase EHR adoption among behavioral health providers because of the critical need for HIE within behavioral health; however, there are roadblocks to this. Minnesota has a very strong data privacy act, which makes sharing behavioral health records difficult. Using the incentive program as an inducement to acquire an EHR only works for psychiatrists, since other behavioral health professionals are not eligible professionals.

Minnesota has created Behavioral Health Homes, as described in the ACA. The health home model expands upon the concept of person-centered medical homes (Health Care Homes in Minnesota) and makes a more concerted effort through design, policy levers, and outcome

measures to serve the whole person across primary care, mental health, substance use disorder treatment, long-term services, and supports, and social service components of our health care delivery system. Minnesota is also applying to be a demonstration site that will show the benefits of certified community behavioral health clinics, which also promote continuity of care. Although EHRs are not required for either of these programs, care management is more effective when health care information is shared.

5.2.9 Leverage of HIT-Related Grant Award

If the State included a description of an HIT-related grant award (or awards) in Section 4, to the extent known, how will that grant, or grants, be leveraged for implementing the EHR Incentive Program (e.g. actual grant products, knowledge/lessons learned, stakeholder relationships, governance structures, legal/consent policies and agreements, etc.)?

The State has fully implemented its transformation grant goals and DHS will incorporate the lessons learned from these efforts.

The TEFT grant, which is funding the creation of an untethered personal health record (PHR) for people receiving community-based long term services and supports, has shown the issues, challenges, and benefits of such a system, even though the user group is small. MEIP and health care reform staff are working with TEFT staff to determine the best way to create a Medicaid HIE in a short period of time which exchanges basic health information.

5.2.10 Legislative and State Law Changes

Does the SMA anticipate the need for new or State legislation or changes to existing State laws in order to implement the EHR Incentive Program and/or facilitate a successful EHR Incentive Program (e.g. State laws that may restrict the exchange of certain kinds of health information)? Please describe.

DHS required new legislation in order to implement MEIP which was passed by the 2011 state legislature. This language authorized the Commissioner of the Minnesota Department of Human Services to develop, administer, and audit MEIP, adopted Code of Federal Regulations, title 42, part 495 definitions, and established an appeals process. Legislation has not been changed since 2011, and it is not anticipated to change.

6. ACTIVITIES NECESSARY TO ADMINISTER AND OVERSEE THE EHR INCENTIVE PAYMENT PROGRAM (SECTION C)

Section 6.1 describes Minnesota EHR Incentive Program's (MEIP) scope, project administration, and the activities necessary to administer and oversee MEIP. Section 6.2 addresses the specific CMS questions.

6.1 MEIP Overview

State Medicaid programs established EHR Incentive Programs under the provisions of the HITECH Act. These programs provide for incentive payments to certain health care professionals and hospitals that meet specific eligibility requirements when they adopt, implement, upgrade and meaningfully use certified EHR technology. In Minnesota, DHS administers the MEIP. To be eligible for MEIP, health care professionals and hospitals must fall within the defined classifications and meet minimum Medicaid patient volume (MPV) thresholds.

Eligible Professionals

Minnesota's eligible providers are Physicians, Dentists, Optometrists, Certified Nurse-Midwives, Nurse Practitioners, and Physician Assistants who meet CMS requirements.

Minimum Medicaid patient volume (MPV) for most providers is 30% of their patients.

- For pediatricians, the threshold is 20% Medicaid patients. Pediatricians who meet this lower threshold receive only 2/3 of the incentive payment. Pediatricians who meet a 30% threshold are eligible to receive the full amount of the incentive payments.
- Eligible professionals who practice predominantly (50% or more) in an FQHC, RHC or TUF may include "needy individual" patient encounter services to the threshold, which encompasses Medicaid, Children's Health Insurance Program (CHIP), and services provided on a sliding scale fee or uncompensated care.
- Eligible professionals must not be hospital-based. Hospital-based means 90% or more of his or her Medicaid-covered professional services during the relevant EHR reporting period were furnished in an inpatient or emergency department setting. Inpatient services include those with place of service code (POS) 21. Emergency department services include those with POS 23.

Eligible Hospitals

Eligible hospitals (EH) for MEIP are those whose last four digits of their CMS Certification

Number (CCN) fall into one of the following ranges:

- 0001-0879 for acute care hospitals
- 1300-1399 for critical access hospitals
- 3300-3399 for children’s hospitals

Eligible hospitals for MEIP also include those registered as hospitals to CMS and enrolled as Indian Health Service facility provider and category of service hospital with Minnesota Health Care Programs (MHCP).

To be eligible for a MEIP payment, acute care, and critical access hospitals must have at least a 10% MPV. Children's hospitals have no MPV requirements.

Expected Number of Eligible Providers

Estimating the potential number of eligible providers is challenging because of an inability to calculate the denominator, or total number of encounters, for MPV. Factors to consider in estimating the number of eligible providers include:

- EPs may calculate patient volume individually or at the clinic level
- A group practice’s claims are sometimes reported under the supervising physician
- Minnesota implemented a significant Medicaid (Medical Assistance) program expansion. This expansion increased the number of Medicaid enrollees by up to 95,000.

In 2011, DHS identified both high and low estimates because of the challenges in estimating eligible providers and other states’ experiences of underestimating. DHS conservatively estimated that at least 1,408 of enrolled providers were eligible for incentive payments: 1,336 eligible professionals and 72 eligible hospitals. The vast majority of providers are physicians.

Table 6.1A: Estimated Number of Providers Meeting Patient Volume Thresholds

Provider Type/Description	MN Medicaid Providers	Projected EPs and EHs – Low Estimate	Actual number of participants as of program year 2016
20/ Physicians, including	20,973	656	1,260

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Provider Type/Description	MN Medicaid Providers	Projected EPs and EHs – Low Estimate	Actual number of participants as of program year 2016
some pediatricians ¹⁷			
69/ Pediatricians	1,287	547	303
69/ Physician Assistants	1,407	10	38
66/ Nurse Midwives	177	6	156
65/ Nurse Practitioners	2,110	37	1,086
30/ Dentists	2,059	80	643
35/ Optometrists	1,068	30	15
01/ Hospitals	278	72	81
Total	28,291	1,408	3,582

Note: The projected number of EPs is based on Medicaid provider 2010 claims (numerator) divided by published national benchmarks for the average number of patients seen per day by a healthcare practitioner (denominator) and compared to the provider type’s patient-volume threshold.

Current CMS registration numbers support that Minnesota has underestimated participation in the incentive program. As of July 13, 2017, CMS reports 3,188 eligible professionals and 126 eligible hospitals have completed CMS incentive program registration, and had received at least one payment within MEIP.

6.1.1 Project Administration

CMS approved DHS’s first SMHP in November 2011 and has approved two updates and two addenda since then. In addition, CMS has approved Implementation Advance Planning Documents (IAPDs) and their updates since 2011.

Project Team: The MEIP team has the following members. See the MEIP Organizational

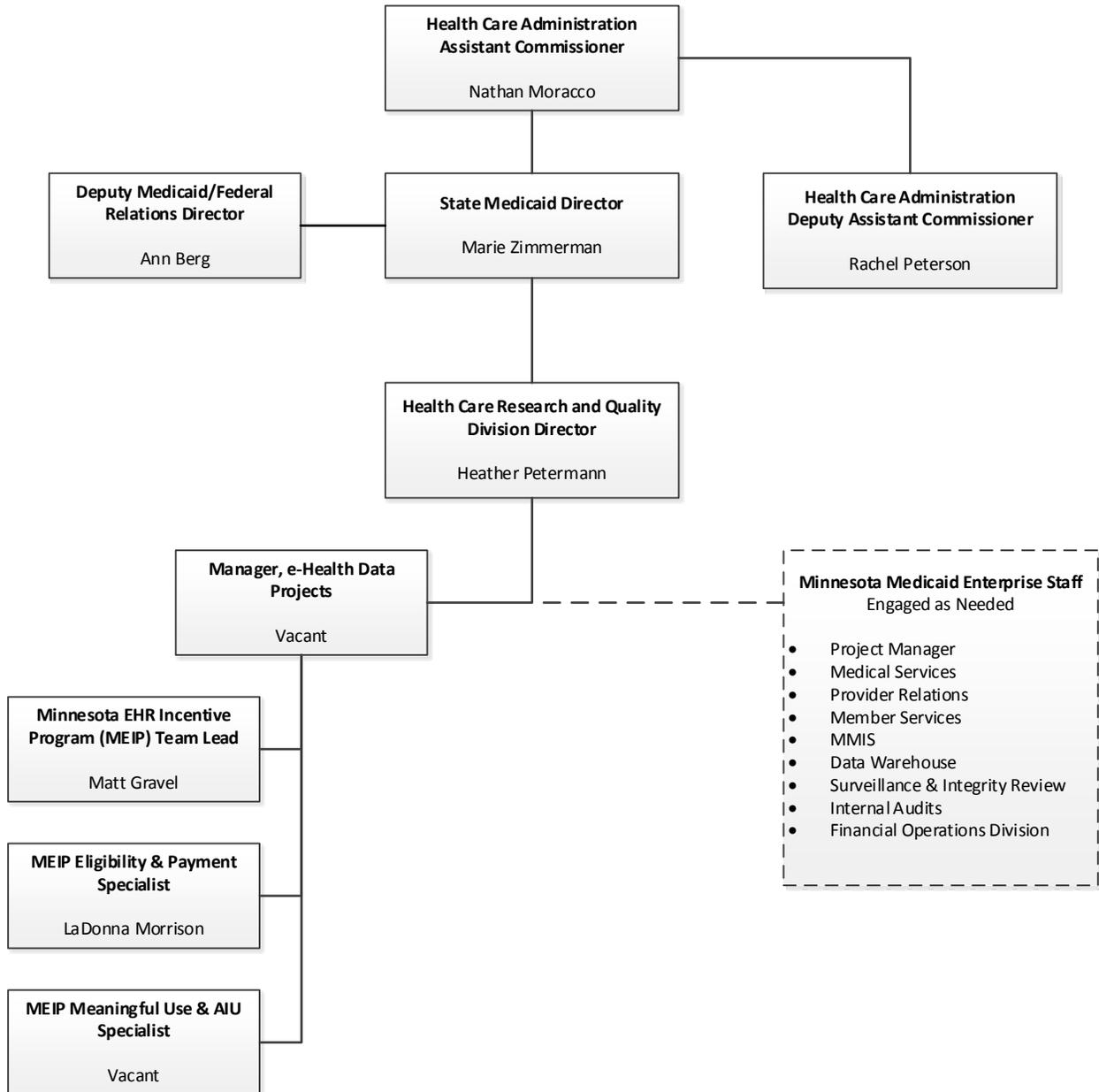
¹⁷ If a pediatrician meets 30% MPV, then they are paid the full incentive payment and they are recorded as physicians. The pediatrician provider type is a subset of physicians.

