



State of Maine

Department of Health & Human Services (DHHS)

Office of MaineCare Services

State Medicaid Health Information Technology Plan

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MAINE SMHP INTRODUCTION AND EXECUTIVE SUMMARY

This document is Maine’s State Medicaid Health Plan (SMHP) which serves as the “vision” for the future of the State’s health information technology environment.¹ Maine’s Implementation Advance Planning Document (IAPD) which is the “action plan” to implement the vision was submitted in draft form in April 2011.

Combined, the SMHP as the vision, and the IAPD as the action plan, provide the framework of the Maine Medicaid HIT program. The SMHP and IAPD should be read and understood in the context of being aligned and integrated with the broader Maine State-wide HIT initiative.

As background, America’s health care system has developed from many independent networks at the local, state and national levels in both the public and private sectors. As the health care system became increasingly fragmented and costly, over the past several decades, different approaches were attempted to manage costs, integrate health care, and improve quality of care. While done with good intentions, these approaches relied heavily on paper documents and did not result in truly integrated care or full patient involvement in health care decisions. They also did not produce a system of electronic reporting mechanisms that would enable patients, the medical community, and decision-makers, to fully measure quality and to improve health outcomes.

The 2009 federal Health Information Technology for Economic and Clinical Health (HITECH) Act² brings health information technology into the 21st century. Its goal is improve general population health, encourage better health care through quality outcomes, and expand patient involvement in managing their own care through the use of health information technology.

The HITECH provides a three-prong approach to health information technology:

Office of the State Coordinator—The Office of the State Coordinator (OSC) oversees and facilitates the state-wide health information technology efforts, including data, systems and the exchange of health data. The Federal Office of the National Coordinator designates organizations, called Regional Extension Centers that provide technical assistance and access to lower-cost electronic health record (EHR) systems for providers.

Medicaid HIT Program—Health Information Technology programs designed and operated by a state’s Medicaid agency. States develop HIT visions and obtain approval from CMS for funding for incentive payments paid to eligible hospitals and professionals who employ electronic health information technology that is certified by the federal government to meet certain quality and use standards and requirements.

Medicare HIT Program—A program overseen by the federal Medicare agency that similar to the Medicaid HIT program, provides a Medicare vision and an incentive payment program tied to quality and use standards and requirements.

¹ The State submitted a draft SMHP in October 2010. CMS provided written comments in December 2010 which were incorporated into a draft version 2 SMHP that was submitted in January 2011. CMS provided additional comments in April, 2011 advising the State to address the comments in a final SMHP. CMS approved Maine’s SMHP on May 2, 2011. This document addresses the CMS April 2011 comments and is the final Maine SMHP.

² The HITECH Act is part of the 2009 American Recovery and Reinvestment Act (ARRA).

Maine’s HITECH efforts include both the Medicaid and the OSC prongs. In April 2008, before the HITECH Act was passed, Maine published its 2008-2009 State Health Plan which is the vehicle used across State agencies to promote consistency in State health policy. The State Health Plan was the result of a public and private joint effort that included government officials, the medical community, patients, advocates, quality organizations, and others. The goals of the State Health Plan are to promote the highest possible health for all Maine residents, with an efficient, effective and high-performing health delivery system.

When the OSC was established in March 2009, it used a collaborative approach to build on the State Health Plan, to develop an integrated OSC Strategic Plan. The Governor formed an OSC Steering Committee that developed the OSC Strategic Plan as a framework for implementation priorities and long term goals for health information technology throughout the State of Maine.

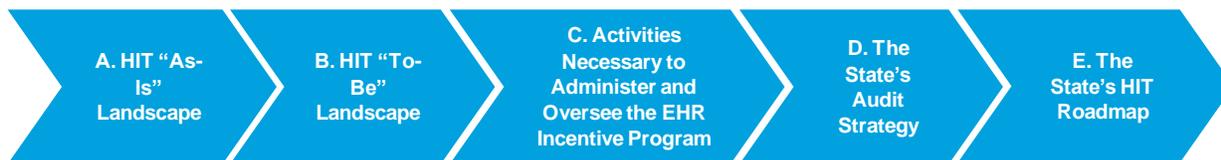
On a parallel track, in May 2009, Maine began its Medicaid HIT program planning effort. Working closely with Maine’s OSC, and using the same collaborative framework and many of the individuals and groups who were participating in the OSC effort, MaineCare performed its advanced planning activities.³

While the parallel initiatives framework worked well, as the planning process of the two programs matured, it became evident that full integration and coordination of the Medicaid SMHP with the OSC Strategic Plan efforts was critical to meet the goals of the federal and State HIT visions. As a result, Maine recently improved its organizational structure by making the OSC a direct report to the DHHS Commissioner and placing the Medicaid HIT program and staff under the leadership of the Director of the Office of the State Coordinator.⁴

Maine’s hard work resulted in this document-- the State Medicaid Health Plan (SMHP). The SMHP is a comprehensive document that provides the framework for the State to oversee the Medicaid HIT program. At the high level, it identifies the vision, goals, and objectives of the Medicaid HIT program for the next five years. At the “ground” level, the SMHP provides the criteria and process for eligible hospitals and medical providers (“Eligible Professionals”) to receive incentive payments to purchase, install, begin use, or improve current electronic records (“Adopt, Implement, or Upgrade”) using technology that meets federal standards (“Certified”). It also lays the foundation to use the technology to improve the integration and quality of health care (“Meaningful Use”). The SMHP also describes the State’s oversight functions including reporting, audit, recoupment, and fraud-prevention measures.

The SMHP serves as the vision for the future state of the Medicaid HIT environment. Its roots are found in the goals of health information exchange and meaningful use under the HITECH Act. In addition to the SMHP, Maine is submitting an IAPD which is the “action plan to implement” the SMHP.

The body of the SMHP is divided into five Sections followed by a conclusion and appendices:⁵



³ Maine’s PAPD was approved by CMS in January 2010 and a PAPD-U was approved by CMS in October 2010.

⁴ The Office of the State Coordinator had been a direct report to the Director of the Center for Disease Control within the Department of Health and Human Services.

⁵ See Appendix A-1 for CMS questions posed to states to answer in their SMHP document.

SECTION A. HIT “AS-IS” LANDSCAPE

The “As-Is” Landscape Assessment provided MaineCare with the baseline of health information technology in Maine. The key tasks performed included a review of Maine’s new MMIS (MIHMS) and Maine’s application inventory; a survey of the status of EHR adoption and any plans for improvement of EHR use by providers; and an examination of the degree to which all State HIT initiatives are aligned.

SECTION B. HIT “TO-BE” LANDSCAPE

Maine’s “To-Be” Medicaid HIT Landscape for 2015 is rooted at two levels:

Visionary level: What the ideal Medicaid health care system looks like--one that provides truly integrated care and improves quality and health outcomes--and how information technology could be improved and used to achieve that “ideal.”

Five Year Level: What the opportunities that the HITECH Act and federal and state cooperative efforts across the spectrum of HIT offer and how to best use these opportunities to build upon and improve health care access, efficiency, quality, and outcomes.

The HITECH Act provides the framework for improving health information technology. The structure of the programs established by the HITECH Act recognizes a federal/state partnership to build the HIT vision and to plan and implement that vision. The ONC vision which guides the 2012 federal efforts is:

A Nation in which the health and well-being of individuals and communities are improved by health information technology.

Maine’s state-wide HIT vision, developed through a collaborative process led by Maine’s OSC, is built upon the ONC’s framework. The State’s vision and mission are anchored in providing or facilitating a system of person-centered, integrated, efficient, and evidence-based health care delivery for all Maine citizens:

Preserving and improving the health of Maine people requires a transformed patient centered health system that uses highly secure, integrated electronic health information systems to advance access, safety, quality, and cost efficiency in the care of individual patients and populations.

The Medicaid HIT program used these two essential building block visions as a foundation for its vision which was developed with a particular emphasis on the children, elderly and disabled people served by Medicaid.

Visioning sessions were conducted with a broad spectrum of stakeholders across the State. Participants were provided background information including summaries of the HITECH Act and CMS rules and

guidance; information from the “As-Is” assessment; reports on other states’ HIT programs; and the Office of the State Coordinator’s HIT Strategic Plan. In addition to other “homework” participants were asked to think about and answer the visionary and five year level questions.

The questions were posed this way to invite the stakeholders to view their assignment without preconceptions and limitations. While everyone recognized that there are funding and technology constraints and that the fragmented history of health care delivery cannot be ignored, this was a time for visioning the ideal.

The question was asked of State agencies, MaineCare providers, members of the public, Office of Information Technology, Office of State Coordinator, State finance officials, quality associations, advocates, and individuals and groups that had participated in the OSC visioning process. These sessions and the thoughtful work done by all of the participants gave MaineCare an understanding of a common vision for the Medicaid HIT program in concert with other State-wide health information technology efforts and under the rubric of the OSC developed State HIT plan. The vision is:

A Medicaid program that employs secure electronic health information technology to provide truly integrated, efficient, and high quality health care to MaineCare Members, and to improve health outcomes.

SECTION C. ACTIVITIES NECESSARY TO ADMINISTER THE HER INCENTIVE PROGRAM

As a brand new initiative, the Medicaid HIT program provides many benefits yet presents the challenges that come from planning and implementing a new program and new technology. MaineCare spent a great deal of time defining the processes and activities necessary to administer the Medicaid HIT Program and used the framework that CMS provided for states to develop its “necessary activities” section of the SMHP: 1) Program Registration and Eligibility; 2) Payment; 3) Appeals; 4) Reporting; 5) Communication, Education and Outreach; and 6) State Oversight. MaineCare developed a step-by-step process flow to identify each activity needed to meet HER program technology and operations requirements and then for each activity, identified specific tasks and technologies to accomplish the activity.

SECTION D. AUDIT, CONTROLS AND OVERSIGHT STRATEGIC PLAN

Maine understands and respects the importance of oversight of the HIT program. MaineCare conducted a thorough examination of the Federal oversight requirements for Medicaid HIT programs which it used to develop its audit, controls, and oversight processes and requirements. Maine will use a risk-based auditing approach to help ensure program integrity, prevent making improper incentive payments, monitor the program for potential fraud, waste, and abuse, and recoupment procedures.

SECTION E. GAP ANALYSIS AND HIT ROADMAP

Maine compared its “As-Is” current-state with the “To-Be” future-state to identify what the State needs to do to plan and implement a successful Medicaid HIT Program. “Success” can only be met if the State

makes progress towards both the EHR incentive payment effort and the long- term HIT vision. The results of the gap analysis were fed into the HIT Roadmap and the Activities sections of the SMHP.

CONCLUSION AND APPENDICES

The SMHP concludes with a summary and appendices that supplement and provide more detail in support of the State Medicaid Health Plan.

SECTION A. “AS-IS” HIT LANDSCAPE

This section Maine’s “As-Is” HIT Landscape which serves as a current baseline assessment of the HIT and health information exchange (HIE) activities in Maine.⁶ This section is divided into eight parts:

Part	Summary
1. State Level HIT Governance	<ul style="list-style-type: none"> • Provides detail on the existing structures in place to facilitate HIT/HIE • Illustrates the role of Medicaid in the larger picture • Details role and responsibilities of the Office of the State Coordinator (OSC) and the State HIE
2. MITA Status	<ul style="list-style-type: none"> • Summary of the State of Maine MITA SS-A
3. DHHS HIT/HIE Technology Assets	<ul style="list-style-type: none"> • Includes an inventory of existing Medicaid HIT/HIE assets • Illustrates interoperability of Medicaid enterprise assets
4. DHHS Organizational Assets	<ul style="list-style-type: none"> • Includes an inventory of existing organizational assets • Describes the organizations that should be assessed when developing the plan to administer and oversee the Medicaid EHR incentive payment program
5. EHR Adoption	<ul style="list-style-type: none"> • Details results of provider surveys conducted regarding intent to participate in the EHR incentive payment program and EHR usage or acquisition
6. Parallel State Initiatives	<ul style="list-style-type: none"> • Describes other activities underway by MaineCare and DHHS with potential to influence the direction of HIT, HIE, and EHR technology adoption

⁶ The “As-Is” Assessment is based on the guidance provided by the CMS regional office, 42 CFR Parts 412, et al. Medicare and Medicaid Programs; Electronic Health Record (EHR) Incentive Program Final Rule, and the Medicaid Directors letter released on September 1, 2009 as well as subsequent guidance issued by CMS.

Part	Summary
7. HIE Initiatives	<ul style="list-style-type: none"> Describes other HIE activities underway across the State
8. Privacy and Security	<ul style="list-style-type: none"> Describes the privacy and security landscape of sharing data

Section A. Part 1. State Level HIT Governance

This Part of the “As-Is” Assessment focuses on the State governance model and how the Medicaid HIT plan fits within the model. CMS and the Office of the National Coordinator for HIT encourage State Medicaid Agencies to collaborate with statewide HIT/HIE planning efforts. The State is currently engaged in two major HIT planning and implementation efforts – the Statewide HIT Plan; and the State Medicaid HIT Plan. A key component of the State planning efforts is to establish a governance structure that supports both of the HIT planning efforts.

The Office of the State Coordinator (OSC) for HIT, established in 2009, is responsible for Statewide HIT/HIE planning, aligning the HIT planning efforts with the State Health Plan, ARRA Planning/Implementation, State Agency Coordination on all HIT related efforts, and financial and regulatory oversight of HIT initiatives. The governance structure of the OSC is: 1) State HIT Coordinator, 2) a 28-member Executive Steering Committee appointed by the Governor and Legislature,⁷ and 3) Standing Committees.

The OSC has a contractual relationship with HealthInfoNet (HIN), the designated Statewide HIE organization which also includes Maine’s Regional Extension Center (MeREC).⁸ To assure appropriate collaboration between the OSC, HIN, Maine Quality Forum (a state-wide quality association) and Maine Health Data Organization (MHDO), the Director of the OSC participates on the Board of each of these organizations. Standing Committees whose members are appointed by the OSC, support the State-wide efforts and provide a direct venue for other stakeholders to advise the OSC.

Committee	Committee Responsibilities
HIT and HIE Adoption/Implementation	Works to assure implementation and adoption issues are addressed to align HIT activities
Privacy, Security, and Regulatory Committee	Addresses HIT laws and regulations to overcome barriers to electronic sharing of information.
Consumer Committee	Supports both the OSC and HealthInfoNet in addressing consumer safety, privacy, and security concerns.
Financial Accountability and Sustainability	Conducts financial and sustainability planning for HIE for a viable HIT operation in the long-term.

⁷ See Appendix A-2 for a complete list of the OSC Executive Steering Committee

⁸ For more detailed information about HealthInfoNet, Appendix A-3.

Committee	Committee Responsibilities
Quality and Systems Improvement Committee	Brings together Maine's quality and systems improvement groups to assure that HIT tools used to improve health.
Technical and Architectural Committee	Addresses issues of system compatibility of various State systems and HIN. (Chaired by an OIT senior manager.)
Workforce Development Committee	Plans and implements Labor and Community College effort focusing on HIT health sciences at college level.

The Standing Committees consider the key issues relevant to HIT and HIE by functioning as work groups to support the OSC and assure that the OSC addresses a variety of interests across the State.