Chart below.

- A manager
- A team lead
- An eligibility and reimbursement specialist
- A meaningful use specialist

CGI Technologies and Solutions Inc. (CGI), which created the MI360 solution, is the MEIP vendor that manages the State level repository (SLR), which is where EPs and EHs attest to MEIP.

MEIP Organizational Chart



Initial SMHP development and review: Key DHS and MDH personnel provided further information and answers to additional questions. The team combined this information with existing MN HIT/E documents to develop a preliminary draft SMHP, which was distributed for internal DHS review. Once reviewed by DHS staff, the SMHP was routed through the existing stakeholder group via the MN e-Health Advisory Committee for comments and feedback. This resulting SMHP was submitted to CMS for feedback and approved by CMS to initiate the program.

Stakeholder input: Minnesota has a long history of engaging stakeholders in developing HIT, HIE, and EHR approaches and projects. DHS solicited broad input regarding the 2010 State Medicaid HIT Plan, and meaningful use development was shaped in the MN e-Health Initiative's Adoption and Meaningful Use Workgroup. Stakeholder input has been critical to SMHP development and will continue to inform MEIP. DHS collects and incorporates stakeholder input through the Minnesota e-Health Advisory Committee and via strengthened connections with additional key stakeholders:

- DHS gathers feedback from external stakeholders from the MN e-Health Initiative's Advisory Committee, and associated workgroups, for input on the development of the SMHP. The MN e-Health Initiative is guided by a 25-member public-private advisory committee representing consumers, the health care delivery community, purchasers, public health, government, professional organizations, and others. Dozens of volunteers serve on work groups related to a statewide implementation plan, standards, privacy and security, population health and public health information systems, as well as communications, education, and collaboration. DHS will continue to work with and receive input from this wide range of stakeholders working with the committee on the mutual goal of accelerating the adoption and use of HIT in order to improve health care quality, increase patient safety, reduce health care costs, and improve public health.
- DHS leverages other key stakeholder relationships to plan, improve and communicate about MEIP. For example, DHS and REACH, Minnesota's REC, collaborated in providing education and encouragement to providers regarding EHR.
- DHS continues to build new and strengthen existing relationships with additional key stakeholders such as:
 - Minnesota Medical Association
 - Minnesota Hospital Association
 - Minnesota Dental Association

- Minnesota Nurses Association
- Minnesota Academy of Physician Assistants
- Minnesota Health Information Management Association
- Minnesota Chapter of Healthcare Information & Management Systems Society
- Minnesota Medical Group Management Association
- Minnesota Tribal Health Directors

6.1.2 Administrative Activities Overview

The EHR incentive payment process is hosted by CGI, Inc. on a secure portal, which serves as a repository for MEIP enrollment records and communicates between the host portal and existing business processes at DHS. A high level overview of activities is provided below and in Figure 6.1.3A. Responses to CMS questions in Section 6.2 explain the specifics of MEIP administration.

DHS leverages the MMIS claims payment system to make payments to providers. A gross adjustment within MMIS triggers the payment after completion of all appropriate verifications. A funding code value has been assigned specifically for MEIP reimbursement. DHS leverages a mailbox application within the DHS provider portal named ‘MN-ITS’ to send a MEIP payment notification file to the assigned payee. The notification is a supplement to the payee’s remittance advice and provides the national provider identifier of the eligible professional or of eligible professionals who assigned payment to the payee.

The final rule allows states to make hospital incentive payments based on a three to six year payment schedule. DHS has determined that hospital EHR incentive payments will be paid over three years. Fifty percent of the total incentive will be paid in the first year, 40% in the second, and 10% in the third year. This payment approach rewards hospitals for adopting, implementing, or upgrading (AIU) EHRs and supports ongoing efforts to meet meaningful use (MU) incentive program requirements. Minnesota considered balancing the payments across additional payment years, but determined that the incentive is best placed at the beginning of the transition to meaningful use within the minimum payment schedule allowed to the states.

When determining the hospital payment disbursement schedule, DHS met with the Minnesota Hospital Association and the Minnesota chapter of the Healthcare Financial Management Association. In addition we consulted with representatives from hospitals individually and via our e-Health Initiative Committee and workgroups. Our hospital stakeholders supported the hospital incentive disbursement schedule over three years.

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Table 6.1.2A: Overview of Administrative Activities

Stakeholder	MEIP Role and Goals
Centers for Medicare & Medicaid Services (CMS)	Federal agency responsible for administering the Medicare and Medicaid EHR Incentive Program as defined by the regulations in the Final Rule, 42 CFR 495.
Office of National Coordinator of Health Information Technology	Manages the Certified Health IT Product List (CHPL), which comprises the EHR systems that meet the qualification for program eligibility.
Minnesota Department of Human Services (DHS) MEIP	State program sponsor and administrator for the State of Minnesota on behalf of the Medicaid EHR Incentive Program in accordance with the regulations developed and maintained by CMS.
MMIS (Medicaid Management Information System)	<p>Application responsible for paying the Medicaid program within the State of Minnesota. MN DHS MMIS is also responsible for providing key information required to operate the MEIP, including:</p> <ul style="list-style-type: none"> • Provider information (names, type, status, group affiliations) • Encounter volumes • Payment processing • Payment results
Minnesota Health Care Programs (MHCP) Enrolled Providers	Potential EHR program participants.

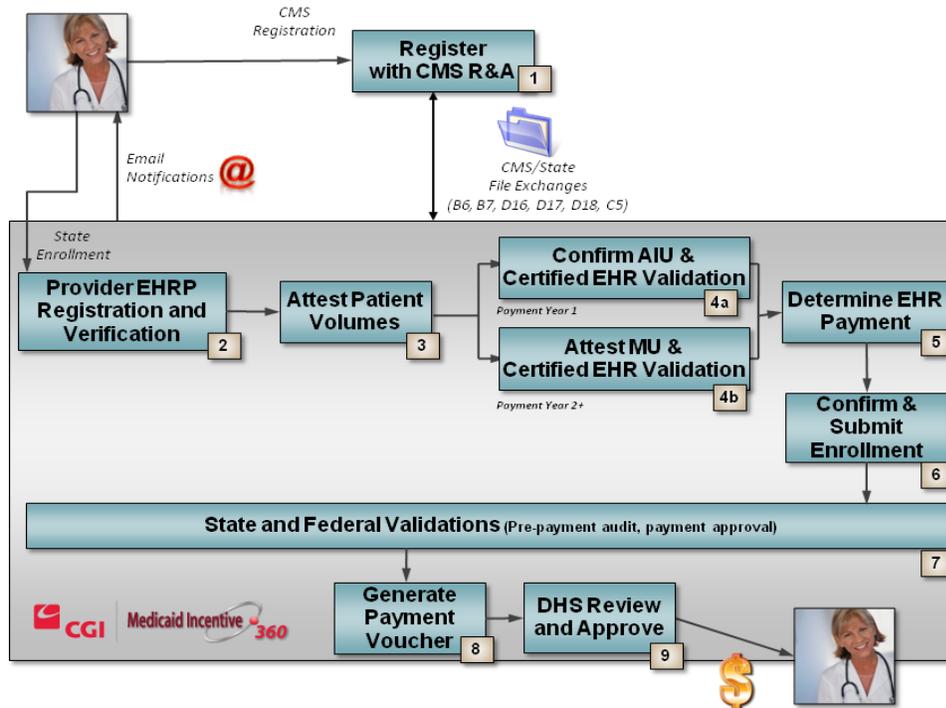
2017 State HIT Plan
State of Minnesota
Department of Human Services

Stakeholder	MEIP Role and Goals
Minnesota Department of Health (MDH)	<ul style="list-style-type: none"> Collect EHR incentive public health data objectives: submitting electronic data to public health agencies on immunizations and reportable lab results.
REACH Regional Extension Assistance Center for Health Information Technology	Provided guidance and support to the MHCP community for participating in MEIP. REACH closed in February 2016.
CMS Registration and Attestation (R&A) System	<p>MEIP participants must register with the CMS R&A prior to participation in MEIP.</p> <p>MEIP and CMS R&A coordinate provider registration and payment status through a series of interfaces.</p>
CGI MI360 Program	Vendor contracted by MN DHS to configure, implement, operationalize and support the MEIP system through a Software as a Service model, including provision of call center business services support. CGI MI360 Program also performs pre-payment reviews and first level reconsideration management in coordination with the MN DHS MEIP team.

6.1.3 Provider Eligibility and Enrollment

The basic process for enrolling and paying potential EPs and EHs into MEIP is shown in Figure C2. See responses to CMS questions in 6.2 for more detail on eligibility and enrollment.

Figure 6.1.3A: MEIP Provider Enrollment



6.2 Response to CMS Questions

This section contains DHS’s responses to the CMS questions on EHR Incentive Payment Program administration and oversight.