The diversity in representation on the HITSC brings together multiple viewpoints from a variety of stakeholder groups to ensure that all perspectives are accounted for in developing the vision and goals of HIT and HIE throughout the State of Maine. MaineCare is represented on the OSC Health Information Technology Steering Committee (HITSC) and the HIN Board to further facilitate collaboration of effort. When Maine began its Medicaid HIT planning process, the OSC was located in the Governor's Office of Health Policy and Finance. In April 2011 the organizational structure of Maine's HIT initiatives was improved through moving the OSC to a position that reports directly to the Maine DHHS Commissioner and placing MaineCare's HIT Program with the OSC. This framework has proven successful for the OSC efforts and it is anticipated that it will work well with the OMS HIT Program. A more detailed discussion of the new organizational framework is discussed in the "To-Be" Section of this SMHP.

Part 1. Summary of State Level HIT Governance Findings

- The Statewide HIT Strategic Plan and SMHP have aligned goals such as better quality outcomes through comprehensive information, increasing access to health care via efficiencies in care delivery, and reduced administrative cost that must continue.
- Communication and education about HIT efforts must be coordinated to ensure that consistent messages and information is being disseminated to all stakeholders.
- The SMHP must be a component of and fit under the State-wide HIT Strategic and Operational Plan.

Section A. Part 2. Medicaid Information Technology Architecture (MITA)

MITA is a CMS initiative that fosters integrated business and IT transformation to improve the administration of the Medicaid program. The purpose of MITA is to provide states with a process to plan technology investments and design, develop, enhance or install Medicaid information systems. MITA is a model to assess the state's current capabilities for measuring progress toward its desired future state.

The objectives of HIT and the MITA initiative are similar. One of the goals of MITA, like HIT, is to develop reusable services that can be shared across multiple programs. HIT, like MITA aims to provide a better integrated quality of care through supporting the integration of clinical and administrative data, interoperability, integration, open architecture, and coordination with partners to integrate health outcomes.⁹

A2a. MITA SS-A Approach

⁹ See appendix A-4 for a table that displays the alignment of MITA vision, goals, and objectives with the vision, goals, and objectives of HIT.

When the SMHP “As-Is” Assessment began in late 2009, MaineCare’s MMIS, called MeCMS, was being replaced by a new MMIS, Maine Integrated Health Management Solution (MIHMS).¹⁰ In March 2010, Maine completed a MITA State Self-Assessment (SS-A) which focused on MIHMS and MaineCare business processes to evaluate if there were any functional gaps that might affect managing the MaineCare HIT Program, which resulted in:

- A benchmark for MaineCare to assess any additional functions needed to meet outstanding Federal and State initiatives
- A process to identify any critical functional gaps
- The feasibility of quickly implementing new initiatives based on what the current functions can or cannot support

A2b. Maine’s High-level Findings--Business Assessment

Maine’s business processes were already aligned with MITA through the system design and development phase. Maine’s MITA SS-A used the defined Business Model and Processes that encompass the Business Areas essential to the operation of a Medicaid health plan.

The results of the MITA SS-A indicated that MaineCare did an excellent job in defining its business needs using State-specific requirements, industry best practices, and MITA-defined capabilities. Many of the individual business process were determined to be functioning at a capability level of three (3). This level is the highest that can be attained at this time because the Business Capability Matrix (BCM) for levels 4 and 5 has not yet been defined. However, the overall average capability maturity level of the MaineCare Enterprise was at Level 2.¹¹ (CMS defines capability maturity Level 2 as: "Agency focuses on cost management and improving the quality of and access to care within structures designed to manage costs [e.g., managed care, catastrophic care management, and disease management.]")

The information in the MITA SS-A will help inform the requirements and design of the EHR Incentive Program. The business areas most likely to be affected include:

- Business Relationship Management
- Operations Management
- Program Management
- Program Integrity Management
- Provider Management

Knowing the deemed maturity levels for each of these areas will help Maine design the EHR Incentive Program.

¹⁰ MeCMS was never fully functional and has never received Federal Certification. The CMS Boston Regional Office and MaineCare agreed that performing an “As-Is” Assessment of the current MeCMS system would not be effective and indeed may be counter-productive. The actual “As-Is” Assessment was “performed” during the requirements analysis and definition process for the procurement of a new MMIS. That effort encompassed assessing the current capabilities, researching industry best practices, identifying additional business needs, defining gaps, and then detailing the requirements based on current and future needs.

¹¹ See Appendix A-5 for a table summarizing the MITA Business Assessment including the MITA Business Area, the capability maturity model level, and high level findings.

A2c. Maine's High-level Findings – Technical Assessment

Interviews with MaineCare Technical Subject Matter Experts (SME) provided an understanding of the technical capabilities of MIHMS and helped to build the Technical Capabilities Matrix that assessed each of the technical areas:

The table below summarizes the MITA Technical Assessment including the MITA Technical Area and high level findings:

MITA Technical Area	High-level findings
Business-enabling services/Decision Support	<ul style="list-style-type: none"> • A workflow process is included in the MIHMS solution • Claims Management is an example of the successful incorporation of BRM • There is no Foreign Language support • A Decision Support System / Data Warehouse (DSS/DW) is used • Ad-Hoc reporting capability exists • Data Mining is not being used in MIHMS • Manual statistical analysis is being performed by the Muskie Institute • There are no Neural Network Tools employed in MIHMS
Access channels	<ul style="list-style-type: none"> • Providers and Members have access to information via the web portals • Browser and Integrate Voice Responder (IVR) are access points to the system
Interoperability channels	<ul style="list-style-type: none"> • MIHMS does not use Service Oriented Architecture (SOA); no service structuring and/or invocation of services in MIHMS • An Enterprise Service Bus approach is not being employed in the MIHMS • No orchestration and/or composition is being used in the MIHMS • Data exchanged with external interfaces uses MITA standards and formats
Data management and data sharing	<ul style="list-style-type: none"> • The capability exists to monitor all incoming information from all interfaces • There are no Electronic Health Records in use at this time
Performance measurement	<ul style="list-style-type: none"> • Performance measures are primarily systems focused • The capability exists to generate performance dashboards but it may not be used

MITA Technical Area	High-level findings
Security and Privacy	<ul style="list-style-type: none"> • Public Key Infrastructure is not being incorporated in MIHMS • No authentication devices are being used in MIHMS • A full history is being captured according to individual sign-on • Access restriction does not go down to the data element level
Adaptability and extensibility	<ul style="list-style-type: none"> • MIHMS uses rules engine functionality • Coding changes may be necessary if changes are being made to the base system • MIHMS supports XML and a number of other platforms

Part 2. Summary of MITA Findings

- The goals and objectives of HIT and MITA are similar, with an emphasis on improving the quality and efficiency of health care delivery and improving population health. Results of the MITA SS-A provide information about the business processes and technical assets to use to manage, administer, and oversee the EHR Incentive Program.

Section A. Part 3. DHHS HIT/HIE Technology Assets

CMS directed states to evaluate current technology applications to determine how they could be used to manage, administer, and oversee the Medicaid HIT Program.

To understand the interdependencies of the assets, the following diagram provides a high level representation of the current state of the systems which support the Medicaid business functions:

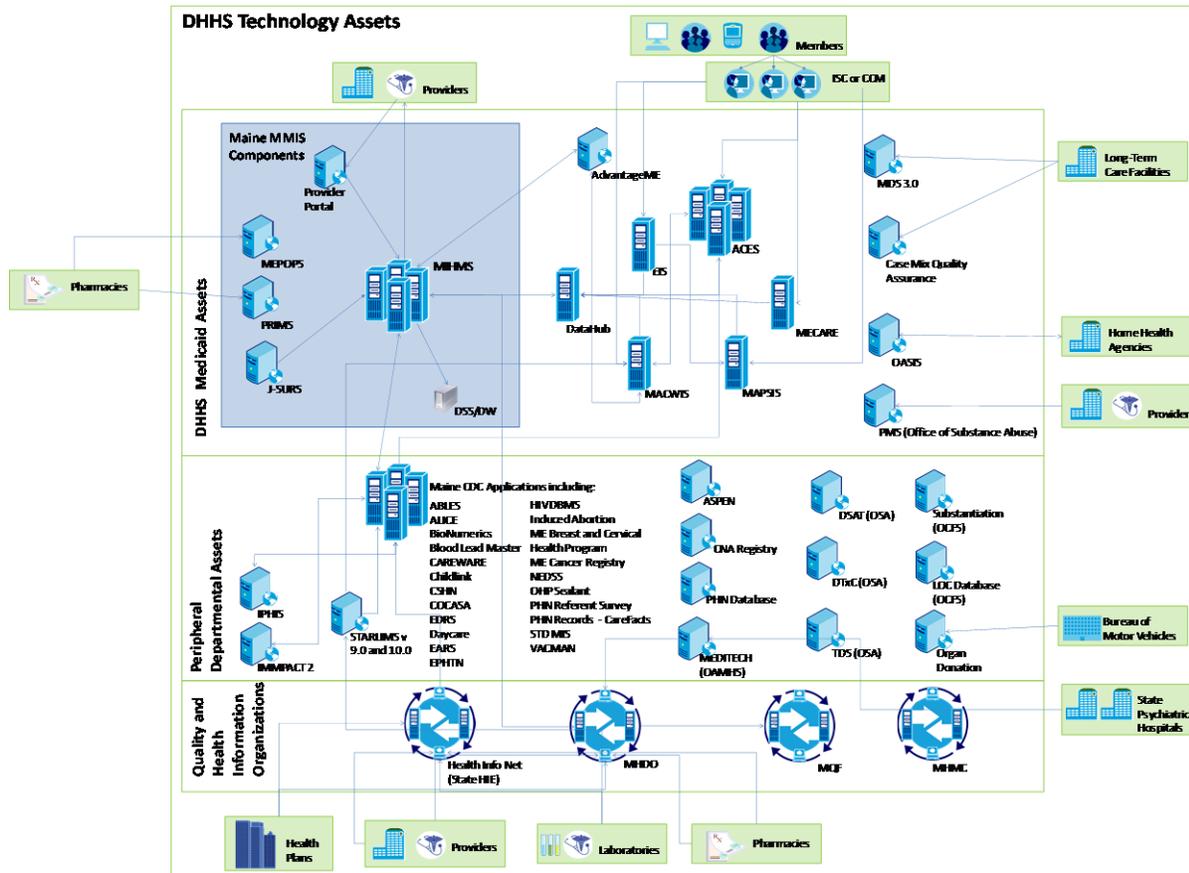


Figure 1: DHHS Technology Assets Schematic

The Office of Information Technology (OIT) created an applications inventory of all DHHS Systems and a detailed applications map of how each system relates to the business and what data is exchanged between applications. The OIT/DHHS Applications Inventory and the applications map were critical documents in completing this assessment. The following categories of assets were reviewed:

- Maine Integrated Health Management Solution (MIHMS), Maine’s MMIS
- Member Management Assets (Eligibility-related Systems)
- Provider Management Assets
- Operations Management Assets
- All-Payer Claims Database and Universal Hospital Discharge Data Set
- Maine Centers for Disease Control (CDC) Assets
- Licensing Status Program Assets
- DHHS Clinical Program Assets such as DSAT and DEEP

Within each category, Maine separated the assets by type: a. Technology assets that directly support Medicaid; or b. Technology assets that are related to Medicaid.

The CMS Final Rule lists ten administration and oversight areas that technology assets may be used to meet CMS requirements:¹²

- Verifying Eligibility
- Program Registration
- Tracking Attestations
- Payment Process
- Audit Process
- Reporting Requirements
- Tracking Expenditures
- Appeals Process
- Provider Questions
- Provider Communications

There are also State HITrelated services that technology assets may be used to meet:¹³

- Diagnostic Results Reporting
- Laboratory Results
- Consultations/Transfer of Care
- Eligibility and Claims Exchange
- Medication Management
- Care Coordination Management
- Quality Reporting
- Public Health
- Consumer Empowerment/Access
- Research
- Provider
- Patient Identifier
- Record Locator
- Audit Trail
- Cross-Enterprise User Authentication
- Integration Engine (Data Transformation)
- Patient Consent Management
- Clinical Portal
- PHI De-identification
- Terminology Service
- Clinical Decision Support
- Advance Directives Management

This Part summarizes the review of the assets that align with and could be used for the Medicaid HIT Program.¹⁴ Also shown are assets where the asset also aligns with and

¹² For definitions and requirements of each of the 10 areas, see Appendix A-6.

¹³ For a list of the assets that were mapped and a title of HIT/HIE Related Services and Definitions, see Appendix A-7.

could be used for the State HIT Program. Assets reviewed, but not being considered for use for the State HIT are in appendices.

A3a. Medicaid Direct Support Assets

1) Maine's Medicaid Management Information System (MMIS)

As mentioned above, the As-Is assessment is based on the new MIHMS system. As Maine gears up to accept CMS auditors to perform certification activities in the fall of 2011, it is important to protect the integrity of the stabilization process and allow all individuals who are working with the MIHMS certification process to continue that critical work without interruption.

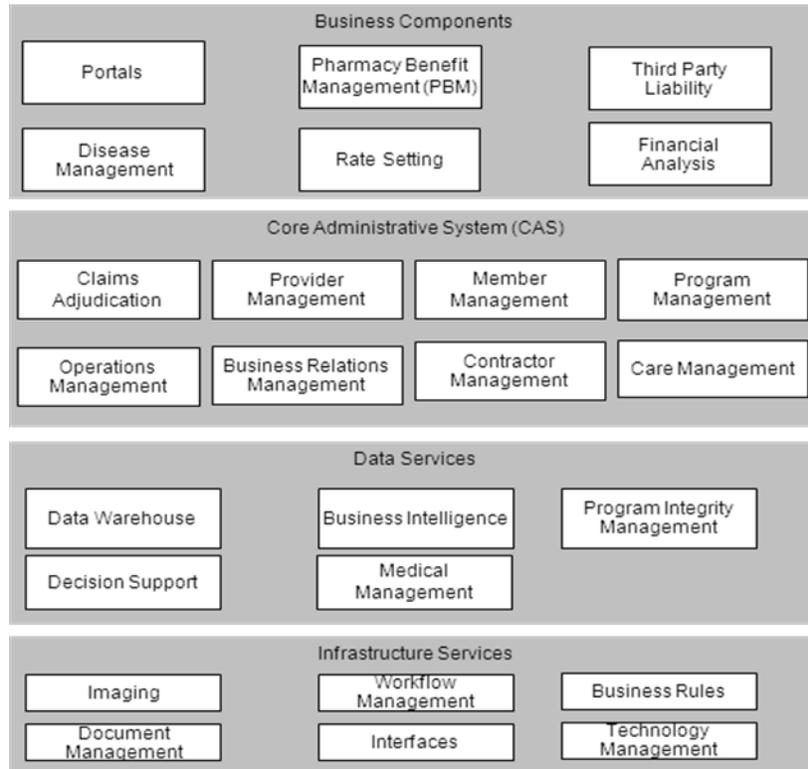
Maine has decided to develop, test and implement an in-house OIT technical solution for the OMS HIT Incentive Payment Program. This decision allows Maine to leverage existing systems and develop a phased in system approach that is needed as new phases of Meaningful Use are developed.

For illustrative purposes, MaineCare is including an assessment of MIHMS in the SMHP, yet OMS will use only the provider portal, information management, SURS, and contact manager MIHMS applications. This will maintain the focus on stabilization of MIHMS. When Maine submits an updated SMHP and IAPD for the second year of the OMS HIT Program which begins July 1, 2012 (or as needed) the State will provide a thorough analysis of the technical solution that will be used going forward.

MIHMS is an integrated system that supports claims processing, provider enrollment, care management, program integrity, information management, and case management. It also provides the administrative and operation system support for Maine's health care programs including MaineCare, Maine Eye Care, Maine Rx Plus, Drugs for the Elderly, Children's Health Insurance Program (CHIP), Adult Mental Health, Adults with Cognitive and Physical Disabilities, Children's Health Services, Substance Abuse, and Elder Services. The diagram below depicts the functions within MIHMS. The box that lies outside of MIHMS is Pharmacy Benefit Management which includes the pharmacy point of sale system and pharmacy claims adjudication.