6.2.1 Verification of Licensed/Qualified Providers

How will the SMA verify that providers are not sanctioned and are properly licensed/qualified providers?

DHS credentials its providers at initial enrollment and once every five years thereafter. The MMIS Provider File receives the Office of Inspector General’s (OIG) national-level sanction information. On a monthly schedule, these files are run against the MMIS Provider File and sanctioned providers are terminated from participation in Medicaid immediately. According to their contract with MN DHS, managed care organizations are expected to follow the same process with their providers.

DHS assures that existing providers have not been sanctioned or excluded since the time of their original enrollment, prior to making EHR incentive payments, by running the MMIS provider file against the Office of Inspector General sanctions report and state licensing

boards on a monthly schedule. When exceptions are found, they are given to a provider enrollment specialist who then terminates those providers from the system, making them ineligible for any future payments from MMIS.

The monthly automated check also covers these state licensure boards:

- The Minnesota Department of Health licenses hospitals:
<http://www.health.state.mn.us/divs/fpc/directory/fpcdir.html>
- The Minnesota Board of Medical Practice licenses physicians and physician assistants:
<http://www.state.mn.us/portal/mn/jsp/home.do?agency=BMP>
- The Minnesota Nursing Board licenses Certified Nurse Practitioners and Certified Nurse Midwives: <http://www.state.mn.us/portal/mn/jsp/home.do?agency=NursingBoard>
- The Minnesota Board of Dentistry licenses dentists:
<http://www.dentalboard.state.mn.us/>

Minnesota requires termination of a provider who is convicted of:

- fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance
- a pattern of presentment of false or duplicate claims or claims for services not medically necessary
- a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled
- suspension or termination as a Medicare vendor
- refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment
- failure to repay an overpayment finally established under this section
- any reason for which a vendor could be excluded from participation in the Medicare program under Section 1128, 1128A, or 1866(b)(2) of the Social Security Act

Providers convicted and terminated for the above reasons will not be eligible for incentive payments. In addition to the conviction reasons listed above, if DHS has determined there is reliable evidence of fraud or willful misrepresentation a provider may have lesser sanctions applied, other than termination, after notification and before a hearing. In these instances the provider will be referred to the EHR auditing team for a pre-payment audit.

Minnesota Statutes, section 256B.064 subd. 1a. and Minnesota Rules, Part 9505.2210, subp. 2 define the available lesser state sanctions that can be applied after notification and before a hearing. These sanctions can include:

- Suspend payments
- Withhold payments
- Suspend participation
- Terminate participation
- Suspend or terminate those with ownership or control interest
- Require education sessions
- Require prior authorization of any services
- Lock out participation

In addition to the actions listed above the agency may also require:

- Limited duration provider agreement
- Stipulated provider agreement
- Review of provider's claims pre-payment

Before incentive payments are sent to MMIS for payment, DHS will perform one more manual or automated check against the OIG Sanctions Report and all state licensing boards. The MEIP system also communicates with the CMS national level repository to verify there are no sanctions for a provider at the federal level. This process will ensure that a provider who has been sanctioned within the last month will not receive an EHR Incentive.

[6.2.2 Verification of Whether Eligible Professionals are Hospital-Based](#)

How will the SMA verify whether Eligible Professionals (EPs) are hospital-based or not?

Providers who perform 90% or more of their services in a hospital inpatient setting or emergency room are ineligible for the incentive program. EPs attest that the EP is not hospital-based during MEIP enrollment. DHS post-payment audit strategy includes hospital-based verification.

It is possible for an EP who was deemed hospital-based to request a redetermination of their status. An EP will first need to be determined hospital-based; they may then request that their status be reevaluated. EPs will be required to submit additional documentation in the

redetermination process, supporting that they meet the definition of a non-hospital-based EP as defined in 42 CFR § 495.5. The documentation would demonstrate that the EP funds the acquisition, implementation, and maintenance of certified EHR technology (CEHRT), including supporting hardware and any interfaces necessary to meet meaningful use without reimbursement from an eligible hospital or critical access hospital; and uses such CEHRT in the inpatient or emergency department of a hospital (instead of the hospital's CEHRT).

6.2.3 Verifying Provider Attestation

How will the SMA verify overall content of provider attestations?

Providers must attest to AIU to a certified EHR system and a Medicaid patient volume equal to or above the minimum percentage for the provider type before payment is approved. DHS attestation criteria include all requirements for AIU or MU as defined by CMS in the final rules that have been adopted since 2010.

Per the regulations, Minnesota will deem a Dual-Eligible Hospital (DEH) that demonstrates MU under Medicare to have met the Medicaid MU requirement for that same payment year. The DEH will be required to attest to AIU in the first Medicaid payment year.

Overall attestations: The following verifications are assured by DHS.

- **Applying for Medicaid EHR Incentive Program, active Medicaid provider:** DHS MEIP system receives notice of registration from the national level repository (NLR), and validates Medicaid enrollment by validating against DHS provider demographics file data shared with the MEIP system.
- **Provider eligibility, sanctions:** DHS compares NLR data with DHS provider demographics file data to verify provider type and sanctions information. The NLR only accepts valid National Provider Identifiers (NPI), making a cross check between NLR and the state provider file an important first verification step.
- **Tax identification number (TIN) and designated participating program:** DHS verifies that the TIN used in the transaction is on file in the MMIS provider database.
- **Hospital-Based EP verification:** See 6.2.2.
- **Compliance with HIPAA laws, contractual agreement with displayed TIN:** DHS verifies HIPAA information through provider attestation. DHS verifies a contractual agreement with the displayed TIN by validating against the provider database.
- **Patient volume is met:** Providers enter their MPV and total patient encounters, and the

application calculates the percentage.

- **Patient-volume sources for EPs and acute care hospitals:** Providers upload the source documents for their MPV and total patient encounters. DHS verifies Medicaid encounters through MMIS claims data.
- **EP practices at FQHC/RHC/IHS predominantly:** See 6.2.7.
- **Payment amount:** DHS MEIP system ensures that the EP payment methodology is followed and the appropriate payment is made. DHS system ensures that the EH payment calculation methodology is followed and the appropriate percentage is reimbursed. MEIP Business Services staff perform a pre-payment verification on the EH payment calculation.
- **AIU and MU:** Providers may attest to AIU or MU in their first payment year. DHS supported MU submission beginning in 2012.
- **Pre-payment controls:** Pre-payment audits are defined as enrollments that meet one or more configurable criteria that are defined in the MEIP desk audit determination function. The desk audit determination process is triggered when a potentially eligible provider, either EH or EP, completes their enrollment and selects “Confirm & Submit.” At this point, the enrollment is evaluated against the criteria. If the enrollment meets one or more of the criteria, it is placed “on hold” in the Pre-Payment Audit queue of the Business Services Portal for evaluation and validation of the triggering attributes. All enrollments have pre-payment audits to review and validate any aspect of the enrollment.

DHS’s contracted staff are responsible for performing all pre-payment audits for MEIP enrollments.

In addition to the pre-payment verification performed by contracted staff, DHS has assigned staff to perform a secondary review of 100% of EPs and 100% of EHs in the payment queue. Any areas of interest for post-payment audit will be marked. Any EPs or EHs that lack sufficient patient volume, eligibility or appropriate supporting documentation will be removed from the payment queue until the record can be discussed with contracted staff and necessary steps taken to pass or fail the request.

See the MEIP Audit Plan for more details on the pre-payment verification process and the pre-payment secondary review.

Table 6.2.3A: Pre-payment Verification Triggers

Description	Criteria Threshold/Frequency
Eligible Hospital (EH)	100%
EP - Hospital Based	100%
EP - Entered Volumes greater than (Encounter Volumes + threshold %)	100% *1.33
Variance threshold (entered volume/MMIS encounters)	133%
EP - Group Audit	100% first person in group to confirm and submit
EP – Panels	100% (N/A in MN)
EP - Physician's Assistant (PA)	100%
EP - Out-of-State Encounters	100%
EP – Multiple	100%
Multi – Group	100% (distinct from EP)
FQHC EP - Entered Volumes greater than Claims Volumes	100% *1.33
EP MU attestation	100%
EP - Supporting Documentation Review	100%
Pediatrician attesting at 20%	100%

- **Post-payment controls:** DHS post-payment control details can be found in the MEIP Audit Plan.
- **Documentation:** EPs and EHs must upload documentation to demonstrate the accuracy of all attestations. The MEIP Guidance on Supporting Documentation can be found as Appendix A of the [MEIP Attestation Basics](#) .
- **Attestation signature:** The EP’s or EH’s attestation is completed online with an electronic signature. The user completing the MEIP enrollment enters their name and title in relationship to the EP or EH and enters the CMS Registration ID. The CMS Registration ID is the key element that provides the authorization to complete the

attestation. DHS's application attestation page contains a statement that the signing provider is authorized to receive payment, that all the information provided is accurate, that the provider is subject to legal penalty for providing false information and that any funds received under false pretense is recouped.

6.2.4 SMA Communication to Providers Re: Eligibility, Payments, etc.

How will the SMA communicate to its providers regarding their eligibility, payments, etc.?

DHS MEIP system notifies the provider of the approved payment amount or denial reason. MEIP initiates electronic fund transfers through MMIS. The program also issues a notice of the transferred amount to the TIN receiving the payment. DHS leverages a mailbox application within the DHS provider portal named 'MN-ITS' to send a MEIP payment notification file to the assigned payee. The notification is a supplement to the payee's remittance advice and provides the NPI of the EP or EPs who assigned payment to the payee.

6.2.5 SMA Methodology to Calculate Patient Volume

What methodology will the SMA use to calculate patient volume?

Guidance for EPs and EHs in gathering the data and documents needed for payment approval is found online in MEIP Attestation Basics ([LINK](#)). This document has detailed definitions of encounters and the valid programs for Medicaid. Below are very general descriptions of how DHS calculates patient volume.

Eligible Providers

Minnesota EPs use Option 1: Patient Encounter, as described in the rule, for calculating their Medicaid patient encounters and can:

- Choose the 90-day period. Eligible professionals may select from one of two reporting periods to calculate patient volume:
 - Any representative continuous 90-day period in the most continuous 12-months preceding the providers attestation
 - Any continuous 90-day period in the calendar year preceding the payment year for which the provider is attesting
- Count out-of-state encounters
- Calculate volume using the group clinic/proxy methodology

- Count participants in programs that are fully or partially paid by the federal government
- EPs practicing predominantly in FQHC/RHC/TUF and Physician Assistants also include:
 - CHIP program participants
 - Services provided on a sliding scale or that were uncompensated

Eligible Medicaid Volume Period

A representative 90-day continuous calendar day period in normal operations with no unusual or one-time increase in Medicaid encounters.

For EPs: For payment year 2013 and all subsequent payment years, at least one clinical location used in the calculation of patient volume must have CEHRT.

For FQHC/RHC/TUF: Per federal regulations, DHS defines a “needy individual encounter for FQHC/RHC/TUF” as services rendered on any one day to an individual for which medical services were one of the following:

- Paid for by Title XIX Medicaid or Title XXI Children’s Health Insurance Program (CHIP) funding, out-of-state Medicaid programs or a Medicaid or CHIP demonstration project approved under Section 1115 of the Act
- Furnished by the provider as uncompensated care
- Furnished at either no cost or reduced cost based on a sliding scale determined by the individual’s ability to pay

Eligible Hospitals

DHS follows the definition in federal regulations for EH Medicaid patient encounters which are services rendered to a Medicaid enrolled individual per inpatient discharge, or on any one day in the emergency department, regardless of payment liability. Per federal regulations, children’s hospitals are not required to meet any Medicaid patient-volume percentage and do not provide information on patient encounters. Minnesota has created a hospital incentive calculation template which is available on our EHR incentive website.

Eligible hospitals may select from one of two reporting periods to calculate patient volume: (A) any representative continuous 90-day period in the most continuous 12-months preceding the provider’s attestation; or (B) any continuous 90-day period in the federal fiscal year preceding the payment year for which the provider is attesting.

6.2.6 Data Sources to Verify Patient Volume

What data sources will the SMA use to verify patient volume for EPs and acute care hospitals?

Eligible Professionals

DHS verifies through MMIS data the individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under Section 1115 of the Act) at the time the billable services were provided.

The EP selects a 90-day reporting period and attests to the number of Medicaid encounters (numerator) and total patient encounters (denominator). DHS verifies the selected 90-day period's Medicaid patient encounters with the MMIS claims system. EHR program staff will receive an exception report if the provider's submitted Medicaid patient-volume is substantially different than what was calculated by the EP-provided denominator and MMIS numerator claims data. EHR program staff will contact the provider to resolve the Medicaid patient-count discrepancy. DHS will work with other states, as needed, if the discrepancy is due to out-of-state enrollees excluded from Minnesota's claims data.

The following zero-pay and denied claims may be included in the calculation of patient volume:

- Claims denied because the Medicaid beneficiary has exceeded the service limit.
- Claims denied because claim was not submitted timely.
- Claims paid at \$0 because another payer's payment met or exceeded the Medicaid payment.

If a provider can meet patient volume without including zero-pay/denied claims, the provider will be encouraged to do so. Eligible providers will in no way be prohibited from using zero-pay/denied claims in their encounters. If zero-pay/denied claims are used, eligible providers will be asked to submit additional documentation to support their patient volume attestation and the inclusion of zero-pay/denied claims. To verify total encounters, the provider uploads the total patient encounters' source document, such as admitting records or filed claims.

Eligible Hospitals

The hospital selects a 90-day reporting period and attests to the number of Medicaid and total patient encounters. Eligible hospitals will be asked to complete a questionnaire and utilize the hospital calculation spreadsheet located on Minnesota's EHR incentives website at <http://www.dhs.state.mn.us/ehrincentives>. In addition to the fillable spreadsheet, there is also

an example of a completed spreadsheet for their review. This spreadsheet requires that hospitals provide the applicable worksheets from the Medicare cost report (referenced as documentation on the EH spreadsheet). DHS also verifies Medicaid patient encounters and average lengths of stay with the MMIS system, the Medicare Cost Report, and the Hospital Annual Report.

6.2.7 Verifying “Practices Predominately”

How will the SMA verify that EPs at FQHCs/RHCs/TUF meet the “practices predominately” requirement?

An EP is considered to practice predominantly when the clinical location for over 50% of their total patient encounters over a period of 6 months, within the most recent calendar year (CY), OR within the 12-month period preceding attestation, occurs at an FQHC, RHC, or a TUF.

DHS queries MMIS data for Place of Service codes to confirm FQHC/RHC/TUF attestation and to ensure that an EP is not hospital-based. DHS has two separate FQHC/RHC/TUF verification methods:

- As part of its audit strategy, DHS contacts each RHC/FQHC clinic¹⁸ to positively confirm any EP who attests he or she works there or at multiple RHC/FQHC clinics more than half time. These EPs are assumed to meet the 50% requirement.
- EPs under 50% can submit patient information to meet the 30% threshold as other non-RHCs/FQHCs/TUF providers do. DHS verifies the providers’ reported Medicaid patient encounters with the MMIS claims system. To verify total patients seen, the provider uploads a patient check-in, billing, or filed claims report for the 90-day period.

¹⁸Minnesota has 84 Rural Health Clinics (RHC) <http://www.health.state.mn.us/divs/orhpc/funding/grants/pdf/rhc.pdf> and 18 Federally Qualified Health Clinics (FQHCs) <http://www.health.state.mn.us/divs/orhpc/shortage/chc15main.pdf>

6.2.8 Verifying Adopt/Implement/Upgrade (AIU)

How will the SMA verify adopt, implement or upgrade certified electronic health record technology by providers?

To verify adopt/implement/upgrade (AIU) providers will upload copies of contracts, user agreement, purchase order, license agreements, invoices, vendor letters, or other documents. Documentation of AIU is required only in the first payment year.

6.2.9 Verifying Meaningful Use (MU)

How will the SMA verify meaningful use of certified EHR technology for providers' second participation year?

Minnesota's contractor, CGI Technologies and Solutions (CGI), maintains the MEIP attestation portal and performs all pre-payment reviews of attesting providers and hospitals. MEIP requires that providers and hospitals upload MU summary reports for MU that are percentages and screen shots for MU that are not percentages. Before payment is approved, CGI makes sure that the percentages make sense and that the screen shots are valid. Minnesota's meaningful use specialist randomly reviews attestations before they are paid as a final check to verify the provider has met the requirements for attestation.

6.2.10 Proposed Meaningful Use Definition Changes

Will the SMA be proposing any changes to the meaningful use definition as permissible per rule-making? If so, please provide details on the expected benefit to the Medicaid population as well as how the SMA assessed the issue of additional provider reporting and financial burden?

No. Minnesota Medicaid will comply with the meaningful use measures and objectives published in 42 CFR § 495.6 and 42 CFR § 495.8 and has no current plan to change MU definitions. This includes changes and new requirements as set forth in the Stage 2 Final Rule published on September 4, 2012, the modified Stage 2 rule published on October 15, 2015, and the changes published in October 2016. Minnesota leaves open the option for the future addition of Medicaid-specific criteria through formal submission to CMS.

6.2.11 Verifying Certified EHR Technology

How will the SMA verify provider's use of certified electronic health record?

DHS's automated interface to the ONC's online Certified HIT Product List (CHPL) validates the product's CMS EHR Certification number. However, with the additional requirement of

certification for specific years, Minnesota's contractor, CGI, has added a check for the correct certification to the MEIP portal. As CMS updates or changes rules that impact the incentive program, the MI360 portal is changed, and CMS approves the changes. The portal walks attesters through all of the requirements and exceptions, giving feedback to attesters if they are not meeting specific requirements, including the appropriate CEHRT for their attestation year.

6.2.12 Collection of Meaningful Use Data and Short/ Long-Term Approach

How will the SMA collect providers' meaningful use data, including the reporting of clinical quality measures (CQM)? Does the State envision different approaches for the short-term and a different approach for the longer-term?

DHS's portal collects meaningful use data and is now able to accept CQMs electronically. DHS is also:

- Expecting to have most of its data collection be done electronically, including CQMs and other reporting
- Planning to create, using SIM and 90/10 HITECH funds, an HIE for Medicaid providers to gain real-time information about their clients through an encounter alert system
- Continuing to assess the current capacity of HIE to address MU
- Continuing to refine the SMHP, MU criteria and collection/verification methods
- Finalizing the implementation of MU, including the collection and verification of CQM

6.2.13 Deferrable: Alignment with Other CQM Data

How will this data collection and analysis process align with the collection of other clinical quality measures data, such as CHIPRA?

Minnesota is aware of this reporting. MEIP's emphasis has been to facilitate use of the portal for EPs and EHs, which is why we have concentrated on the functionality of electronic CQM reporting.

What IT, fiscal and communication systems will be used to implement the EHR Incentive Program?

IT and Financial Systems

Through a contracted vendor (CGI) DHS constructed and implemented MEIP's web-based

application system on October 18, 2012.

- The year-one deliverable was state registration, eligibility determination, attestation, and AIU payment
- The year-two deliverable was MU attestation and clinical data submission.

The MEIP web application interfaces with the NLR and ONC's certified health IT product list.

Financial payments and reporting are handled through existing MMIS capabilities with the addition of a new MEIP payment code. The MMIS provider and claims databases verify providers' eligibility, such as licensing, sanctions, place of service, and Medicaid encounters. The MEIP web application system feeds approved payments to the Claims Module, which provides the MEIP's payment tracking and financial/fiscal reporting. DHS uses the standard CMS 64 Report to report administrative expenditures and provider payments under the EHR Incentive Program.