¹⁴ Appendix A-8 summarizes the review of the assets that may support the overall State HIT Program but are not aligned with nor used to support the Medicaid HIT Program.

Figure 2: Maine’s Medicaid Management Information System



All of the MIHMS’s applications are supported by the fiscal agent vendor’s hardware and software. MIHMS has over 80 interfaces with other systems including Automated Client Eligibility System (ACES), Enterprise Information System (EIS), Maine Automated Child Welfare Information System (MACWIS), Maine Adult Protective Services Information System (MAPSIS), AdvantageME and others. MIHMS is an enterprise application built on a Java Framework providing access to the Oracle database that supports the application.

MIHMS Claims and Financial Management

The primary functions of MIHMS are getting and adjudicating claims; providing the data for reporting, analysis, and payment; and all activities having the necessary level of auditing and security to maintain the integrity of the process and system.

Claims submissions can be through the Provider Portal, the EDI Gateway for switch vendors, and elements of the Reports Manager combined with a subcontracted imaging solution using Goold Health Systems (GHS) for paper claims. All claims are available in MIHMS including pharmacy claims. Claims status can be obtained via Contact Manager, Provider Portal, and MaineCare’s Customer Service Representatives (CSR).

The financial claim payment process (Flexi) which occurs on a scheduled basis, examines and extracts the claims in MIHMS that are ready for payment. Payments can be generated upon DHHS request and the financial information is transferred to the State’s payment system, AdvantageME.

MIHMS Provider Enrollment Portal

A key feature of MIHMS is the new web provider portal which allows providers to enroll as a MaineCare provider and update information, and the Direct Data Entry (DDE) where providers submit individual claims, track the status of their submitted claims, and determine what claims are in “pay” status. If a claim contains an error, providers will be able to correct it via the Provider Portal and resubmit it to MIHMS. The Provider Portal is built on a Java Framework providing access to the Oracle database supporting the application.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
✓ Verifying Eligibility	✓ Eligibility and Claims Exchange
✓ Program Registration	✓ Provider
✓ Appeals Process	
✓ Provider Communications	
✓ Provider Questions	

MIHMS Information Management – Data Warehouse/Decision Support System

The Decision Support System/Data Warehouse (DSS/DSW) includes a large data warehouse and decision support application that collects and maintains data from MIHMS. The DSS/DSW delivers advanced health care analytic capability with a Medicaid-specific data model and reports. The system meets Federal MIHMS certification and DHHS requirements and all MITA standards.

The application is built on an integrated, analytically ready database that feeds data to the Executive Information System (EIS) and Decision Support System (DSS). The EIS is a Web-based interface that provides fast access to hundreds of ‘dashboard’ indicators of program performance and disseminates quick, reliable summary-level information. It includes a comprehensive suite of built-in Medicaid reports with the ability to analyze data in a variety of ways. The summary database matches to record-level detail in the DSS.

Within the DSS, a Decision Analyst provides flexible access to record-level detail in the data warehouse and offers customizable report templates designed specifically for health care analytics. It provides Management and Administrative Reporting System (MARS), and capabilities that support health care analysis and fraud and abuse

detection and investigation. Each week the Decision Analyst function provides data from MIHMS to the user’s workstation via Internet technology on:

- Medical claims data
- Drug data from the PBM
- Reference data
- Provider data
- Member data

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
✓ Reporting Requirements	✓ Quality Reporting
✓ Verifying Eligibility	✓ Public Health
✓ Tracking Attestations	✓ Record Locator
	✓ Clinical Decision Support
	✓ Research

Program Integrity–J-SURS

Maine’s Program Integrity unit is responsible for monitoring provider and Member compliance with applicable laws. The J-SURS system uses a statistical analysis program on claims data that is fed from the MIHMS claims system to identify potential health care fraud and abuse cases.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
✓ Audit Process	➤ No alignment identified at this time

MIHMS Contact Manager

The MIHMS Contact Manager system provides help desk and call tracking workflow. Authorized users can access a wide variety of reports based on a number of statistical variables. The engine behind Contact Manager provides a tool to deliver Member eligibility and claim status information via telephone. Contact Manager can also deliver call center capabilities; member pre-qualification, eligibility and registration; prior approval; claim status; intelligent call routing, agent client (call tracking, workflow initiation, and CTI screen pop); web chat; real-time contact metrics; and historical reporting.

The Automated Voice Response System (AVRS) queries data MIHMS via Web services showing any needed data, Member pre-qualification, prior approval, provider account payment status, claim status, third-party liability, drug coverage, and pricing.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
---	------------------------------------

- | | |
|---------------------------|--|
| ✓ Program Registration | ➤ No alignment identified at this time |
| ✓ Provider Communications | |
| ✓ Provider Questions | |

MIHMS Interface with AdvantageME

AdvantageME is the state financial accounting system that interfaces with MIHMS to pay claims and track financial information. The application is built on a Java Framework and provides access to the Oracle database supporting the application.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
---	------------------------------------

- | | |
|-------------------|--|
| ✓ Payment Process | ➤ No alignment identified at this time |
|-------------------|--|

2) DHHS Technology Assets Related to Medicaid

All-Payer Claims Database

Maine has established the first-in-the-nation, all payers, all settings claims database. Maine law established a partnership between OnPoint Health Data, formerly The Maine Health Information Center (MHIC), an independent private organization, and the Maine Health Data Organization (MHDO), a State agency to develop data collection rules and regulations. Three types of administrative data are collected: individual eligibility data, paid medical claims, and pharmacy claims. Across all file types, encrypted and protected health information links patient specific information together. The All-Payer Claims Database includes all MaineCare claims data up to 2008; commercial payers data up to 2009; and Medicare data up to 2006.

Claims data, while powerful in its own right, does have limitations. It does not provide information about the outcome of the services provided, and often the information related to diagnoses and procedures is limited to what the carrier requires to adjudicate the claim. The advantage of Maine's All-Payer Claims Database is the availability of data on all services across all health care settings. HIN, once fully developed, will be able to combine the State-wide claims database with the clinical information from the HIE. The integrated database will provide detailed clinical utilization data, outcome information, and cost/payment information.¹⁵

¹⁵ It is important to note that the All-Payer Claims Database excludes the uninsured.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
---	------------------------------------

- | | |
|---|---|
| <ul style="list-style-type: none"> ✓ Verifying Eligibility | <ul style="list-style-type: none"> ✓ Eligibility and Claims Exchange ✓ Care Coordination ✓ Quality Reporting ✓ Provider ✓ Patient Identifier ✓ Record Locator ✓ Audit Trail ✓ PHI De-Identification |
|---|---|

Maine CDC Assets

Integrated Public Health Information System (IPHIS)

The Integrated Public Health Information System (IPHIS) is a tool that consolidates public health information from all Maine CDC systems to improve information flow between all of the CDC systems. The core of the system is the National Electronic Disease Surveillance System (NEDSS) Base that provides various lab systems and data sources, and in the future, data from the immunization registry. The components are integrated with a web portal, with a proposed single sign on, and a central data repository.

It conforms to Public Health industry standards by adopting Public Health Information Network (PHIN) interoperability standards and provides a central data repository for public health data from NEDSS Base System, various lab systems, and electronic lab reporting systems. It receives data from two commercial labs; Maine’s Health and Environmental Testing Lab (HETL); reportable diseases from HealthInfoNet; data from 15 Maine hospitals; and symptoms reported in emergency rooms for syndromic surveillance.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
---	------------------------------------

- | | |
|---|---|
| <ul style="list-style-type: none"> ✓ Tracking Attestations | <ul style="list-style-type: none"> ✓ Quality Reporting ✓ Laboratory Results ✓ Public Health ✓ Research ✓ PHI De-Identification |
|---|---|

IMMPACT 2 – Immunization Information System

Maine’s web-based Immunization Information System is a tool to ensure effective public health strategies through the use of secure, accurate, and accessible information. The registry promotes client and vaccination management functions for a majority of pediatric providers Statewide and serves as a resource application for MaineCare. IMMPACT2 tracks and reports provider vaccination administration, vaccine inventories, and child Bright Futures preventive health visits; provides health tracking and quality assurance tools for clinician use; and provides internet access to current immunization trends, standards, and health information. IMMPACT2 contains detailed immunization records for over half of the children in Maine. These records are electronic, portable, and patient-centric.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ✓ Tracking Attestations 	<ul style="list-style-type: none"> ✓ Quality Reporting ✓ Diagnostic Results Reporting ✓ Public Health ✓ Research ✓ Provider ✓ Record Locator ✓ Clinical Portal ✓ Clinical Decision Support ✓ PHI De-Identification

Automated Survey Processing Environment (ASPEN)

The Automated Survey Processing Environment (ASPEN) Central Office is a Windows based program that enables State agencies to implement information-based certification and oversight of the health care providers under their supervision.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ✓ Program Registration 	<ul style="list-style-type: none"> ✓ Provider

Part 3. Summary of DHHS HIT/HIE Technology Assets Findings

- The All-Payer All-Claims database is a valuable tool for verifying eligibility of providers for the EHR Incentive Program. The Database collects health care claims from all payers across the State and could be used to verify patient volume. The database does not include the uninsured which must be measured for the federally Qualified Health Clinics (FQHC), yet the FQHC federal reports do include that information.

- Maine’s CDC has technology assets that collect clinical information to improve population health, provide data for research efforts, enable quality reporting, and facilitate the coordination of care. Many of these systems could be used to track attestations of Meaningful Use. Some of the assets are “stand-alone” applications that do not interface or are not integrated with other application and systems. This is a potential gap in facilitating the State-wide exchange of information.
- The State has a wealth of systems that may support the OMS HIT Incentive Payment Program and which will be considered as Maine moves into later phases of the HIT Program.

Section A. Part 4. DHHS HIT/HIE Organizational Assets

Similar to the way that technology assets were assessed, Maine evaluated the organizational assets from the perspective of current roles and potential alignment with the Medicaid HIT Program.

A4a. Office of MaineCare Services

The Office of MaineCare Services (OMS) administers Maine’s Medicaid Program (MaineCare), Maine Eye Care, Maine Rx Plus, and Drugs for the Elderly and Disabled. As a result, OMS has an existing organizational structure that supports key business processes to administer and operate the EHR Incentive Program:

1) OMS Administration Division

Administration oversees and manages MaineCare operations and staff development. It also includes the Payment Error Rate Measurement Program (PERM) unit which conducts an audit of eligibility and claims on a three-year cycle as mandated by CMS.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
✓ Reporting Requirements	➤ No alignment identified at this time

2) OMS Claims Division

Claims Division manages claim submission and processing, including manual review of complex claims and quality assurance. The fiscal agent, Molina, performs claims processing, payment and reporting functions. As mentioned earlier in this SMHP, Maine is in the stabilization phase of its MIHMS system implementation and will be using an in-house OIT solution for the MaineCare HIT Incentive Payment Program. Yet it is worthy to note the alignments in case Maine does decide to operate its HIT Incentive Payment Program using other applications of the MIHMS system in the future. (Maine would include any consideration of changes to the in-house OIT solution in an SMHP or IAPD update.)

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
---	------------------------------------

- | | |
|---|--|
| <ul style="list-style-type: none"> ✓ Verifying Eligibility ✓ Program Registration ✓ Payment Process ✓ Tracking Expenditures ✓ Audit Process ✓ Appeals Process ✓ Reporting Requirements | <ul style="list-style-type: none"> ➤ No alignment identified at this time |
|---|--|

3) OMS Customer Services Division

Customer Services interacts with MaineCare’s medical and community providers to process provider enrollments, provide information and training, and answer questions related to policy, billing, claims status, and other payment issues. This fiscal agent supports this function through help desk and call tracking workflow, and an Automated Voice Response System (AVRS).

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
---	------------------------------------

- | | |
|---|--|
| <ul style="list-style-type: none"> ✓ Tracking Attestations ✓ Provider Communication ✓ Provider Questions ✓ Program Registration | <ul style="list-style-type: none"> ➤ No alignment identified at this time |
|---|--|

4) OMS Health Care Management Division

Health Care Management oversees and manages services provided to MaineCare Members including the MaineCare Pharmacy program; prior authorizations; and care management. A fiscal agent supports this function by processing pharmaceutical rebates.

This division also oversees Maine’s Primary Care Case Management and Patient Centered Medical Home initiatives which are performance based incentive programs that use HEDIS-Based measures for emergency room diversion, and quality and performance indicators from claims data to provide additional payments to providers who meet higher-quality standards. Integrating various data into the HIE dataset could provide significant value to the State, health systems, and decision-makers.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
---	------------------------------------

- | | |
|--------------------------|--------------------------------------|
| ✓ Tracking Attestations | ✓ Changes in contract with providers |
| ✓ Reporting Requirements | |
| ✓ Provider Communication | |
| ✓ Provider Questions | |

5) OMS Policy Division

Policy promulgates rules for MaineCare, oversees State Plan Amendments, and coordinates legislative activities.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
---	------------------------------------

- | | |
|--------------------------|------------------------------|
| ✓ Tracking Attestations | ✓ Audit Trail |
| ✓ Reporting Requirements | ✓ Patient Consent Management |

6) Third Party Liability Division

Third Party Liability (TPL) coordinates the avoidance of MaineCare costs through paying private insurance premiums when cost-effective, a COBRA-like insurance for some children, and estate recovery. The fiscal agent supports this function by hosting a database that contains information related to other insurance coverage available to MaineCare Members.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
---	------------------------------------

- | | |
|-----------------|--|
| ✓ Audit Process | ➤ No alignment identified at this time |
|-----------------|--|

A4b. DHHS Divisions supporting MaineCare

1) Division of Licensing and Regulatory Services

Licensing and Regulatory Services is responsible for all human services licensing and certification activities for Maine, except for Foster Care Licensing at the Office of Child and Family Services (OCFS) and certain public health licensing functions at the Maine Center for Disease Control and Prevention

(MCDC). The Division oversees Departmental responsibility for Continuing Care Retirement Communities, the Hospital Cooperation Act, Certificate of Need, Maine C.N.A. Registry, Charity Care Guidelines, and workforce initiatives, including the Maine C.N.A. Registry, Registration of PCA Agencies and training programs for Certified Residential Medication Aids and Personal Support Specialists.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ✓ Tracking Attestations ✓ Audit Process 	➤ No alignment identified at this time

2) Financial Management Services

Finance is responsible primarily for management, tracking and reporting of the MaineCare budget. With direct oversight of MaineCare fiscal management systems, resources from Finance are key to planning efforts for developing processes for providers requesting EHR incentive payments, paying EHR incentive payments, auditing, CMS reporting requirements, and Federal funds for HIT administration.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ✓ Payment Process ✓ Tracking Expenditures 	➤ No alignment identified at this time

3) Audit Division

Audit is part of the Financial Management Services and is comprised of five units:

- MaineCare Audit – conducts cost settlement reviews on MaineCare providers receiving reimbursement on a cost basis such as Nursing Facilities, Hospitals, Residential Care Facilities, Private Non-Medical Institutions and Intermediate Care Facilities for the Mentally Retarded (ICF/MR);
- Social Service Audit– conducts desk reviews on A-133 audits submitted by community agencies as well as close-out reviews on all Department contracts to sub-recipients;
- Internal Audit – oversees all auditing of DHHS conducted by external agencies, assures corrective action plans are implemented and meeting their objective and conducts specialized audits as needed;
- Program Integrity – oversees payments under MaineCare for non-cost settled programs, conducts post payment reviews to prevent/limit fraud abuse and waste and to recoup funds when appropriate; and
- Rate Setting – sets reimbursement levels and oversees all rate setting activities.