Communication System

DHS developed a MEIP communication plan to educate and inform key audiences of the EHR Incentive Program as the program moved into the implementation phase (Table 6.2.14A).

DHS established the MEIP website in January 2011. The website allows providers to link to the application and provides key program information, links and resources, including the hospital calculation spreadsheet.

DHS communicates with providers through email. Providers with questions can contact DHS using this email address or can contact the contractor's Business Services staff for more information about the program.

DHS communicates with providers through the MEIP e-listserv to those providers who have registered. The MEIP e-listserv informs providers of changes to the MEIP website, the program and webinar opportunities.

DHS also communicates with providers through e-mail via the MEIP system. DHS captures an applicant's e-mail address when s/he has registered with the NLR, and that will serve as an initial point of contact.

Table 6.2.14A: Communication Plan Highlights

Highlights
Objectives
<ul style="list-style-type: none"> • Create an awareness and understanding of the impact of EHR technology and meaningful use across Minnesota’s provider community.
<ul style="list-style-type: none"> • Build support (outreach) among providers and industry groups to support EHR technology and HITECH in general.
<ul style="list-style-type: none"> • Provide information to providers and other stakeholders to make the transition of EHR technology to meaningful use as seamless and advantageous as possible.
Strategies
<ul style="list-style-type: none"> • Use existing communications vehicles to provide information and keep audiences informed.
<ul style="list-style-type: none"> • Create and maintain a MEIP website, listserv, and e-mail box.
<ul style="list-style-type: none"> • As needed, use in-person and web-based information sessions and trainings with various stakeholder groups to ensure that everyone is well-informed.
<ul style="list-style-type: none"> • Partner with external organizations to promote standard approaches and state-wide resources.
<ul style="list-style-type: none"> • Clarify the financial impacts of the EP and EH application process, per organization (clinic) or per individual.
<ul style="list-style-type: none"> • Continue to leverage current communication channels through the MN e-Health Initiative and its work groups, MDH <i>MN e-Health Updates</i>, and other communications.
Key Messages
<ul style="list-style-type: none"> • Funds are available to EPs and EHs for AIU.
<ul style="list-style-type: none"> • Technical assistance is available through Minnesota’s MEIP team and Business Services.
<ul style="list-style-type: none"> • EHR can be successfully integrated into existing clinical systems or as a stand-alone system.
<ul style="list-style-type: none"> • EPs and EHs must meet Medicaid patient-volume thresholds to qualify, and must submit quality measurements to prove MU in future payment years.

2017 State HIT Plan
State of Minnesota
Department of Human Services

Highlights
Objectives
<ul style="list-style-type: none"> EHR results in improved health care quality, efficiency, and patient safety (includes care settings beyond those eligible for incentives).
<ul style="list-style-type: none"> Highlight state law that requires EHR technology by 2015.
<ul style="list-style-type: none"> Minnesota provides a website for the EHR Incentive Payments program.
Audiences
<ul style="list-style-type: none"> Current and potentially eligible EPs and EHS enrolled with Minnesota Health Care Programs (includes physicians (non-pediatricians and pediatricians), certified nurse midwives, dentists, optometrists, nurse practitioners, and physician assistants in FQHCs/RHCs/TUFs as well as acute care hospitals, critical access hospitals, and children’s hospitals).
<ul style="list-style-type: none"> Provider clinics and/or organizations that employ EPs.
<ul style="list-style-type: none"> DHS staff and legislators/legislative staff (as needed); CMS, other states, vendors, and the general public.
Tools
<ul style="list-style-type: none"> DHS public website, MEIP-specific website, listserv, and e-mail
<ul style="list-style-type: none"> MEIP Business Services email and call center
<ul style="list-style-type: none"> DHS Provider Call Center
<ul style="list-style-type: none"> Minnesota e-Health Initiative Advisory Committee
<ul style="list-style-type: none"> News releases, talking points, FAQs, Factsheets.
<ul style="list-style-type: none"> Targeted e-mails (internal and external), DHS Managers’ Memo, and DHS Today/iNET/ articles.
<ul style="list-style-type: none"> Hospital calculation spreadsheet

6.2.15 IT System Changes (First Payment Year)

What IT Systems changes are needed by the SMA to implement the EHR Incentive Program?

DHS contracted with CGI to develop a web-based solution for providers to complete Medicaid attestation and request first year payments and for providers to attest to meaningful

use and request payments for additional years. Specific features of the application are:

- Receive the provider's National Level Repository (NLR) data
- Validate data from the MMIS Provider Subsystem
- Conduct licensing, suspension, and sanctions checks through MMIS Provider Enrollment data
- Document attestations per final rule
- Calculate patient volume and payments
- Determine eligibility based on entered, calculated, and validated data
- Document denial, audit, and appeal processes
- Accept, store, validate, and exchange health and meaningful use information
- Authorize payments through the MMIS remittance advice module
- Create report summaries on registration, attestation, payment, audit activity, and patient volume
- Create notifications to providers regarding future payments
- Create notifications to the NLR regarding payments issued
- Upload the provider's supporting documentation

6.2.16 IT Modification Timeframe

What is the SMA's IT timeframe for systems and modifications?

DHS launched the web-based solution on October 18, 2012, to accept, store, and validate AIU and MU attestations and clinical data. When CMS introduces new rules that impact the incentive program, the MEIP portal is updated to accommodate the changes. So far every update has been implemented on the earliest date possible, according to CMS rules.

6.2.17 Interface with NLR

When does the SMA anticipate being ready to test an interface with the CMS National Level Repository (NLR)?

MEIP launched CMS registration in August 2012 and began receiving B6 registration files.

6.2.18 Plan for Accepting NLR Data

What is the SMA's plan for accepting the registration data for its Medicaid providers from the CMS NLR (e.g. mainframe to interface or another means)?

DHS processes the inbound and outbound interfaces between the MEIP system and CMS’s Registration and Attestation (R&A) system. Minnesota accepts the CMS NLR data on the MEIP portal.

6.2.19 Program Website

What kind of website will the SMA host for Medicaid providers for enrollment, program information, etc.?

The MEIP website, launched January 2011, provides users with key program information, links and resources, including the hospital calculation spreadsheet and a link to the MEIP portal for providers to attest to AIU and MU and upload supporting documentation online. The MEIP website also links to the CMS EHR Incentive Program website. The website URL is included in our presentations to stakeholder groups and is also referenced in communications from our partners at the Minnesota Department of Health.

Table 6.19.1A: Minnesota EHR Incentive Program Website Information as of 12.2016

Website Information as of 12.2016
Overview of the MEIP
<ul style="list-style-type: none"> • Key Milestones to Date
<ul style="list-style-type: none"> • Minnesota’s Phased Approach for MEIP Implementation
Definition of Eligible Professionals (EPs)
<ul style="list-style-type: none"> • Is my practice eligible to receive incentive payments?
<ul style="list-style-type: none"> • How much are the incentives for EPs?
Definition of Eligible Hospitals (EHs)
<ul style="list-style-type: none"> • Hospital Incentive Payment Calculation
<ul style="list-style-type: none"> • Hospital Calculation Spreadsheet (Sample)
Minnesota EHR Incentive Program (MEIP) - Provider Preparation
Provider Preparation for EHR Incentive Payment Audits
Reference Material
<ul style="list-style-type: none"> • Frequently Asked Questions

Website Information as of 12.2016
<ul style="list-style-type: none"> • MEIP Guidance Manual
<ul style="list-style-type: none"> • MEIP Payment Notification File Instructions
<ul style="list-style-type: none"> • Forms
<ul style="list-style-type: none"> • MEIP Presentations
<ul style="list-style-type: none"> • MEIP Meaningful Use Reference Materials
Additional Resources
<ul style="list-style-type: none"> • Links to MEIP Portal, Final Rule, CMS EHR sites, MN e-Health
<ul style="list-style-type: none"> • Website address: www.dhs.state.mn.us/ehrincentives

6.2.20 MMIS Modifications

Does the SMA anticipate modifications to the MMIS and if so, when does the SMA anticipate submitting an MMIS I-APD?

DHS did not modify MMIS to accommodate the incentive program.

- The MEIP system receives a provider demographics file from MMIS for provider verification and eligibility determination
- The MEIP system stores all NLR, with provider submitted and calculated data
- An interface between the MEIP system and MMIS was established to communicate payment and financial processes

DHS is working on system modernization of MMIS, but that project is completely separate from MEIP.

6.2.21 Call Centers, Help Desk and Related Assistance

What kinds of call centers/help desks and other means will be established to address EP and hospital questions regarding the incentive program?

DHS has established a MEIP call center. In this system, provider calls will be routed to staff specially trained in MEIP policies and procedures. Call center staff will:

- Field calls from EPs, using MEIP scripts and talking points developed by MEIP program staff or vendor

- Advance especially complex calls to the MEIP program team staff as needed
- Field calls from EHs, using MEIP scripts and talking points developed by MEIP program staff or vendor including hospital calculation calls

The Minnesota Health Care Programs (MHCP) Health Care Provider Call Center staff are trained to answer calls for MHCP enrollment and to create and maintain provider affiliations. The Health Care Provider Call Center will direct all other questions to the MEIP Business Services staff.

6.2.22 Appeals Process

What will the SMA establish as a provider appeal process relative to: a) the incentive payments, b) provider eligibility determinations, and c) demonstration of efforts to adopt, implement, or upgrade and meaningfully use certified EHR technology?

DHS has developed a comprehensive appeal process in accordance with EHR final regulations, with the following purpose and scope.

Purpose: to allow providers to appeal incentive payments, incentive payment amounts, provider eligibility determinations, and the demonstration of AIU and MU of certified EHR technology in accordance with CFR 447.253(e).

Scope: This process is available to EHs, EPs or the clinic administrator involved in submitting a clinic level application to the MEIP.