Alignment with Plan to Administer and Conduct Oversight

- ✓ Audit Process
- ✓ Appeals Process

Potential Alignment with State HIE

- No alignment identified at this time

A4c. Other DHHS Program Offices

1) Office of Adult Mental Health Services

This Office oversees programs for Maine adults with mental health needs, including community services, hospital services, and consumer-directed services to eligible adults and members.

2) Office of Adults with Cognitive and Physical Disability Services

This Office oversees programs for Maine adults with mental retardation or autism and adult developmental services, brain injury services, and physical disability services.

3) Office of Child and Family Services

This Office oversees programs for eligible children including behavioral health programs, child welfare services, and early childhood programs.

4) Office of Elder Services

This Office oversees three program areas: Elder Services Community Programs, Long-Term Care Services and Supports, and Adult Protective Services. Some of the services funded by MaineCare include Adult Day Health Services, Adult Family Care Homes, Home and Community-Based Waiver Services, Home Health Services, Home-Based Care, Hospice Services, Nursing Facilities, Private Duty Nursing/Personal Care Services, and Residential Care Services.

5) Office of Integrated Access and Support

This Office determines eligibility for all entitlement programs, collects child support, and assists with disability determination. Programs provided through OIAS include TANF, Parents as Scholars, Transitional Programs, and the Food Supplement Program.

6) Office of Substance Abuse

This Office oversees substance abuse prevention, intervention, education and treatment.

7) Maine Center for Disease Control and Prevention (Maine CDC)

CDC is Maine's public health agency that monitors the health status of the population, and addresses emerging health concerns. The Maine CDC oversees the development of the State Health Plan which establishes priorities for a two-year period of time for public health, as well as the health care community. CDC is organized as follows:

- **The Offices of Minority Health and Local Public Health** work with other State agencies and communities on cross-cutting and system issues related to minority health, local public health and public health system accreditation.
- **The Chronic Disease Division** tracks, prevents and reduces the impact of major chronic diseases using an ecological approach that considers individuals within the social, organizational, and environmental contexts in which they live. Programs include: the Partnership for a TobaccoFree Maine, Healthy Maine Partnerships, Comprehensive Cancer (includes the Cancer Registry), Physical Activity and Nutrition, Diabetes, Breast and Cervical Health, Oral Health, Cardiovascular Disease, and Coordinated School Health.
- **Environmental Public Health** protects people from environmental hazards through public health strategies such as Safe Drinking Water, Health Inspection, Environmental and Occupational Health, Wastewater, and Radiation Control.
- **Family Health** uses population-based public health strategies to address the health of certain segments of the population. Programs include: Public Health Nursing; Early and Periodic Screening, Diagnostic and Testing Services; Injury Prevention; WIC; Genetics and Newborn Screening; Women's Health; and Teen and Young Adult Health.
- **Infectious Disease** focuses on preventing and controlling infectious diseases. Programs include: Immunization; Epidemiology; and HIV, STD, and Viral Hepatitis.
- **Public Health Systems** provide some of the cross-cutting and foundational public health functions. Programs include: Health and Environmental Testing Laboratory, Vital Records and Vital Statistics, Public Health Emergency Preparedness and Public Health Informatics.

8) Office of Quality Improvement Services

The services and functions of the Office of Quality Improvement Services (OQI) support and enhance the quality and integrity of services provided to the people DHHS serves. OQI emphasizes consumer and family involvement, building strong relationships with internal and external stakeholders, and the use of outcome measurements to guide policy and decision-making.

9) Office of Information Technology

The Office of Information Technology (OIT), within the Department of Administrative and Financial Services, is responsible for the delivery of safe, secure and high performing networks and systems to State agencies for daily performance of their missions.. OIT plays a key role in supporting MaineCare and DHHS programs by providing and supporting systems that enable programs to meet the needs of their Members and clients.

10) Quality and Health Information Organization Assets

Given Maine’s long history of using quality data to inform policy on the public side and as a basis for incenting quality and safety from both public and private perspectives, there is significant potential to leverage existing quality reports along with others to build more comprehensive views of the health care system and of provider performance.

A4d. External Organizations

1) OnPoint Health Data

HealthInfoNet and the Office of the State Coordinator (OSC) are reviewing partnership options with OnPoint Health Data (formerly the Maine Health Information Center) to develop and produce quality and “Meaningful Use” reporting for participating providers. Though the decision to partner with OnPoint has not yet been formalized, as HIN moves into data access and use, it will be helpful to have a well-known and trusted partner like OnPoint to develop this area of quality reporting. OnPoint staff members have worked with a wide range of health care data and they program, report, and analyze data on virtually all NCQA HEDIS measures that can be reasonably estimated from administrative claims data without medical chart review. Among the HIT Standards Committee (NQF) endorsed measures, OnPoint has programmed and reported on the relevant denominator populations and in some cases numerators using administrative data. For non-NCQA HEDIS quality measures, the OnPoint staff has worked on many other projects that include measures closely related to those in the HIT Standards Committee (NQF) list. The regional CMS contractor, Masspro, selected OnPoint to implement and analyze the results of the Doctors Office Quality Information Technology (DOQ-IT) Survey, an early effort at profiling physician practice against nationally recognized standards. OnPoint has a longstanding relationship with Maine hospitals and clinicians.

2) Maine Quality Forum

In 2003 the Maine Quality Forum (MQF) was created to provide consumers with a reliable resource for information about health maintenance, health care, and quality of health care services and health information. MQF’s mission is to advocate for high quality health care and help each Maine citizen make informed health care choices. MQF has been charged with collecting research, promoting best practices, collection and publishing of comparative quality data, promoting electronic technology, promoting

healthy lifestyles, and reporting to consumers and the Legislature. MQF collects data through another state agency, the Maine Health Data Organization and its Data Processing Center, which is described below. MQF uses data to inform state policy and for legislative studies, such as hospital associated infections. MQF through MHDO analyzes and publicly reports performance of hospitals on CMS core measures, care transition measures, and geographical variation.

3) Maine Health Data Organization

The Maine Health Data Organization (MHDO) maintains the State's health care databases. Maine requires all commercial and public payers of health care to submit 100% of claims to MHDO for the All – Payer Claims database. MHDO receives data from Maine hospitals through their inpatient and outpatient discharge databases. MHDO also analyzes cost data and publishes a cost-calculator for consumers to use to inform their choice of health care services.

4) Maine Health Management Coalition

The Maine Health Management Coalition (MHMC), a business coalition focused on public reporting efforts, was formed to improve health care safety and quality issues. The Coalition has over fifty member organizations, representing the largest employers in Maine. MHMC publicly posts performance data on health care providers including hospitals. These data are shown in a comparative form to assist the public in making health care choices based on quality. Employers also use the data for provider tiering. MaineCare also has a performance based incentive program based on HEDIS-based measures for targeted conditions such as chronic diseases in reports generated from claims data.

Part 4. Summary of DHHS Organizational Assets

As with the systems assets, the State has valuable organizational assets that may be used to serve the OMS HIT vision and Incentive Payment Program. Maine has worked hard on coordination of programs and offices which needs to continue to have a successful HIT program. The recent placement of the OSC and OMS HIT Programs together with the Director of the OSC reporting to the DHHS Commissioner will add much value to the HIT Programs.

Section A. Part 5. Maine EHR Adoption

In the Spring of 2010 MaineCare and the OSC commissioned a survey of providers, with a particular emphasis on professionals who were listed in the CMS regulations as meeting the definition of an “eligible professional,” dental practices, and hospitals. Researchers from the Muskie School, Cutler Institute for Health and Social Policy at the University of Southern Maine performed the survey.¹⁶

It is important to note that the “As-Is” survey and analysis were performed for the initial SMHP draft that was submitted to CMS in October 2010. This final SMHP, having had the benefit of two rounds of comments from CMS and ONC, reflects the “As-Is” from 2010 with updates that reflect newer CMS rules, federal law, guidance documents and activities performed by the State during the planning process.

¹⁶ For a description of the survey development and methods, see Appendix A-9.

The results of the survey function as a baseline assessment and will be used to set goals for EHR adoption through 2016, create the State's plan for the administration and oversight of the EHR Incentive Program, and assist the Regional Extension Center (MeREC) in targeting their efforts to educate providers on EHR technology.

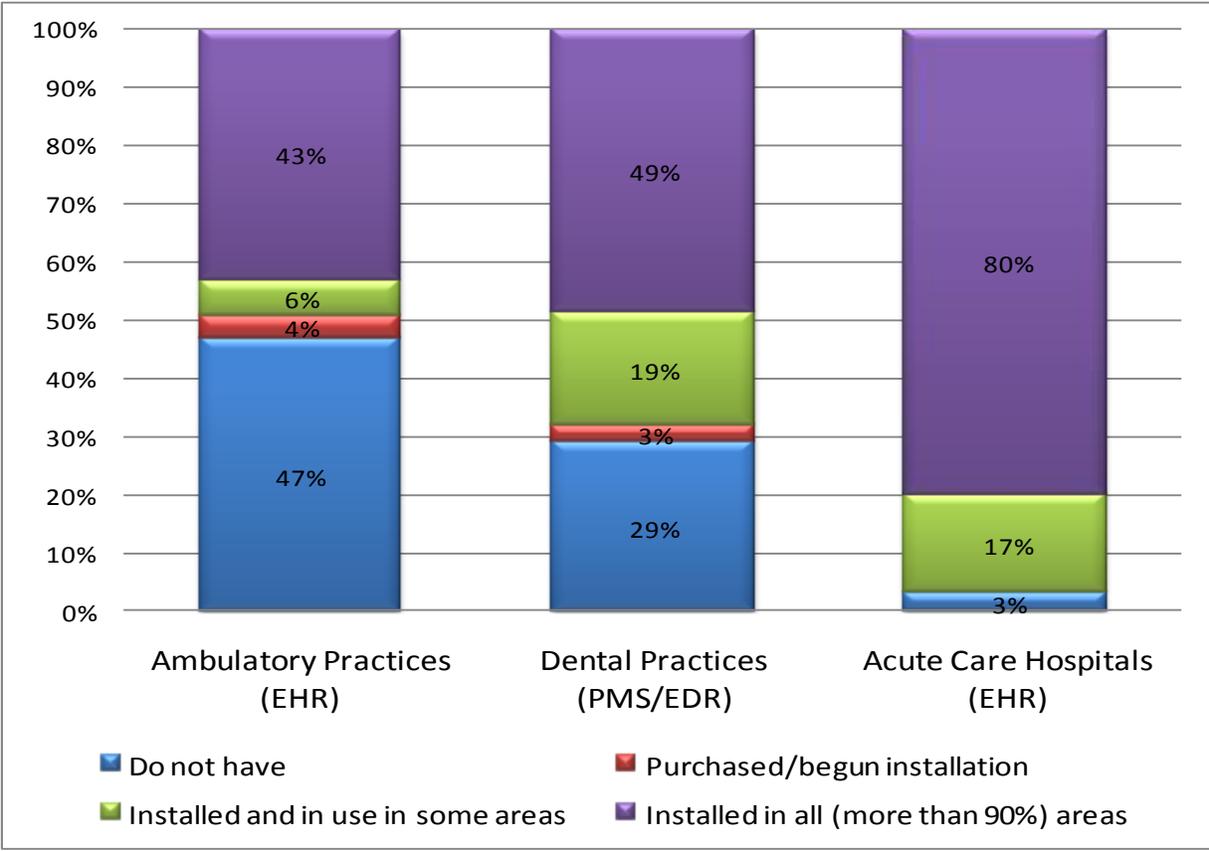
Questions in the HIT Provider and Hospital surveys focused on eleven survey domains:

- EHR Adoption and Capabilities
- EHR Systems
- Decision Support Tools
- Electronic Practice Management System
- Information Exchange
- Meaningful Use
- Medical Records
- Patient Specific Information
- Privacy and Security
- Quality Improvement Functions
- Telemedicine

A5a. Survey of Maine Providers on EHR Use

As the data depicts in Figure 4, a higher proportion of acute care hospitals have adopted HIT than practice (including eligible professional) sites. Of the acute, short-term hospitals responding to the survey, 80 percent reported that they had implemented EHR systems in all or most of their departments or areas. About half (49 percent) of the practice sites that responded to the survey indicated that they had either partially or fully implemented EHRs in their practice.

Figure 3: EHR Adoption Rates for Acute Care Hospitals, Medical Practices (Including Eligible Professionals) and Dental Practice Sites



The use of HIT in dental practices typically varies substantially from HIT in acute hospitals and medical practices (including eligible professionals) in that they do not refer to HIT systems as EHRs. Rather, they may use Practice Management Systems (PMS) that may computerize a number of billing or administrative processes and sometimes clinical information, or Electronic Dental Records (EDR), which focus on patient records. Of these types of systems, 49 percent of dental practice sites reported full implementation of a PMS/EDR system and another 19 percent reported partial implementation.

The data indicate, however, that acute care hospitals and Medical practices (including eligible providers) practices, while not generally well-positioned at this time to meet Meaningful Use criteria of HIT, are better prepared than dental practice sites. On the whole, the status of dental practices' software and quality reporting efforts have not evolved to the extent of acute care hospitals or Medical practices (including eligible providers) practices.

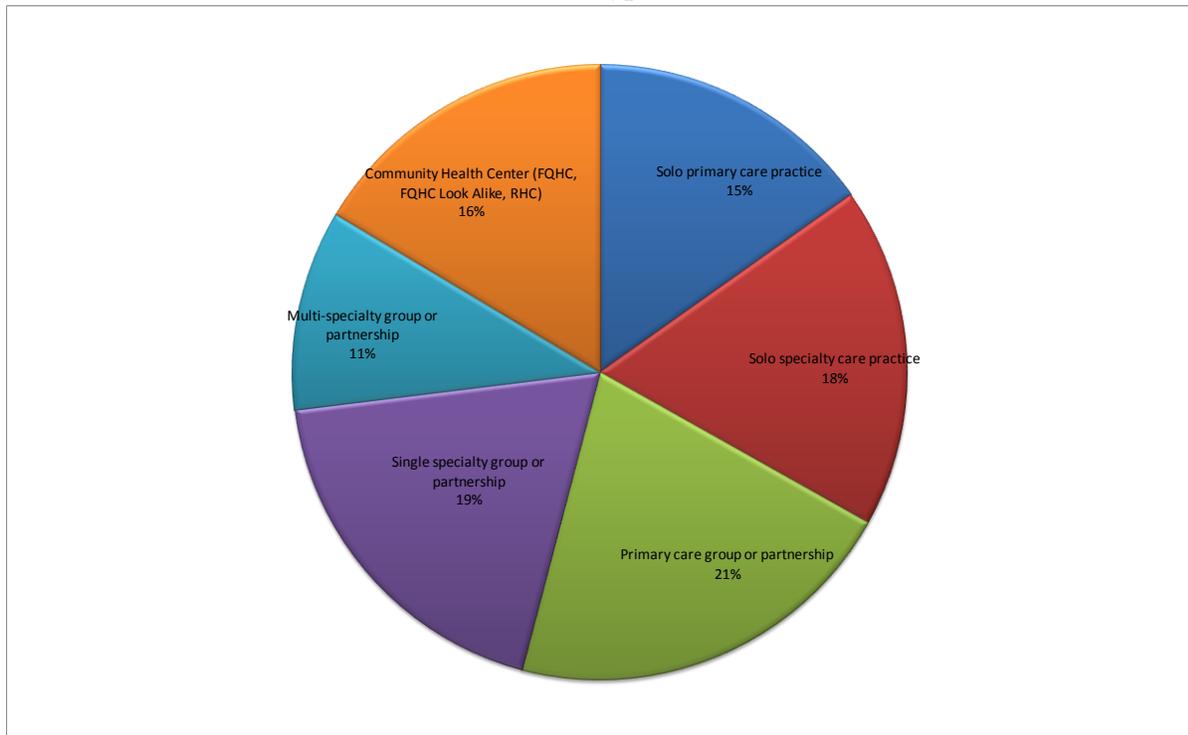
A5b. Medical Practices (Including Eligible Professionals) Survey

This medical practice survey was administered at the practice level and included "Eligible Professionals": physicians, certified nurse-midwives, nurse practitioners, and

physician assistants practicing in an FQHC or RHC led by a physician assistant. The dental practice survey captures data on dentists which would be EPs for the Medicaid EHR Incentive Program. Of the 1,166 practice sites that were sent the survey, 525 (45%) Medical practices completed the survey.