The MEIP appeals process can be found in statute at [Minn. Stat. § 62J.495 Subds. 11 to 15](#).

6.2.23 Accounting for Federal Funding

What will be the process to assure that all Federal funding, both for the 100% incentive payments, as well as the 90% HIT Administrative match, are accounted for separately for the HITECH provisions and not reported in a commingled manner with the enhanced MMIS-FFP?

The 100% incentive payments and 90% HIT administrative match are accounted for separately. The MMIS Claims Module has a unique EHR incentives payment code and makes payments following standard MMIS claims policies and procedures. The Claims Module also provides another validity check of providers' tax identification number, and the CMS-64 financial report shows payments in a separate line item.

The 90% HIT administrative match is tracked separately through distinct budget accounts. A separate account will be established if MMIS modifications become necessary (though

unlikely). Separate project codes with these accounts separate ARRA project expenses for the planning and implementation phases.

6.2.24 EHR Payment Frequency

What is the SMA's anticipated frequency for making the EHR payments (e.g. monthly, semi-monthly, etc.)?

EHR payments are anticipated to be made every two weeks on the same published schedule as all Minnesota Medicaid claims. The schedule lists the submission deadline for receiving payment in the next biweekly cycle. The EHR pre-payment verification process is anticipated to occur within the published schedule.

6.2.25 Assuring Direct Payments without Deduction or Rebate

What will be the process to assure that Medicaid provider payments are paid directly to the provider (or an employer or facility to which the provider has assigned payments) without any deduction or rebate?

The HIPAA-required remittance advice (RA) lists EHR payments as gross adjustments. Minnesota Medicaid providers receive their RAs in one of the following formats:

- Human readable PDF file placed in the provider's MN-ITS mailbox
- X12 835 batch file placed in the provider's MN-ITS mailbox

DHS leverages a mailbox application within the DHS provider portal named 'MN-ITS' to send a MEIP payment notification file to the assigned payee. The notification is a supplement to the payee's remittance advice and provides the NPI of the EP or EPs who assigned payment to the payee. Additionally, the MEIP system notifies the provider of payment approval or denial after the pre-payment verification process.

6.2.26 Assuring Payments go to an Entity Promoting EHR Adoption

What will be the process to assure that Medicaid payments go to an entity promoting the adoption of certified EHR technology, as designed by the state and approved by the US DHHS Secretary and made only if participation arrangement is voluntary by the EP and that no more than 5% of such payments is retained for costs unrelated to EHR technology adoption?

Minnesota has no state-designated entities.

6.2.27 Disbursing Payments through MCOs

What will be the process to assure that there are fiscal arrangements with providers to disburse incentive payments through Medicaid managed care plans does not exceed 105% of the capitation rate per 42 CFR § 438.6, as well as a methodology for verifying such information?

Minnesota does not disburse payments through managed care organizations. All payments are to provider TINs.

6.2.28 Assuring Payments Conform with Statute and Regulation

What will be the process to assure that all hospital calculations and EP payment incentives (including tracking 15% of the net average allowable costs of certified EHR technology) are made consistent with the statute and regulation?

The MEIP system calculates and verifies the EP payments before sending payment authorization to MMIS. Hospital payments conform to the final rule's formula and will be calculated in accordance with 42 CFR § 495.310. The formula can be calculated by the provider prior to submission using the Minnesota EHR Hospital Incentive Payment Calculation Spreadsheet. Providers enter the calculations into the MEIP system. The MEIP system calculates and verifies the EH payments before sending payment authorization to MMIS. In verifying hospital data, DHS uses MMIS data and provider uploaded supporting documentation including:

- MMIS payment and utilization data
- Provider cost reports
- Minnesota Hospital Annual Report (HAR)
- MMIS payment and utilization information
- Hospital financial statements and hospital accounting records

The MMIS Claims Module makes all incentive payments, ensuring conformity with the statute and regulation. Legislative changes subsequent to the publication of the final rule remove the requirement for calculating the net average allowable cost.

Eligible Hospital and Eligible Professionals Audits and Appeals:

Minnesota designates the Centers for Medicare & Medicaid Services (CMS) to conduct all audits and appeals of a dual-eligible hospital's meaningful use attestation on the State's behalf. This option does not extend to Medicaid eligible professionals. In addition, Minnesota

will remain responsible for auditing all other aspects of eligibility for both eligible professionals and eligible hospitals for incentive payments, including, but not limited to:

- Adopt, implement, or upgrade
- Patient volume
- Average length of stay
- Calculation of payment amounts
- Auditing eligible professionals for compliance with meaningful use of certified EHR technology

System Updates:

The MEIP system is updated to accommodate the changes the state requests or that are required by CMS rule changes. This includes, but is not limited to:

- Update the revised MU measures with new final rules
- Allow the selection of the reporting period for patient volume to be either the previous payment year or the most current twelve months
- Update the definition of practice predominately for EPs attesting at an FQHC/RHC
- Allow providers to use zero-pay and denied claims in their calculation of patient volume

Minnesota's contracted portal vendor, CGI, Inc. provides screen shots of changes for CMS approval.

Communication and Outreach Plan:

In order to communicate to providers about the CMS Modified Stage 2 Final Rule, Minnesota Medicaid engaged providers through several activities, including, but not limited, to:

- Updating and developing web page and educational content, including updating language and adding additional resources specific to Modified Stage 2 Final Rule.
- Reaching out to stakeholders to discuss the Modified Stage 2 implementation timeline and specific program changes through a targeted mailing, as well as outreach through selected provider organizations and direct provider calling.

6.2.29 Role of Existing SMA Contractors

What is the role of existing SMA contractors?

Minnesota is a self-administered state for the Medicaid Management Information System

(MMIS), Post-service Prepayment Audit (PPM) and managed care organizations (MCOs).

6.2.30 Assumptions

States should explicitly describe what their assumptions are, and where the path and timing of their plans have dependencies based upon: a) the role of CMS (e.g. the development and support of the National Level Repository, provider outreach/help desk support), b) the status/availability of certified EHR technology, c) the role, approved plans and status of the Regional Extension Centers, d) the role, approved plans and status of the HIE cooperative agreements, and e) state-specific readiness factors.

The most immediate dependency is, upon receipt, CMS approving Minnesota's SMHP and IAPD updates as quickly as possible. DHS will ensure timely response to any concerns raised during the review process. Many other dependencies are functioning well:

- Successful testing with NLR
- Minnesota providers able to acquire certified EHR systems
- Minnesota stakeholders, agencies and providers participating on the Minnesota e-Health Advisory Committee
- State-certified HIOs and HDIs providing HIE services
- Provider and hospital adoption of e-prescribing and all Medicaid provider adoption of interoperable EHRs

DHS assumes that CMS and ONC will:

- Continue to develop the NLR and all appropriate interfaces
- Provide pre-populated NLR information on the Minnesota application
- Provide policy clarifications and educational materials (e.g., updated CMS website, tip sheets for providers and hospitals, FAQs)
- Maintain list of certified EHR providers

DHS further assumes that it will continue to:

- Build upon the state's long history in implementing statewide HIE, HIT, and EHR initiatives
- Leverage the MN e-Health Initiative work and infrastructure to improve HIT/EHR record access, outcomes measurement, and administrative efficiency
- Develop plans to access HITECH 90/10 funding to improve HIE abilities within Minnesota

7. THE STATE'S AUDIT STRATEGY (SECTION D)

7.1 Summary

The MEIP audit strategy is updated annually and has been approved by CMS. EPs and EHs participating in the program are subject to pre-payment verification and post-payment audits to ensure payments are expended in a proper manner and for a proper purpose. The intent of the audit strategy is to provide a consistent approach and uniform results when completing EP and EH prepayment verifications and post-payment audits. This required that all aspects of the audit strategy be planned, including audit criteria, scope, and methods.

To meet this objective, DHS developed an audit strategy providing adequate oversight, which includes risk assessments and randomly sampled post-payment audits for each EP and EH risk category. The audit strategy focuses on provider eligibility requirements, payment calculations, monitoring and verification, overpayments, disputes and appeals, and the detection and prevention of fraud, waste, and abuse. Therefore, DHS developed and implemented the necessary program integrity activities needed to provide this level of assurance.

1. The audit strategy was developed based upon the specifications for financial oversight and monitoring of expenditures recommended in the CMS Audit Strategy Toolkit.
2. Collect and verify basic information on Medicaid providers to assure provider enrollment eligibility upon enrollment or re-enrollment to MEIP.
3. Collect and verify basic information on Medicaid providers to assure patient volume.
4. Collect and verify basic information on Medicaid providers to assure that EPs are not hospital-based, including the determination that substantially all health care services are not furnished in a hospital setting, either inpatient or outpatient.
5. Collect and verify basic information on Medicaid providers to assure that EPs are practicing predominantly in a Federally-Qualified Health Center (FQHC) or Rural Health Clinic (RHC) or Tribal and Urban Facility (TUF) when EP attests to Medicaid patient volume including "needy" encounters.
6. Have a process in place to assure that Medicaid providers who wish to participate in MEIP have a National Provider Identifier (NPI) and will choose only one program from which to receive the incentive payment using the NPI, a Tax Identification Number (TIN), and CMS' national provider election database.

7.2 Pre-payment Verification

DHS has contracted with CGI to conduct provider eligibility verifications and pre-payment attestation reviews. Eligibility verifications and pre-payment attestation reviews are in response to an array of audit criteria triggers built into the MI360® portal and are completed by collecting and disseminating data, e.g., provider type, license status, patient volume, and practice location.

All verifications and attestation reviews are conducted by CGI staff to ensure each provider is eligible to receive the incentive payment. When additional documentation or evidence is needed, CGI will contact the provider to request added records that will be uploaded into the MI360® portal.

In addition, CGI reviews EH attested payment calculations by collecting and reviewing Medicare cost reports (MCRs) and patient census data. Lastly, CGI performs a 100% AIU & MU review on behalf of DHS for every EP, EP group, and EH who attests to the program.

7.3 Post-Payment Audit Strategy

MEIP conducts post-payment audits of EHR incentive payments consisting of desk audits or field audits, or both. For quality control, post-payment audits may re-review the pre-payment process, or a sampling thereof. Post-payment audits will address issues not covered during the pre-payment verification process, either because the level of risk is measured too low, the review would be too cumbersome or complicated to accomplish within an acceptable time frame, or both. The number of post-payment audits will be based upon a random selection from a risk assessment and those providers flagged during the pre-payment verification process, providers with past audit issues or sanctions, or fraud.

In the first participation year, the procedures focus on obtaining documentation supporting eligibility assertions made by EPs and EHs, as well as documentation supporting the payment amount made to hospitals. A provider selected for a post-payment audit may be required to present additional documents that will support the provider attestation MPV, MU, and/or other CEHRT data offered by the provider to determine eligibility during the attestation process. This documentation will be used to verify that the provider did not receive an improper payment. In subsequent participation years, this activity will also include procedures to obtain documentation which provides reasonable assurance that EPs meaningfully used certified EHR technology. Meaningful use reviews for dual eligible and Medicaid only EHs will be performed by CMS.

After the completion of the post-payment audit MEIP delivers to the provider, or the

provider's designee, the final audit notice, including adverse audit findings or recommendations. An EP or EH who has received notification of an adverse action may appeal the action pursuant to Minnesota Statutes Section 62J.495, subdivision. 12 to subdivision 15.

Providers that are not flagged for a mandatory post-payment audit or for a randomly selected post-payment audit during the risk assessment process will remain subject to an audit for a period of up to six years after disbursement of the MEIP incentive payment.

7.4 Appeals Process

To appeal, the provider shall file with the commissioner a written notice of appeal. The appeal must be postmarked or received by the commissioner within 30 days of the date of issuance specified in the notice of action regarding the appealable issue. The appeals process pursuant to Minnesota Statutes Section 62J.495, subdivision 12 to subdivision 15, described below is subject to change based on Minnesota legislation.

1. Upon receipt of an appeal notice satisfying Minnesota Statutes, chapter 62J, section 495, subdivision 14, the commissioner of human services shall review the appeal and issue a written appeal determination on each appealed item within 90 days. Upon mutual agreement, the commissioner and the provider may extend the time for issuing a determination for a specified period. The commissioner shall notify the provider by first class mail of the appeal determination.
2. In reviewing the appeal, the commissioner may request additional written or oral information from the provider.
3. The provider has the right to present information by telephone, in writing, or in person concerning the appeal to the commissioner prior to the issuance of the appeal determination within 30 days of the date the appeal was received by the commissioner. The provider must request an in-person conference in writing, separate from the appeal letter. Statements made during the review process are not admissible in a contested case hearing absent an express stipulation by the parties to the contested case.
4. For an appeal item on which the provider disagrees with the appeal determination, the provider may file with the commissioner a written demand for a contested case hearing to determine the proper resolution of specified appeal items. The demand must be postmarked or received by the commissioner within 30 days of the date of issuance specified in the determination. A contested case demand for an appeal item nullifies the written appeal determination issued by the commissioner for that appeal item. The

commissioner shall refer any contested case demand to the Office of the Attorney General.

5. A contested case hearing must be heard by an administrative law judge according to Minnesota Statutes, chapter 14, sections 14.48 to 14.56. In any proceeding under this section, the appealing party must demonstrate by a preponderance of the evidence that the Minnesota electronic health record incentives program eligibility determination is incorrect.
6. Regardless of any appeal, the Minnesota electronic health record incentives program eligibility determination must remain in effect until final resolution of the appeal.
7. The commissioner has discretion to issue to the provider a proposed resolution for specified appeal items upon a request from the provider filed separately from the notice of appeal. The proposed resolution is final upon written acceptance by the provider within 30 days of the date the proposed resolution was mailed to or personally received by the provider, whichever is earlier.

8. MINNESOTA'S HIT ROADMAP (SECTION E)

8.1 Introduction

Minnesota has had a vision for e-health and health information exchange for over ten years, as evidenced by the existence of the e-Health Initiative and the e-Health Summit, both of which are in their 12th year. Minnesota received one of the early State Innovation Model (SIM) awards because of its creative approach to health care delivery and to payment reform. Providers participating in Minnesota's ACOs are taking on increased accountability for cost and quality outcomes, heightening the imperative for these providers to coordinate care with any other members of a patient's care network. Minnesota welcomed the guidance in State Medicaid Director letter 16-003 that supported inclusion of activity with Medicaid providers who are not eligible for incentive payments as they are critical partners in helping EP and EHs meet meaningful use objectives.

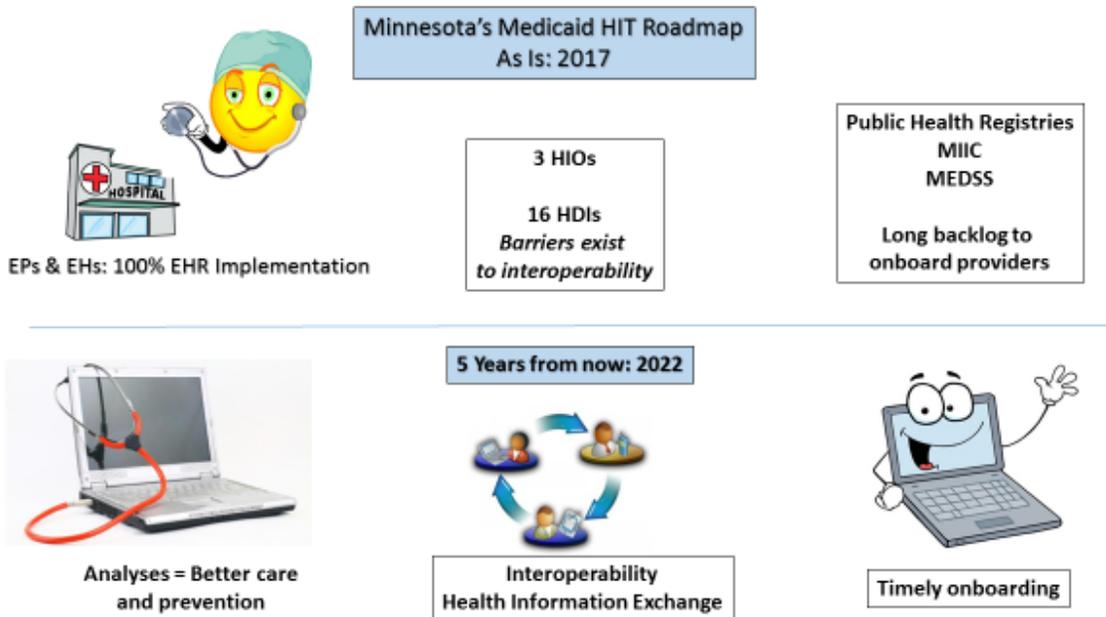
8.2 Response to CMS Questions

The e-health environment has changed in Minnesota since the MEIP started. This section is an update of the HIT roadmap.

8.2.1 Narrative Pathway

Provide CMS with a graphical as well as narrative pathway that clearly shows where

the SMA is starting from (As-Is) today, where it expects to be five years from now (To-Be) and how it plans to get there.



In 2017, Minnesota’s Medicaid providers are technologically ready to use their EHRs to meet the triple aim: improve the patient experience and population health while reducing total cost of care. Almost 100% of Minnesota’s physicians and hospitals have implemented and are using certified EHR technology. With its market approach to HIE, Minnesota has three HIOs and 16 HDIs to assist in health information exchange. However, barriers to true interoperability still exist.

The top five barriers and possible solutions are as follows:

- Challenges to HIE implementation (e.g., workflow). Potential solution: provide guidance and education on implementing priority transactions and integrating HIE into practice, with options for when HIE integrates into EHR, does not integrate into EHR, or when provider does not have an EHR.
- Establishing partner relationships/agreements is often difficult, time-consuming and costly. Potential solution: build on others’ experiences, sharing lessons learned to establish “rules of the road” for information sharing.
- Key transactions need to be prioritized (e.g., notification and alerting) to support implementation statewide. Potential solution: prioritize HIE transactions for

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implementation (e.g. ADT, CCD - as ranked by HIE workgroup) so providers and State-Certified HIE Service Providers can focus on those priorities.

- Competing organizational priorities. Potential solution: review and identify potential policy levers that could help advance HIE statewide.
- Minnesota HIE approach is not fully implemented. Potential solution: convene State-Certified HIE Service Providers (Minnesota Health Information Network- MNHIN) to identify options for developing and implementing core HIE functions and transactions.

In 5 years:

1. HIE among Medicaid providers, sharing admit, discharge, or transfer information
2. Interoperable EHRs – 75% - actual health info exchange
3. Behavioral health and long term care providers - 50% usage

Integrated Health Partnerships (IHP) – Minnesota’s IHPs are an accountable care model that incentivizes health care providers to take on greater financial accountability for the cost of care for Medicaid patients. In an IHP, DHS contracts directly with providers in a new way that allows them to share in savings for reducing the cost of care for enrollees while maintaining or improving quality of care and patient experience. IHPs include flexible risk models based on the size of your organization to ensure broad participation, while building off of current payment and care delivery reform efforts and structures to work within existing FFS and managed care structures to allow faster implementation timelines. IHPs align with payments models in the commercial market as well as other merging national models to drive delivery system transformation where possible.

The Minnesota Department of Health has also been approved for the use of HITECH 90/10 funding for two major HIE/HIT projects, the Minnesota Immunization Information Connection and the Minnesota Electronic Lab Reporting for use as specialized registries to help providers meet the requirements for meaningful use.