Excluded from the analysis in the “As-Is” Assessment are respondent practices that indicated that they provide more than 90 percent of their services in a hospital setting. Of the 407 remaining practices, practices were fairly evenly distributed among six organizational types, with approximately 52 percent being primary care practices.

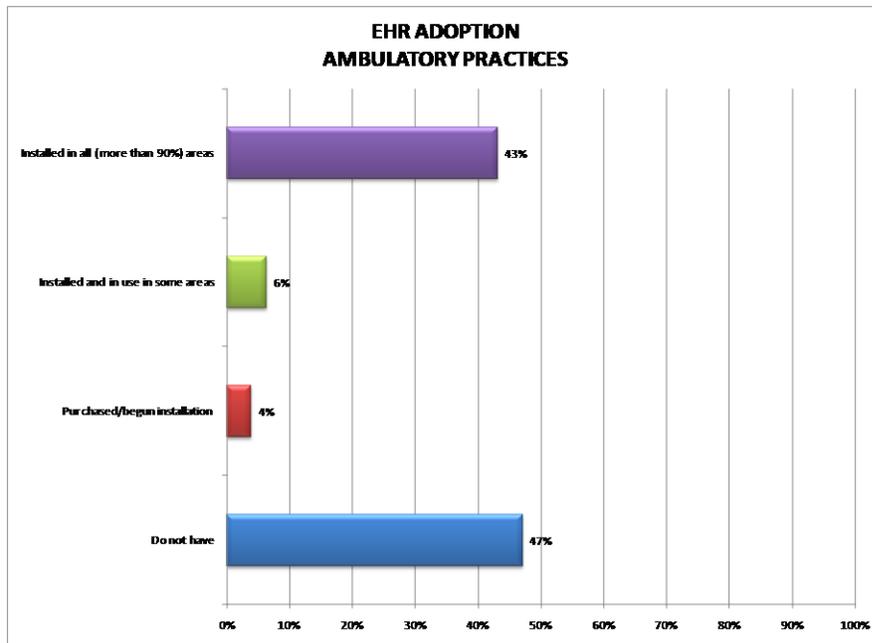
Figure 4: Medical Practices (Including Eligible Professionals) – Responses by Practice Type



1) Medical Practice EHR Adoption

Among the 407 practices responding, almost half or 47 percent have not adopted or implemented an EHR. Another 4 percent have purchased or begun installation of an EHR, but are not yet using it. Six percent of the practices have an EHR installed and are using it in some areas of their practice, and 43 percent reported having an EHR installed and in use in all or nearly all areas of their practice (see Figure 6).

Figure 5: Medical Practices (Including Eligible Professionals) – HER Adoption Rates



EHR adoption varies greatly by Medical practices (including eligible providers) practice size and type throughout the State. Figure 4 shows, 66 percent of 96 large practices have adopted and implemented EHR technology in their practice. Fifty-eight percent of 120 medium size practices have adopted and implemented EHR technology; but only 32 percent of 180 small practices have adopted and implemented EHR technology in their practice. These data show that providers in small practices, which happens to be the largest group by number of providers, may need the greatest assistance and focus in adoption HIT and EHR technology.¹⁷

Figure 6: Medical Practices (Including Eligible Professionals) – EHR Adoption by Practice Size

Number of total practices	Percent that have EHR	Size of Practice

¹⁷ For survey results about practices using EHR in ways that meet draft “Meaningful Use” criteria as they stand today, see Appendix A-10.

96	61%	6 or more providers
120	50%	3 to 5 providers
180	27%	1 to 2 providers

As shown above, EHR adoption varies by medical practices (including eligible professionals) type. Figure 8 shows that 38% percent of 188 specialty practices have adopted and implemented EHR technology in their practice. This includes multi-specialty groups which may include primary care providers. Sixty percent (60%) of 209 primary care practices have adopted and implemented EHR technology in their practice. These additional data inform MaineCare that providers in specialty and multi-specialty practices are less likely to have adopted or implemented EHR technology.

Figure 7: Medical Practices (Including Eligible Professionals) – EHR Adoption by Practice Type

Number of total practices	Percent that have EHR
190 Specialty	31%
215 Primary Care	52%

Almost 70% of the respondent practices with EHR systems reported completing installation of their current EHR in 2008 or earlier. Another 26% completed installation in 2009 or 2010. Six percent (6%) are in the process of installing their EHR system.

Of the practice sites that reported having an EHR, 198 reported using a broad range of EHR systems certified by the Certification Commission for Health Information Technology (CCHIT). The CCHIT-certified EHR systems in use include Allscripts, EpicCare, GE Centricity, NextGen, and eClinicalWorks. A small percentage of practices reported using EHR systems that were not CCHIT certified. However, more than three-quarters of the practices reported having the capacity to perform tasks required under Meaningful Use. The table below displays the certified EHR systems in use grouped by vendor.

Medical Practices (Including Eligible Professionals) – Certified EHR Technology Solutions used	
Allscripts	12%
AmazingCharts	3%
EpicCare	10%
GE Centricity	26%
HealthPort	4%

Medical Practices (Including Eligible Professionals) – Certified EHR Technology Solutions used

McKesson	2%
NextGen	10%
eClinicalWorks	7%
Other	33%

Of the practices with EHRs, nearly 90% of clinical staff and providers use the EHR system routinely, and 67% of respondent practices with an EHR reported that they do not maintain paper charts.

Practices reported using their EHR systems for a variety of purposes such as order entry, decision support, and other purposes. Of the practices with EHR systems, 82% reported having and using a computerized provider order entry (CPOE) system by some or all providers, another 5% reported that their EHR has this capacity, but that it is not in use at this time. Thirteen percent (13%) of the practices with EHRs reported that they did not have or did not know whether they have a CPOE.

Practices also reported using their EHR systems' clinical decision support tools during a patient encounter. As shown below, of about 200 practices with EHRs, a majority or near majority reported using the EHR routinely for a number of clinical decision supports during a patient encounter.

Medical Practices (Including Eligible Professionals) - Electronic Clinical Decision Making Support Tools Accessed Routinely During Patient Encounters

Medication guide alerts	75%
Chronic care plan	55%
Identification of patient-specific or condition-specific reminders	52%
Identification of preventive services due	50%
Use of clinical guidelines based on patient problem list, gender, age	48%
Automated reminders for missing labs and tests	25%
High tech diagnostic imaging decision support tools	15%

Of the 210 Medical practices (including eligible providers) practice sites that have not adopted or implemented EHR technology, 70% plan to adopt and implement EHR technology in the next five years:

Medical Practices (Including Eligible Professionals) – Plan to adopt and implement EHR technology

Will implement within 1 year	17%
Plan to implement in 1 – 3 years	40%
Plan to implement in 4 – 5 years	13%
No plans to implement in 1 – 5 years	30%

Based on these data, 63 Medical practices (including eligible providers) practice sites without an EHR have no plans to adopt or implement EHR technology within the next five years.

Medical practices (including eligible providers) practices that currently do not have EHR technology identified that the primary barrier was the cost to acquire EHR technology; second was cost to maintain EHR technology; and the third was a mix of return on investment concerns and internal knowledge/technical resources barriers.

2) Medical Practices' Intent to Apply for Incentives

Of the total responses, 36% of the practice sites anticipate that there will be eligible professionals from their practices applying for either the Medicaid or the Medicare incentive payments. Another 7% anticipate that all of the professionals in their practice who meet EP status will apply for the Medicaid EHR Incentive Program and another 9% anticipate that all of the eligible professionals in their practice will apply for the Medicare EHR Incentive Program. Thirty-four percent (34%) of the practice sites indicated that they are not sure whether they will apply for an incentive payment and 13% that they were not anticipating applying for either of the incentive payment programs. Because the survey was distributed at the practice site level rather than the provider level, some practices will have providers choosing to participate in either the Medicaid or Medicare incentive payment program. It is important to note that this survey was performed in mid-2010 and the State has learned much since that time.

Over 200,000 MaineCare Members participate in the PCCM program. Maine identified 355 Non-FQHC PCCM sites from the provider enrollment system. Using CMS estimates and applying Maine-specific numbers, the survey results indicate that approximately 70 Non-FQHC PCCM sites would apply for the Medicaid HIT Incentive Payment Program.

Maine has 18 corporate FQHCs, all of which were included in the survey. Since the time the survey was conducted in early 2010 using 2009, FQHCs have reported that with more current 2010 data, all FQHCs qualify. According to the Medical Practices (Including Eligible Professionals), 70% percent of the centers indicate they are planning to apply for the Medicaid EHR Incentive Payment Program. This would result in a final estimate of 250+ eligible professionals from FQHCs.

The Medical Practices (Including Eligible Professionals) Survey indicated that 26 percent of specialty providers intended to apply for the Medicaid EHR Incentive Program for an estimate of 14 providers.

Providers with over 90% of services in the hospital were excluded¹⁸.

It is important to note that there are likely to be many more eligible professionals once the most current claims and other data are analyzed. Also, this survey was done in Spring 2010 before the Final Rule and subsequent legislation passed. In summer of 2010, which was when the survey results were tabulated, Maine would have predicted that about 300 providers would be “eligible professionals” who meet the Medicaid patient volume. Since that time, legislation about the hospital-based professional, changes to the application process, such as the proxy amount for the cost of EHRs, and further discussions with provider associations, lead Maine to believe that the 300 estimate needs to be raised as high as 1,000 to 1,200 EPs. The IAPD has been developed to take into consideration the higher number of potential EPs.

A5c. Acute Care Hospitals Survey

Based on the lists provided from Maine’s MMIS and other resources, all of the 36 potentially eligible hospitals were sent the Acute Care Hospital Survey. Thirty hospitals, or 79% of all potentially eligible hospitals responded.

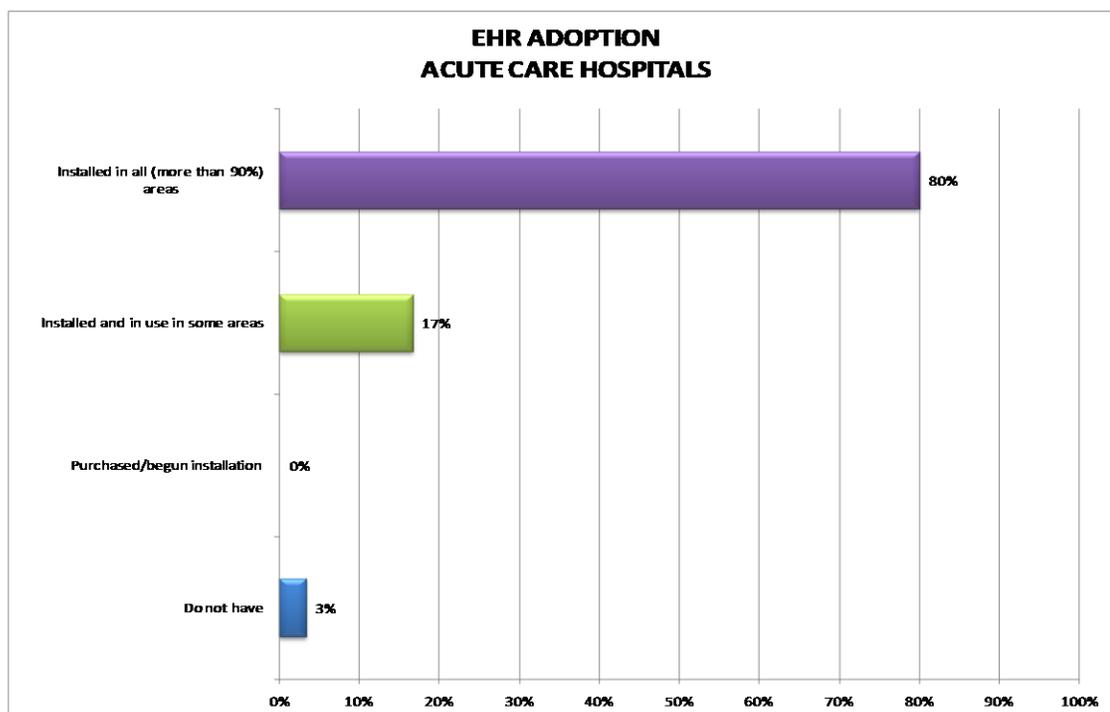
1) Acute Care Hospitals EHR Adoption

Eighty percent of the respondent hospitals reported having an EHR installed in more than 90 percent of the hospital’s areas or departments. Another 17 percent reported having an EHR installed and in use for some areas or departments. Three percent, or one hospital, reported not having EHR technology.¹⁹

¹⁸ Providers with 90% of services provided in inpatient (place of service code (POS)=21) and emergency room (POS=23) as indicated from claims were excluded.

¹⁹ For a discussion of hospitals with EHR and the use of technology to meet draft proposed Meaningful Use measures, see Appendix A-11.

Figure 8: Acute Care Hospitals – EHR Adoption



Of the hospitals with an EHR, 80 percent of the responding hospitals reported implementation in 2006 or earlier. The remainder implemented their EHR between 2007 and 2009.

The 29 hospitals that have an EHR reported using Meditech, Cerner, Eclipsys, McKesson, and other systems for their primary inpatient EHR. Hospitals also reported using GE, Allscripts, Meditech, Cerner, Epic, eClinicalworks, McKesson, Sage and other systems for their primary outpatient EHR. Sixty-two percent of hospitals describe their EHR system as a product primarily from one vendor while 38 percent describe their EHR system as a mix of products from different vendors. When asked if they are planning for any EHR system changes within the next 18 months, 60 percent of hospitals responded that they are planning to add significant functions to their EHR systems. Ten percent of hospitals replied that no major changes are planned. Table 6 below displays the certified EHR systems in use grouped by vendor for inpatient EHR systems, and the table below shows the certified EHR systems in use grouped by vendor for outpatient EHR systems.

Acute Care Hospitals – Certified EHR Technology Solutions used for primary inpatient EHR system	
Cerner	28%
Eclipsys	14%
McKesson	3%
Meditech	31%
Other	24%

Acute Care Hospitals – Certified EHR Technology Solutions used for primary outpatient EHR system

Allscripts	17%
Cerner	10%
Epic	3%
eClinicalworks	3%
GE	21%
McKesson	3%
Meditech	17%
Sage	3%
Other	17%

Nearly all of the hospitals reported that a majority of clinical staff use the EHR routinely with 66 percent reporting over 90 percent, and 28 percent reporting between 51 and 90 percent. Nearly three-quarters of the hospitals reported that a majority of providers use the EHR system routinely. Another 14 percent reported that between 25 and 50 percent of providers use the EHR system routinely and another 14 percent reported that fewer than 25 percent of all providers use the EHR system routinely. One of the hospitals reported no longer using paper charts; 34 percent reported that they maintain paper charts, but that the EHR is the most accurate, complete source of patient information; 59 percent use a mix of paper and electronic information; and one hospital primarily uses paper charts, but maintains electronic records for some clinical information.

Only one hospital responded that they have not adopted or implemented EHR technology. This hospital did respond that they intend to adopt and implement an EHR system in the next one to three years. This hospital indicated that the cost to acquire EHR technology, cost to maintain EHR technology, and internal knowledge/technical resources were barriers to implementation.

2) Intent to Apply for Incentives Among Acute Care Hospitals

Forty percent of the responding hospitals indicated that they planned to apply for the Medicaid EHR Incentive Program in 2011 and another 40 percent indicated that they will apply in 2012. Four percent of the responding hospitals indicated that they intended to apply in 2013. Sixteen percent were unsure of when they would apply for the Medicaid EHR Incentive Program.

Of the responding hospitals, 86% indicated that they intend to apply for both the Medicaid and Medicare EHR Incentive Payments. Another 10% indicated that they intend to apply for the Medicare Program and 3% (1 hospital) reported uncertainty. Sixty-nine percent had done the calculation to determine the expected amount of the

hospital's incentive payment and another 14 percent had not yet done the calculation, but are planning to do so. Seventeen percent have not done the calculation.

At the time of analysis, of the 36 Maine hospitals, 33 met the 10% MaineCare volume threshold just using the inpatient discharge days (not adding in the ER visits) with 23 of these indicating an intent to apply for the EHR Incentive Payment Program. Since the dates the survey was administered, Maine further understands that hospitals may add the ER encounters to the inpatient encounters in the numerator and denominator to determine whether the hospital meets the 10% Medicaid patient threshold. The State believes that all of Maine's 36 potentially eligible hospitals (using the CMS definition) will meet the 10% Medicaid patient threshold requirement of eligibility.

Of the 20 general acute care hospitals that meet the 10% Medicaid volume threshold, 13 indicated they planned to apply for both Medicare and Medicaid Incentive Programs; 2 to Medicare only; one was not sure; and four did not respond to that question.

Of the 13 critical access hospitals that meet the 10% Medicaid volume threshold using the inpatient discharge data, all but one indicated their intent to apply for the Medicare and Medicaid EHR Incentive Programs.

In sum, it appears that almost all, if not all, of Maine's hospitals will meet the 10% eligibility thresholds and the challenge for the State is to get them to apply.

A5d. Dental Practice Survey

The survey went to all of the 220 dental practice sites that serve MaineCare Members, with a response rate of 72, or 33 percent. Approximately 47% of the respondents practice general dentistry in solo practices, 11% specialty dentistry in solo practice, 17% community dental clinics, 16% general dentistry in group practice, and 9% specialty dentistry in group practice.²⁰ Nearly 60% of the practice sites have only one dentist working at the practice site. Another 22% have two dentists working at the practice site.

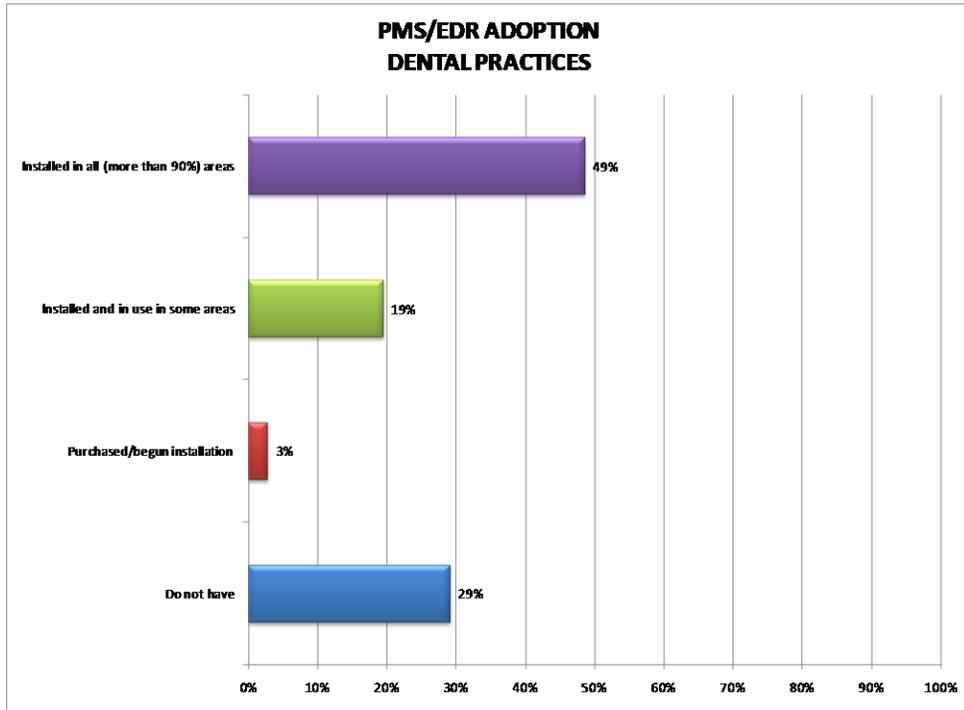
1) Dental Practice EHR Adoption

Dental practice HIT terminology differs from other EP terminology. Rather than using Electronic Health Records, dental practices use Practice Management Systems (PMS) or Electronic Dental Records (EDR). Of the practices responding over 70% have adopted or purchased a PMS/EDR. Almost 50% have a PMS/EDR installed in all areas of their practice. Another 19% use a PMS/EDR for some of their practice staff and providers and another 3% have purchased/begun installation, but are not yet using such a system. However, 29% indicated that they do not have a PMS/EDR in use at all.²¹

²⁰ Hospital-employed dentists may have been included in the survey as they were not delineated from the dental practice survey.

²¹ For a discussion about Dental practices with EHR and draft Meaningful Use measures, see Appendix A-12.

Figure 9: Dental Practices – PMS/EDR Adoption



Seventy-three percent of the respondent dental practices with PMS/EDR systems reported installing their system in 2005 or earlier. Another 6 percent completed installation in 2006, 2007, 2008, and 2009 respectively. Two percent of respondent practices completed installation in 2010.

Of the dental practices that reported having a PMS or EDR system, approximately one-third use Dentrix and another third use EagleSoft. Other PMS and EDR systems in use by dentists include Practice Works, SoftDent, ACE, Dentech, and Meditech. The table below displays the PMS/EDR systems in use grouped by vendor.

Medical practices (including eligible providers) Practices – Certified EHR Technology Solutions used	
Dentrix	22%
Practice Works	8%
SoftDent	1%
EagleSoft	19%
Other	49%

Dental practice respondents with a PMS/EDR system were asked to report on their practice’s use of paper charts for patient information tracking. Twenty percent reported that their practice is entirely paperless, 24

percent reported that they maintain paper charts but the PMS/EDR is the most complete source of patient information, 20 percent reported that some patient data is documented in paper charts and some is documented in the PMS/EDR, and 35 percent reported that paper charts are primarily used with some clinical information in the electronic record.

Two-thirds of the dentists reported using a PMS/EDR in their practice. Of these respondents, 76 percent reported that most or all clinical staff and providers routinely use the PMS/EDR. These systems were being used for several clinical purposes displayed below:

Dental Practices – PMS/EDR Functionality Used	
Tracking chief complaint	62%
Medical history	61%
Dental history	74%
Tracking progress notes	61%
Maintaining problem lists/diagnoses	54%
Maintaining treatment plans	83%
Completed treatment	92%
Oral health status	68%
Storing radiographs	74%
Extraoral images	73%
Intraoral images	74%
Scheduling appointments	100%

Half of the practice site respondents indicated that patient-related information is accessed on the computer, “chair side” or in the operatory. Half of the practice site respondents also indicated that information is accessed elsewhere in the dental office. Approximately one-third, 23 practice sites, do not have or use PMS/EDR technology. Of these, 77%, or 17 practice sites, have no plans to implement a PMS/EDR in the next five years. The most frequent barriers to EHR adoption cited include cost to acquire the technology, cost to maintain the technology, and return on investment.

2) Intent to Apply for Incentives Among Dental Practices

Medicaid claims data was used to determine the number of Members, visits, charges and payments with each servicing provider and site. Claims for services in calendar year 2009 and reimbursement of these claims were analyzed. Claims were aggregated to the servicing provider noted on the claim. MaineCare covers dental services for members under the age of 21. CMS does not provide guidance on calculating patient volume for selected members. High and low patient volumes are based on average patient panel

size of 2,300²² and a reduced panel of 529 to estimate the number of children²³. The State used the CMS estimate to ascertain the expected use.²⁴

Claims data identified 310 dental servicing providers²⁵ with services provided to 66,033 MaineCare members with total costs of \$28 million dollars. The most conservative estimate, for the total panel, is 19 providers, while the more liberal for the children panel estimates 47 providers.

²² Estimate of average dental practice size: <http://www.nytimes.com/2009/03/03/us/03dentist.html?em>

²³ MaineCare Adults do not have a dental benefit; 25% of Maine's population are children (< 21).

²⁴ The "As Is" External Provider Survey showed that 49% of dentists have fully installed practice management system (PMS)/ Electronic Dental Record (EDR). This makes the CMS estimate seem reasonable for these providers.

²⁵ FQHC dental services were attributed to the FQHCs in the PCCM analysis and are not included here.

Section A. Part 6. Parallel Initiatives

In addition to current system assets, DHHS has several initiatives currently underway that will likely influence the direction of HIT, HIE, and EHR technology adoption. Ongoing and currently planned initiatives will be leveraged to coordinate activities and create a unified approach for the advancement of health information exchange in Maine.

A6a. Pharmacy Benefit Management

The Pharmacy Benefit Management (PBM) program is a pharmacy benefit program for MaineCare members. The point of purchase application for pharmacy providers will soon be replaced. MaineCare has released a Request for Proposal (RFP) for a new Pharmacy Benefit Management program application. The new system will be implemented by July 2011. Goold Health Systems is the current vendor managing the application. The anticipated capabilities of the new PBM application include:

- Maintain interfaces with POS system and reporting applications
- Provides real-time access to both beneficiary and provider eligibility
- Supports online real-time summary information including number and type of providers, beneficiaries, and services
- Available 24 hours a day, 7 days a week, 365 days a year
- Prior Authorization must be compliant with Federal and State regulations
- E-prescribing solution that would work with Prior Authorizations and Point Of Sale (POS)
- Fully automated PRO-DUR system that meets Federal DUR regulations
- Fully functional RETRO-DUR system that meets Federal DUR regulations
- Implementation of Medication Therapy Management Program
- Transmit adjudicated claims to the Data Hub for the MMIS system
- Pharmacy help desk available to providers for clinical and technical support

A6b. CHIPRA

Maine and Vermont are among 10 state teams that were recently awarded demonstration grants to enhance the quality of care delivered to children in their states and inform best practices for the nation. The grant will allow the states of Maine and Vermont to test, develop, and expand the use of evidence-based child performance measures to include child behavioral health measures.

In addition, the states will be able to expand their information technology systems so that they can improve the exchange of child health data and expedite service provisions to children in foster care. They will also test and evaluate a pediatric medical home model for other states, particularly non-demonstration states, to expand child health improvement efforts. In addition to the core set, Maine plans to consider the feasibility of other data collection and measure reporting. Maine plans to conduct an environmental scan of all child behavioral health outcome measures being used by mental health providers and explore the feasibility of testing and integrating these measures into broader pediatric practice level reports.

A key element of this planning is to ensure that Federal and State resources are fully maximized and complementary, not duplicative or redundant. With the award of the CHIPRA Category B grant, CHIPRA funded HIT resources will also be included in Maine's comprehensive HIT planning and reflected in the State Medicaid HIT Plan.

An example of the complementary use of funds to accomplish those goals would be the utilization of the Medicaid ARRA Section 4201 provider incentive payment program to help pay for the cost of adoption, implementation or upgrades of EHR systems in pediatric practices, ONC HIE funding to pay for interfaces to ensure connectivity to the state HIE network, and CHIPRA grant funding to develop data repositories for the collection, design, implementation, and evaluation of the automation of *Bright Futures*, as well as foster care health data system. This five-year initiative will run from February 2010 – February 2015.

A6c. Federally Qualified Health Center Networks

The Maine Primary Care Association (MPCA), a Health Center Controlled Network, received a grant for 2005 through 2008 from the Health Resources Services Administration (HRSA) to implement the NextGen EHR technology in five FQHC organizations with 19 sites and over 50 providers. Since 2008, the MPCA has received additional HRSA support of over \$1 million for four HIT grants to:

- Develop an immunization interface between the EHRs and the state immunization registry, IMMPACT2
- Plan HIE architecture and business model, to include exchanging data from 19 MPCA members (representing multiple vendor platforms) to HealthInfoNet
- Develop reports for the management of chronic conditions and preventive practices; framework for improving rates of reporting of Pay for Performance; and development of e-prescribing capabilities; and
- Develop decision support tools to assist in identifying patients who may be eligible for Federal or state assistance programs

A6d. Managed Care / Accountable Care Planning and Procurement

When Maine began its SMHP planning activities, MaineCare was conducting a feasibility study to investigate the potential of establishing a risk-based managed care contract for specific MaineCare populations and services.²⁶ In early 2011, the State decided to continue its analysis of the best methods of providing Medicaid services. An update to that work is expected in late spring or early summer 2011.

A6e. Primary Care Case Management (PCCM)

As of November 1, 2008 nearly 187,000 were enrolled in the MaineCare Primary Care Case Management Program (PCCM). Once a Maine Care member enrolls in PCCM, they choose a primary care provider from a list of providers who have agreed to accept MaineCare members and the provider coordinates all

²⁶ An update to that work is expected in late spring or early summer 2011.

the member's health and medical care. In addition, two care management initiatives for particular populations were implemented in 2008 or 2009:

A6f. High Cost Chronic Care Management Initiative

DHHS contracted with a vendor for care management of MaineCare members who have the highest costs and who have medical conditions and utilization histories that can be improved through care management. As an update, in March 2011, the care management functions that had been performed by the vendor were relocated to MaineCare's Health Care Management Division which has a great deal of experience with the type of care management that these Members and could benefit from.

A6g. Patient Centered Medical Home (PCMH)

The Patient Centered Medical Home (PCHM) pilot project was implemented in the fall of 2009, with MaineCare participating as of November 1, 2009. Participants in this new initiative include 25 practice sites, 22 family practice sites and 4 pediatrics sites. The sites include private practices, Federal Qualified Health Clinics (FQHC), and hospital-owned primary care practices. MaineCare has added the pilot project to the Primary Care Case Management (PCCM) program, and pays an extra incentive of \$3.50 per member per month to practice sites participating in the PCMH pilot. The Muskie School of Public Service has designed an evaluation of the PCMH pilot to assess the effects of the program on a number of aspects including quality, patient satisfaction, and efficiency of care both to MaineCare members and all patients served by the pilot.

A6h. State Profile Tool Project – Long Term Services and Supports System

The State Profile Tool (SPT) Project focuses on assessing the current long term services and support system, including how the system is designed to deliver and access services across programs, the costs of services and utilization by population groups. The SPT Project is funded by a three year grant from CMS and focuses on looking at the system's current balance between institutional care and community services. The SPT Project intends to find out:

- Who is receiving long term services and supports
- What are the costs of services across programs and settings
- What is the mix of services across population groups
- What are the strengths and development areas within the current system

The goal is to gain and understanding of the long term services and supports population, how to meet the needs of the population, how to deliver services appropriately, and how to manage costs to ensure that members' needs are met appropriately. The next steps for the SPT Project are to develop recommendations for ongoing system review and integrate the SPT into DHHS policy planning and decision making.