Minnesota’s Medicaid EHR Incentive Program has been paying eligible hospitals and providers since November 2012. In total, as of March 23, 2017, 126 eligible hospitals have been paid \$126,086,971 and 3,394 unique eligible professionals have been paid \$84,060,800.

Minnesota’s EHR incentive program intends to build on this momentum to achieve the “To-Be” goals.

To-Be

Minnesota’s five-year goals are:

Goal 1: Achieve 80% eligible provider and eligible hospital return for meaningful use by the end of payment year 2018.

Because program year 2016 is the final year to attest to the Medicaid incentive program for the first time, program years 2017 and following will have emphasis on provider returns. One qualifier is that hospitals are only paid for three years, so most of Minnesota's hospitals will have completed their participation with program year 2016. Otherwise, looking at all of the potential returnees, MEIP will work to encourage EPs to re-attest throughout the life of the program (2021 or six years of payments.)

Goal 2: Support ongoing Meaningful Use criteria through 2021

DHS's goal is to support the electronic exchange of MU transactions through all current and future stages of MU as defined through future rule making.

Goal 3: Support Minnesota's goal for HIE within the Medicaid patient and provider population through the use of EAS and ADT.

Minnesota is in the planning stages for the implementation of an encounter alert system for Medicaid providers. This system, once functional, will provider alerts to participating providers relating to admit, discharge, and transfer of all Medicaid patients within the state. Minnesota is currently utilizing funds through the SIM grant for the request for proposal of this initiative. Work on this project will be a stepping stone to implementation of further HIE projects within the state.

Goal 4: Further the adoption of EHR technology throughout the full continuum of care, including long-term care and behavioral health.

DHS is seeking to increase EHR use among all Medicaid providers, with or without federally-financed EHR incentives because of the critical need for the HIE to have comprehensive patient data. The primary effort is adding the broader range of care settings regardless of available incentives. DHS is already supporting this through its own efforts through Direct Care and Treatment.

Pathway

Minnesota will achieve its five-year goals through:

- Maximizing eligible hospitals' and providers' participation in AIU and meaningful use through financial incentives

- Outreach by the MEIP team to encourage completion of the EHR incentive program to providers/hospitals that have previously attested but chose to discontinue their participation
- Collaboration with the MDH e-Health Initiative to promote the use of HIE/HIT and any projects we may initiate in the future
- Use of HITECH 90/10 funding for state projects to complete HIE/HIT projects currently underway as well as future projects Minnesota may pursue
- Leveraging value-based payment initiatives and associated contracts to encourage use of e-health data and provide a possible sustaining source in the future for the infrastructure after implementation

8.2.2 SMA Expectations re: Provider EHR Technology Adoption

What are the SMA’s expectations regarding provider EHR technology adoption over time? Annual benchmarks by provider type?

Almost nine in ten (87%) ambulatory clinics and two-thirds of acute care hospitals have partially or fully adopted EHR technology (Section A), though not all systems are ONC certified. Minnesota law mandates all health care providers to have a certified EHR by January, 2015.

Table 8.2.2A: SMA goals for eligible vendor EHR adoption

Provider Type	2010	2011	2012	2013	2014	2015	2016
Eligible providers	75%	80%	85%	87%	92%	100	100
Eligible hospitals	66%	75%	85%	87%	92%	100	100

2013 percentages are based on survey data of all clinics and hospitals. See Section A, Question 1: “Data on Current EHR Adoption.”

DHS will actively target small providers, who likely require technical assistance, and all hospitals, which receive the largest incentive payments.

8.2.3 Annual Benchmarks for SMA Goals

Describe the annual benchmarks for each of the SMA’s goals that will serve as clearly measurable indicators of progress along this scenario.

Table 8.2.3A presents the annual benchmarks, which are tracked quarterly and adjusted based on actual experience.

Table 8.2.3A: SMA Preliminary Annual Benchmarks

Goal	2016	2017	2018	2019	2020	2021
EPs with EHR	100%	100%	100%	100%	100%	100%
EHRs with EHR	100%	100%	100%	100%	100%	100%
MN health care program providers exchanging information outside their system	60%	65%	70%	75%	80%	85%

The MEIP registration system contains these reports:

- Registration Summary (including provider specific demographics)
- Attestation Summary (including complete and incomplete)
- Payment Summary
- Audit Activity
- Medicaid Patient Volume Summary
- Payment Request File Summary
- Inactive Registration Summary (to identify providers who completed the NLR registration at least 30 days ago but have not completed the Minnesota registration)

8.2.4 Annual Benchmarks for Audit and Oversight Process

Discuss annual benchmarks for audit and oversight activities.

CMS requires that MEIP’s auditor perform post-payment audits based on a percentage of incentive payments disbursed each year. To meet this objective, DHS has developed an audit strategy providing adequate oversight, which includes risk assessments and randomly sampled post-payment audits for each EP risk category. With the current auditing methodology it is difficult to speculate the number or types of audits that will be performed. The selection process is performed annually. Meaningful use reviews for dual eligible and

Medicaid only EHs will be performed by CMS.

For quality control, post-payment audits may re-review the pre-payment process, or a sampling thereof. In addition, a provider selected for a post-payment audit may be required to present additional documents that will support the provider attestation MPV, MU, and/or other CEHRT data offered by the provider to determine eligibility during the attestation process. MEIP may perform either post-payment audits consisting of desk audits or field audits, or both. Providers that are not flagged for a mandatory post-payment audit or for a randomly selected post-payment audit during the risk assessment process will remain subject to an audit for a period of up to six years after disbursement of the MEIP incentive payment.

Post-payment audits began in the second payment year. As of January 2017, MEIP is reviewing incentive payments disbursed in 2015. We are attempting to shorten the period between the actual incentive payment and post-payment audit, and anticipate performing 2016 audits in late 2017.

9. APPENDIX A: SELECTED ACRONYMS

Acronyms are spelled out the first time used. For the convenience of readers, acronyms which are repeated frequently, or in multiple sections after their first use are listed here for quick reference.

Acronym	Term
ADT	Admission, Discharge, Transfer
AIU	Adopt, Implement, Upgrade
ARRA	American Recovery and Reinvestment Act
CAH	Critical Access Hospital
CCN	CMS Certification Number
CEHRT	Certified EHR Technology
CHIC	Community Health Information Collaborative
CHIPRA	Children's Health Insurance Program Reauthorization Act
CHPL	Certified Health Information Technology Product List
CMS	Centers for Medicare & Medicaid Services
CPOE	Computerized Physician Order Entry
CQM	Clinical Quality Measures
DHS	Department of Human Services

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Acronym	Term
EAS	Encounter Alert System
EH	Eligible Hospitals
EHR	Electronic Health Record
EP	Eligible Professional
ESB	Enterprise Service Bus
FFP	Federal Financial Participation – The percentage of budgeted money that CMS will pay. For HITECH projects, it is 90%.
FFS	Fee for Service
FQHC	Federally-Qualified Health Center
HDI	Health Data Intermediary
HIE	Health Information Exchange
HIO	Health Information Organization
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	Health Information Technology
HITECH	The Health Information Technology for Economic and Clinical Health
HRSA	Health Resources Services Administration
IAPD	Implementation Advanced Planning Document
IHP	Integrated Health Partnership, formerly Health Care Delivery System
IT	Information Technology
MA	Medical Assistance (Medicaid in MN)
MCO	Managed Care Organization
MDH	Minnesota Department of Health
MEIP	Medicaid Electronic Health Record Incentive Program
MHCP	Minnesota Health Care Program
MIIC	Minnesota Immunization Information Connection
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information Systems
MN-ITS	Minnesota Information Transfer System
MU	Meaningful Use
NPI	National Provider Identifier

Acronym	Term
OIG	Office of Inspector General
ONC	Office of the National Coordinator for Health Information Technology
SIM	State Innovation Model

10. GLOSSARY

Adopt, implement or upgrade (AIU) – (1) Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements; or (2) Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training.

American Recovery and Reinvestment Act (ARRA) – The 2009 federal economic stimulus package that contains an investment of \$59 billion in health care initiatives, including \$19 billion in health information technology (IT). The health IT provisions of ARRA are found primarily in Title XIII, Division A, Health Information Technology and in Title IV of Division B, Medicare and Medicaid Health Information Technology. These titles together are cited as the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Attestation – Confirmation by a provider that they have met the meaningful use standards. During the first year of incentive payments, eligible professionals and hospitals are allowed to provide attestation, or a confirmation of their compliance with the meaningful use standards. The state will verify the attestation when specific compliance criteria are developed.

Certified EHR Technology – electronic health record that has been certified by the Office of the National Coordinator for Health Information Technology (ONC) as meeting Federal requirements. Eligible providers and hospitals must be using CEHRT to qualify for the incentive program.

Certified HIT Product List (CHPL) - provides the authoritative, comprehensive listing of Complete EHRs and EHR Modules that have been tested and certified under the Temporary Certification Program maintained by the Office of the National Coordinator for Health IT (ONC). Each Complete EHR and EHR Module listed has been certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) and reported to ONC. Only the product versions that are included on the CHPL are certified under the ONC Temporary Certification Program.

e-Health – The secure use of electronic information and communications technologies in support of health care delivery, such as electronic health records, electronic prescribing, health information exchange, and telemedicine.

e-Prescribing – The electronic transmission, not including facsimile transmission, of clear and accurate prescriptions bi-directionally to / from pharmacies and the point-of-care; prescribers can also review drug and formulary coverage. E-prescribing software can be integrated into existing clinical information systems to allow physician access to patient-specific information to the screen(s) for drug interactions and allergies.

Electronic Health Record (EHR) – An electronic record of health-related information for an individual that conforms to nationally-recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.

Electronic Health Record (EHR) Incentive Program – A program to pay incentives to certain classes of eligible Medicare and Medicaid professionals and hospitals who adopt and become meaningful users of electronic health records in their day-to-day medical practice. Authorized by the American Recovery and Reinvestment Act of 2009 (Section 4201).