A6i. Dirigo Health Reform and DirigoChoice

In June 2003 Maine created the Dirigo Health Agency as part of the Dirigo Health Reform Legislation. Dirigo Health provided an insurance plan at a reduced or no cost for certain categories of individuals and businesses. As an update, Dirigo is evolving as a result of new policy development, health care reform, and other considerations.

A6j. DHHS Performance Metrics Dashboard

The DHHS Performance Metrics Dashboard provides an accessible summary of key performance measures and indicators through a web-based application for the Commissioner and Deputy Commissioners and their executive teams. A publically accessible version of the tool will be developed for use by additional stakeholders, including legislators, to provide a unified voice of the status of the organization's performance. The tool will streamline data, and make visible key performance indicators to help users quickly see areas that need attention.

Demonstration Release 1.0 is a demonstration of key content and functionality tailored to the DHHS Commissioner and Deputy Commissioners. The Demonstration Release 1.0 was accomplished on April 1, 2010 and provides web-based access (minimally intranet), offering descriptive information on the State demographic and health indicators, and leveraging key performance indicators that are already being used by the various Offices. Characteristics of the indicators include sustainability, consistency, reliability, and validity to purpose. A Production Release 2.0 was introduced on October 4, 2010 to the Executive Leadership and Integrated Management Teams, institutionalizing the Dashboard as a centralized source of information about the Department's performance, including information that the Legislature is frequently requesting by geographic regions (e.g., general assistance receipt by town). A public version of the of the Production Release (2.1) was introduced on October 18, 2010.

The DHHS Performance Metrics Dashboard project will occur in iterative releases. The purpose of the Release 1 demonstration is to further develop the requirement for the content, functions, and look and feel of the tool. Following the Release 1 demonstration, a cross-Department Workgroup was created to ensure participation and collaborative development of the final tool. The Workgroup provides appropriate subject matter expertise and decision-making representation, and will include participation from each Office to continue to develop the tool to meet identified objectives.

MaineCare currently has a monthly dashboard of measures of MaineCare processes and outcomes which is maintained and presented to the MaineCare Senior Management Team on a monthly basis. MaineCare also has representation on the DHHS Dashboard group.

A6k. Health Data Workgroup

The Health Data Workgroup's goal is to obtain information from several groups in the State about their use of information in Maine's health data systems. The workgroup has surveyed seven organizations/entities to get an understanding of how they generate, aggregate, analyze, and use health data. The seven entities are:

- Maine Health Data Organization (MHDO)
- OnPoint
- MaineCare
- Maine Centers for Disease Control (Maine CDC)

- HealthInfoNet (HIN)
- Maine Quality Forum (MQF)
- Major health systems in the State (EMH, MaineHealth, Maine General, Central Maine Medical Center)

The workgroup is made up of various State stakeholders including OSC, MaineCare, DHHS, HIN, MHDO, MQF, Maine CDC, and the provider associations. MaineCare will continue to monitor this initiative as the information that is gathered may influence the direction of HIT in the State.

A6l. Department of Corrections EHR Capabilities

The Department of Corrections (DOC) is currently pursuing the acquisition of an EHR system to manage the health information of individuals in the State's correctional institutions. Correctional Medical Services manages the care provided to inmates in correctional facilities and they currently do not have an EHR system. The Corrections Information System (CORIS) manages all information on adults and juveniles in correctional institutions or the community, but does not contain any health information. MaineCare will have to coordinate with the Department of Corrections once they adopt and implement EHR technology to understand how offender health information can be shared in a statewide HIE to allow for individuals to access their records prior to entering the corrections system and after being released from the corrections system.

A6m. Indian Health Center EHR Capabilities

Maine has six Indian Health Services clinical facilities, three of which responded to the Maine HIT Survey. Two have EHR technology installed in all areas of their practice. The Micmac Service Unit facility uses Indian Health Services – Resource and Patient Management System 2008, and the Penobscot Nation Health Department uses GE Health care – Centricity Enterprise 6.7. Both facilities are using a wide variety of capabilities within their EHR including CPOE, clinical guidelines, chronic care plans, condition specific reminders, active medication lists, and active allergy lists. Both facilities' EHR technology is lacking high tech diagnostic imaging. The Penobscot Nation Health Department's EHR is exchanging information with providers outside the system, hospitals in the system, the State immunization registry, and the Maine CDC. The Micmac facility is not exchanging health information at this time. The Houlton Band of Maliseets responded that they do not use EHR technology in their clinical facility.

All of the Indian Health Center clinical facilities in Maine have an electronic practice management (EPM) system implemented. The Indian Health Centers are currently developing a HL7 interface to facilitate the exchange of health information with HIN, MPCA, and their local hospitals.

A6n. Veterans Administration EHR Capabilities

The Veterans Administration (VA) has been using an EHR in VA clinical facilities since 1985. The VA uses an enterprise-wide information system called VistA, the Veterans Health Information Systems and Technology Architecture, as their HER system which is installed and in use in all VA facilities in the United States.

VistA is a complete EHR that supports both Medical practices (including eligible providers) and inpatient care. VistA includes several common EHR capabilities including computerized physician order entry (CPOE), bar code medication administration, e-prescribing, and clinical guidelines. The VA uses VistA as the primary source of health information for veterans; no paper records are used in VA clinical facilities. The EHR data in VistA is stored at a regional level; all regional databases are connected nationally to allow any VA clinical facility to access any veteran's EHR. VistA is not a commercial product and is available as open source software directly from the VA website.

Maine has fifteen VA clinical facilities which includes one VA hospital and fourteen outpatient clinics and veterans centers throughout the State. These facilities are not exchanging data with HealthInfoNet (HIN). VistA plans to connect directly to the Nationwide Health Information Network (NHIN) which HIN requires the use of NHIN CONNECT to exchange health information with VA clinical facilities. HIN and OSC have been meeting with the Togus VA Medical Center since 2008. In July 2010, the Director, Standards & Interoperability of the VA met with the OSC, HIN, the Beacon Community, and the Togus VA Medical Center to discuss the next steps in developing a CCD C-32 compliant interface with HIN. These activities will be the first step for HIN to incorporate NHIN Connect Specifications. As a result, a review with the current and new vendors is currently underway to assure that the revised HIN architecture will meet all NHIN Connect standards. In addition, as a result of these discussions HIN and its legal council are currently reviewing the Data Use and Reciprocal Service Agreement (DURSA) in regard to current consent policies and business associate agreements in place with HIN participants. The goal is that sometime in 2011, HIN will be a NHIN Connect HIE.

A6o. Broadband Technology Opportunity Program

The National Broadband Plan, Connecting America, was unveiled to Congress on March 16, 2010. Much like the introduction of electricity and the construction of the interstate highway system transformed economic growth, broadband is the foundation for job creation, global competitiveness and advancement of consume welfare, community development, health care delivery, energy independence and efficiency, education, employee training, private sector investment and entrepreneurial activity.

In recognition of the critical importance of technology for education, health and business success in Maine, the Legislature created the ConnectME Authority (the Authority) in 2006, to develop and implement its broadband strategy for Maine. In 2007, the Legislature approved the Authority's major substantive rule that defines the State's broadband strategy and implementation process.²⁷

The Authority is to "identify un-served areas of the State; develop proposals for broadband expansion projects, demonstration projects and other initiatives, and administer the process for selecting specific broadband projects and providing funding, resources, and incentives." The National Broadband Plan has reinforced the effort already underway in Maine and has increased the possibility of funding and support.

²⁷ For more information about the ConnectMe Authority go to www.maine.gov/connectme

To date, the Authority has processed four rounds of grant funding to expand affordable broadband service to the un-served areas of Maine. The Authority has awarded \$3 million in total grants with total projects amounting to \$8.5 million. To further the broadband effort the Authority is funding a mapping and planning project with a \$1.8 million grant from the National Telecommunications and Information Administration (NITA). A \$25.4 million Federal Recovery Act grant, called the “Three Ring Binder” Middle Mile Project, is expanding high-speed Internet service to rural areas of the State through a “looped” service, which includes Internet service for medical facilities. .

The EHR adoption survey distributed to MaineCare providers included a question about access to broadband internet access. The results are being used by MaineCare and the ConnectME Authority as it moves towards implementation of the SMHP.

A6p. Telemedicine

Telemedicine refers to the use of telecommunications technology – ranging from telephone to real-time video and internet connection – to provide health care services to patients who have physical or geographic difficulties in accessing services from physicians or other health care providers. It can be particularly useful in a rural state like Maine, where some health care services are distantly located from the community and where workforce challenges frequently limit access to many services, including, but not limited to, specialty services. This is especially true with time sensitive diagnoses – for example acute stroke – in which treatment windows are very short, and specialty providers are critical to the chain of survival and recovery.

Providers assert that tele-home-health services enhance self-care, medication management, and chronic disease management, therefore improving health and reducing re-hospitalization rates. More commonly, telephone education has long been used to help patients learn how to better manage their diabetes.

Interested in the opportunity to improve access to care in rural communities, the Maine Health Access Foundation (MeHAF) convened a group of stakeholders in 2003 and 2005 with an interest in telemedicine and discovered that while Maine has a telemedicine infrastructure (i.e., the equipment, whose acquisition was largely funded by Federal grants), telemedicine was not being widely used, due to a number of cited barriers, including: licensing; credentialing and privileging; and reimbursement.

Maine's Office of Rural Health and Primary Care is charged with developing a strategic plan for telehealth infrastructure in Maine. Their aim is to provide greater access to telehealth resources and services to providers, patients and payers. In previous months they interviewed early adopters of telemedicine to understand what has worked and what obstacles persist to further telemedicine development. Many clinicians expressed their desire to learn from each other's experience. The Office of Rural Health and Primary Care (ORHPC) recently formed the Maine Telehealth Collaborative (MTC) led by an Advisory Group of Maine health care providers, health professionals, and other interested parties.

A6q. HIPAA2: 5010 / ICD-10

DHHS finalized the first major modifications to HIPAA's transactions and code sets regulation on January 16, 2009. HIPAA covered entities – including Medicaid health plans – are required to implement version 5010 of the X12 standards for health care transactions, NCPDP D.0 /1.2 for retail pharmacy transactions, and ICD-10 diagnosis and procedure coding. The compliance dates are January 1, 2010 for version 5010 and D.0 /1.2 transactions, and October 1, 2013 for ICD-10 diagnosis and procedure coding. A new Medicaid pharmacy subrogation transaction is required by January 1, 2012, except for small health plans which have until January 1, 2013 to comply.²⁸

The anticipated benefits for Medicaid plans include more efficient operations, more accurate claim payments, better disease management, and improved fraud and abuse detection. If changes are properly implemented, that may mean lower program costs and better service and care for Medicaid beneficiaries. Although the compliance dates are three years away, the magnitude of these changes requires that MaineCare begin assessing the impact of the changes on their technology, business processes, and staff. Action is needed now to allow adequate time for developing project plans and budgets and designing, testing, and implementing the necessary changes.

A6r. National Health Care Reform

The 2010 Patient Protection and Affordable Care Act (H.R. 3590) includes several provisions for children and families that took effect in 2010:

- States must at least maintain the Medicaid and CHIP coverage and enrollment procedures that they have in place now (maintenance of effort).
- Small employers receive tax credits covering 35% (increasing to 50% by 2014) of health care premiums.
- A high-risk pool established for qualified uninsured people with pre-existing conditions (until the Exchange is operational).
- Young adults can remain on their parents' health plan until age 26.
- Children with insurance can no longer be denied coverage for pre-existing conditions.
- Insurance plans can no longer impose lifetime caps or restrictive annual limits on coverage, and cannot rescind coverage when a person becomes ill.
- New plans must provide free preventative services to enrollees.

Maine implemented these changes in 2010. Most of the provisions of the health reform package will go into effect January 1, 2014, including the requirement to create state-based health Exchanges where individuals and small employers can buy insurance. The changes specific to Medicaid programs include:

²⁸ Medicaid plans – as well as most of the health care industry – will need to make the following transitions in the next few years: From X12 version 4010/4010A to X12 version 5010; From NCPDP Telecommunications Standard 5.1 / Batch Standard 1.1 to Telecommunications Standard D.0 / Batch Standard 1.2; From ICD-9-CM Diagnosis and Procedure Coding to ICD-10-CM Diagnosis Coding and ICD-10-PCS Procedure Coding

- Medicaid coverage for adults under age 65 with income up to 133 percent of the FPL
- Federal financial assistance for newly-eligible beneficiaries
- Federal financial assistance for expansion states
- Temporary maintenance-of-effort on existing Medicaid coverage
- Optional five-year waiting period for lawfully residing immigrants remains in effect

The changes specific to CHIP include:

- Medicaid coverage for children with income up to 133 percent of the FPL
- Medicaid and CHIP eligibility levels for children maintained above 133 percent of the FPL
- CHIP continued through at least 2019; funding through fiscal year 2015
- Increased Federal financial assistance for CHIP
- Medicaid coverage for former foster care children
- New state options to provide CHIP coverage to children of state employees

Under the approved bills, people will have different avenues through which they will obtain coverage. The bill includes provisions on how these coverage options intersect and how people will be expected to navigate among the different pathways, most notably Medicaid, CHIP, and the Exchanges.

- Screen and enroll procedures between Medicaid/CHIP and the Exchanges
- Enrollment process that is uniform and streamlined
- Support for community outreach
- State Medicaid agency may administer premium tax credits

MaineCare will closely follow the health care reform efforts which will be reflected in its SMHP and IAPDs updates.

A6s. HITECH Extension for Behavioral Health Services Act of 2010 (HR 5025)

The HITECH Extension for Behavioral Health Services Act of 2010 (HR 5025) proposes to provide meaningful use of EHR incentives to mental health professionals and facilities, a category of health care providers that were excluded from the HITECH Act provisions.

The new legislation would make inpatient psychiatric hospitals, as well as licensed clinical social workers and licensed psychologists providing qualified psychologist services eligible for Medicare meaningful use incentives. It also makes psychiatric hospitals and mental health and substance abuse treatment facilities with at least ten percent (10%) of their patient volume being individuals receiving Medicaid assistance eligible for the Medicaid incentives. Behavioral health, mental health, and substance abuse professionals would also be eligible for Medicaid incentives under the proposed legislation. Maine will follow these efforts which will be reflected in updates to the SMHP and IAPD.

A6t. EHR Incentives for Multi-Campus Hospitals Act of 2010 (HR 6072)

The EHR Incentives for Multi-Campus Hospitals Act of 2010 proposes that hospitals with multiple campuses should receive larger incentives that reflect their incremental costs incurred in installing, operating, and using certified electronic health records, and training staff at multiple campuses. The bill provides funds in a way that balances the needs of larger and smaller multi-campus hospital systems. This bill will help ensure that the HITECH Act fulfills its goals of improving health quality and reducing adverse outcomes while reducing overall health care costs.

Section A. Part 7. HIE Initiatives

A7a. HIN Statewide Demonstration Project

HealthInfoNet (HIN) is the single health information exchange (HIE) designated as Maine's Health Information Exchange. In 2008, HIN, which uses national data standards for health and data exchange and open standards for technical solutions, began a statewide demonstration project sharing an extensive clinical dataset from Maine's four largest integrated delivery networks, a mid-sized rural hospital representing over half of all hospital-based care in Maine, a large multispecialty group practice, and a prepaid health plan. Clinical data is presently shared in the emergency departments of participating hospitals. Data elements being shared are a subset of the Continuity of Care Record (CCR) and include transcribed hospital documents including history and physical examinations, discharge summaries, emergency room (ER) reports, radiology reports, prescription data, laboratory data, problem lists, and allergy lists. HIN delivers automated laboratory test results to the Maine CDC to support mandated infectious disease reporting.

The proposed State-wide clinical exchange will build a strong core capacity and system currently managed by HIN. Recently, MaineCare, in conjunction with Goold Health Systems (GHS), as part of an e-Prescribing initiative, has recently begun to transmit pharmacy data to HIN. HIN completed the statewide demonstration phase of the project in June 2010 and plans are being made to expand the list of participants statewide. Today, HealthInfoNet has completed the two-year demonstration project and is working to expand the network statewide. The goal is that all health care providers will be connected to the exchange network by 2015.

A7b. Regional Extension Center Grant Recipient

HealthInfoNet is Maine's grant recipient for the Regional Extension Center funding opportunity from the Office of the National Coordinator for HIT. MaineCare, Maine's major health systems, the Maine Primary Care Association and the EMR implementation and Quality Improvement (QI) organizations that provide technical assistance and support across the State's health care system. HIN is currently not providing technical and other assistance to Maine hospitals and providers. Initial plans are being made to address how to assist hospitals and providers in their acquisition, implementation, and Meaningful Use of health information technology.

A7c. Geographic Reach of HIN

The geographic reach of the HIE exchange is Maine--there is currently no exchange of HIT across state borders. However, MaineCare Members living in border towns do obtain services from providers in New Hampshire. Conversations have been started between Maine, New Hampshire, and Vermont about

opportunities for collaboration of the adoption and use of EHR technology and utilizing current RECs to support HIE.

A7d. Electronic Clinical Laboratory Ordering and Results Delivery

Two of Maine's reference laboratories as well as the five participating Maine hospital systems are participating in the HealthInfoNet Demonstration Phase. Interfacing with these labs has required concept mapping of both the laboratory data (including microbiology) and the registration/ encounter data from the lab's independent registration system. Laboratory orders are being coded to the Logical Observation Identifiers Names and Codes (LOINC) standard for state required reporting and HIE. Laboratory results are also being standardized using Snomed codes where applicable. Using the LOINC and Snomed standards to exchange lab data is allowing for semantic interoperability across Maine and will position HIN to exchange data with the Nationwide Health Information Network (NHIN).

A7e. Electronic Public Health Reporting

HealthInfoNet has a long standing relationship with Maine CDC (MCDC). MCDC is a participant in the Demonstration Phase, and automated laboratory result exchange is supported for 30 of the 72 diseases mandated for public reporting by the State of Maine. HIN has delivered the PHINMS transport standard required by MCDC to communicate automated laboratory test results to the public health information infrastructure. The technical plan calls for the statewide exchange to begin developing a solution for supporting public health syndromic surveillance in the next phase of its roll out.

A7f. Prescription Fill Status / Medication Fill History

HealthInfoNet is currently contracting with DrFirst for prescription medication history and profile information. The data sources accessed by DrFirst to deliver medication history profile information to HIN include RxHub, SureScripts and the DrFirst e-prescribing repository. These current sources provide access to prescription medication information for approximately 53 percent of the residents of Maine. HIN is currently completing negotiations with MaineCare to provide the Medicaid medication history to the statewide exchange. Once access to the Medicaid prescription data is accomplished, HIN will be able to provide access to medication history profiles for approximately 64 percent of Maine residents.

Section A. Part 8. Privacy and Security

Through conducting the assessment, Maine identified additional topics that impact the vision of HIT and should be included in the "As-Is" Landscape for Medicaid HIT. The topic of privacy and security concerns related to the adoption and use of HIT and EHR technology was discussed in a number of interview sessions. Additionally, concerns were raised around the current restrictions for sharing specific health data making it challenging or not possible to share key health information on a statewide HIE. An understanding of the current state of privacy and security controls as well as data use agreements and policies within DHHS are essential to building a roadmap toward private and secure sharing of data within the state.

A8a. Impact of HITECH Act on Privacy and Security

Respecting individuals' right to privacy and protecting their personal health information is critical to the successful widespread adoption and use of health information technology and exchange by health care providers.

EHR technology is a powerful tool for improving the quality of care, the coordination of care, and health care outcomes for MaineCare Members. However, sharing and exchanging personal health information comply with HIPAA law. DHHS, as a covered entity, must comply with privacy and security of health information and must provide individuals with certain rights with respect to their individual health information.

The statewide HIE, HIN, is not a covered entity, but if HIN performs functions or activities on behalf of DHHS within a business associate agreement, HIN would be required to have security and privacy controls in place to safeguard and appropriately protect the privacy of protected health information. Utilizing HIN to manage the auditing, tracking, and aggregation of data could be beneficial for DHHS.

Sharing PHI through EHR technology empowers both health care providers and patients to better manage health. It is essential that health care providers have access to the health information needed to care for patients where and when it is needed, while at the same time protecting patients' information. MaineCare Members have reported that they are as concerned about the quality of care they receive as they are about the privacy and security of their health information. Achieving the right balance of access and privacy is the key to security in the current health care environment.

A8b. Privacy and Security Rules in Maine

Access to data within some DHHS systems is monitored by a data use agreement or a Memorandum of Understanding (MOU) stipulating how data can be used, stored, and shared. The data that lives within each State system “belongs” to the Office where the system resides. Data use agreements and MOUs could be a challenge to exchanging clinical and health data within a statewide HIE. Data use agreements and MOUs will need to be expanded to support the exchange of information with a Statewide HIE.

Maine statutes restrict access to specific health data such as treatment records, substance abuse treatment, mental health data, and HIV/AIDS- related information. Current State privacy laws mirror HIPAA very closely and do not allow mental health information or results of HIV tests to be shared without patient consent. While there have been no recent changes to State laws or regulations regarding privacy and security of health records, the OSC submitted a bill in February 2011 that is working its way through the legislative process.²⁹

Conclusion: Maine’s “As-Is” Landscape assessment shows that Maine has a vast infrastructure of programs and systems that can be, and should be, used for the OMS HIT Incentive Payment Program and

²⁹ See Section B, “To-Be”, Privacy for more discussion of this effort.

the overall HIT initiatives. There is a lot of education, training, and outreach that will be needed to successfully implement HIT efforts, and resources will need to be dedicated to performing HIT activities. The challenge for Maine is to create systems and processes that are truly integrated and informed.

SECTION B – HIT “TO BE” LANDSCAPE

This section is the “To-Be” Landscape of the MaineCare HIT program.³⁰ It is divided into three parts:

Part	Description
1. Vision	a. HIT Visions b. Process to Create the MaineCare HIT Vision
2. 2016 Five Year Plan	a. Governance b. Privacy and Security c. Communication, Education, Outreach d. HIT Initiative Coordination e. Infrastructure and Systems
3. First Year DDI and Operations	Specific steps for the first year

Section B. Part 1. Vision

B1a. HIT Visions

The MaineCare HIT Vision has its roots at two levels:

Visionary level: What the ideal health care system looks like--one that provides truly integrated care and improve quality and health outcomes; and the health information technology that can achieve that “ideal.”

Five Year Level: The opportunities that the HITECH Act and federal and state cooperative efforts across the spectrum of HIT offer and how to leverage these opportunities to improve health care access, efficiency, quality, and outcomes.

Part 1. summarizes the activities Maine conducted to develop its MaineCare HIT vision. The 2016 Five Year Plan is described in Part 2. of this Section. Part 3 summarizes the first year Design and Operations of the HIT Incentive Payment Program.

To build the vision, MaineCare reviewed the history of health care in Maine. From a geographic and organizational standpoint, Maine’s health care systems are dispersed across all of Maine and widely shared among DHHS and other State departments, public and private health care providers and multiple insurance providers. What is needed to bring them together is information capabilities that provide coordinated, shared, and person-centric information about the people being served. Connections and information sharing among those systems is essential for an integrated system that allows providers and patients to make informed decisions which can only happen if the information available, and if the

³⁰ See Appendix B-1 for CMS questions posed to states to answer in their SMHP document.

information is comprehensive and of high quality. And this can only come from improved health information technology.

Although it was important to look at the history of health care in Maine, the future, that the HITECH Act provides is the framework for improving health information technology and health outcomes. The structure of the programs established by the HITECH Act recognizes a federal / state partnership both to build the HIT vision and to plan and implement that vision. The ONC's simple, yet profound, vision which guides the 2012 federal efforts and serves as the foundation of state initiatives is:

A Nation in which the health and well-being of individuals and communities are improved by health information technology.

Maine's state-wide HIT vision, developed through a collaborative process led by Maine's OSC, is built upon the ONC's framework. The State's vision and mission are anchored in providing or facilitating a system of person-centered, integrated, efficient, and evidence-based health care delivery for all Maine citizens:

Preserving and improving the health of Maine people requires a transformed patient centered health system that uses highly secure, integrated electronic health information systems to advance access, safety, quality, and cost efficiency in the care of individual patients and populations.

The Medicaid HIT program used these two essential building block visions as a foundation for its vision which was developed with a particular emphasis on the children, elderly and disabled people served by Medicaid:

A State where access to electronic health information is provided to State users, providers and members to improve individual and population health outcomes through the use of health information technology.

B1b. Process to Create the MaineCare HIT Vision

The State believes that the approach to develop its "To-Be" landscape is as important as the product the work produces. Maine understood the value of integrating its Medicaid HIT program with its OSC state-wide program; with the ONC nation-wide program; and with the CMS Medicare program. Maine elected to use the visioning framework of collaboration and integration employed by the ONC which in turn was used by Maine's OSC, to develop the Medicaid HIT program's "To-Be" landscape.

The key tasks completed to develop the vision for the "To-Be" Landscape were to:

- Identify stakeholders and session groupings
- Develop educational materials and visioning session materials (federal and State rules and regulations and HIT documents described earlier in this Section)
- Conduct sessions
- Analyze findings and develop key vision themes
- Draft and distribute preliminary “To-Be” vision document
- Convene full stakeholder group for additional discussions and input and discuss the “to-Be” Landscape for the Five Year Level: Identify the opportunities that the HITECH Act and federal and state cooperative efforts across the spectrum of HIT offer and use these opportunities to build upon and improve health care access, efficiency, quality, and outcomes.
- Update draft document and redistribute to full stakeholder group
- Reconvene full stakeholder group to formulate final “To-Be” Landscape vision document.
- Use the “To-Be” Landscape as a critical input to the gap analysis, recommendations and roadmap deliverables.

Visioning sessions were conducted with a broad spectrum of stakeholders across the State. Participants were provided background information including summaries of the HITECH Act and CMS rules and guidance; information from the “As-Is” assessment including MaineCare’s new MMIS system (MIHMS) and other State systems; reports on other states’ HIT programs; and drafts of the Office of the State Coordinator’s HIT strategic plan. In addition to other “homework” participants were asked to think about and answer the following question: “What would the ideal health care system look like; one that would provide truly integrated care and improve quality and health outcomes and what kind, and how could, information technology be improved and used to achieve that “ideal?”

The question was posed in this way to invite the stakeholders to view their assignment without preconceptions and limitations. While everyone recognized that there are funding and technology constraints and that the fragmented history of health care delivery cannot be ignored, this was a time for visioning the ideal.

The question was asked of State agencies, MaineCare providers, Members of the public, Office of Information Technology, Office of State Coordinator, State finance officials, quality associations, advocates, and individuals and groups that had participated in the OSC visioning process. These sessions and the thoughtful work done by all of the participants, gave MaineCare an understanding of a common vision for the Medicaid HIT program in concert with other State-wide health information technology efforts and under the rubric of the OSC developed State HIT plan.

Visioning sessions were hosted by MaineCare in the spring and summer of 2010. OMS began the effort by identifying a comprehensive list of stakeholders and groups. OMS then held a kick-off session of the full stakeholder group who then helped MaineCare group like-stakeholders together to form four subgroups:

- I. Department of Health and Human Service Commissioner, Deputy Commissioners, All DHHS Program Directors, DHHS and State Finance managers, and MMIS Operations managers;

- II. MaineCare Members and advocacy groups including but not limited to parents of children receiving Medicaid or CHIP services, and disabled and elderly Members or representatives from advocacy groups;
- III. Office of Information Technology (OIT), including OIT resources dedicated to supporting DHHS applications and technical infrastructure, and representatives from related HIT initiatives including, but not limited to telehealth, Department of Corrections, Department of Education, Department of Labor, ConnectME (Maine’s broadband agency), and others;
- IV. MaineCare providers, including but not limited to Associations, Hospitals, Primary Care Physicians, Specialists, Dentists, FQHC and RHC professionals including physician assistants, nurse practitioners, and nurse midwives.³¹ Although behavior and mental health and long-term care professionals are not on the list of eligible professionals in terms of incentive payments, MaineCare did include representatives from these provider types and MaineCare Members who receive these services in the visioning sessions. This was done in recognition of the importance of these services to integrated health care and health care systems.

Maine understands that interaction with key stakeholders on the SMHP vision and the EHR Incentive Program needs to happen regularly. The success of the HIT Program hinges on buy-in and participation from all of stakeholders--from the DHHS Program Directors, OIT for technology planning and support, providers adopting the technology and getting incentive payments, and the MaineCare Members that ultimately receive the benefits of the efficiencies and quality that control and coordination of care bring. MaineCare is committed to continued and ongoing collaboration with stakeholders and its federal partners to review and update the HIT vision and “To-Be” Landscape.

Section B. Part 2. 2016 Five Year Plan

To help realize its Medicaid HIT vision, MaineCare has developed a “To-Be” Landscape which includes the following Parts: 1. Governance; 2. Privacy and Security; 3. Communication, Education, and Outreach; 4. HIT Initiative Coordination; and 5. Infrastructure and Systems.

B2a. Governance

Goal

The Medicaid HIT Program will operate under a governance structure that is collaborative, integrated, and coordinated with DHHS health information technology initiatives, particularly that of the Maine Office of the State Coordinator for HIT.

Activities to Accomplish Goal

³¹ See Appendix B-2 for a list of all participants in the visioning sessions.

For the period through 2016, the MaineCare HIT Program will be housed with the Office of the State Coordinator within the Department of Health and Human Services

A key component of the OMS HIT Program planning was to establish a governance structure that would also support the development of the Statewide OSC HIT Strategic and Operational Plans and other HIT initiatives.

The Director of the OSC reports to the DHHS Commissioner who in turn reports directly to the Governor. The OSC governance structure includes: 1) The State's OSC Director; 2) Executive Steering Committee; and 3) Standing Committees. The OSC has a 28 member steering committee appointed by the Governor that meets each month to coordinate the HIT activities occurring throughout the State and among the various stakeholders and organizations. This framework ensures true integration and collaboration. The Standing Committees report up to the full OSC steering committee for consideration of ideas and high level decision-making.

Maine envisioned that the Medicaid HIT planning and the Statewide HIT planning efforts would go hand-in-hand to form an integrated effort to achieve the State's broader health information technology and exchange objectives. As the State worked through its SMHP planning stages, the decision was made to take advantage of the economies of scale and the closely related work that both the OSC and OMS HIT programs perform. As a result, the OMS HIT program now operates under the auspices of the OSC organization and structure.

At the April 14th 2011 OSC Steering Committee, the Director of the OSC announced that the OMS HIT program officially joined the OSC steering committee structure and that it would have a standing committee that reports to the OSC steering committee. The OMS standing committee is chaired by the OMS HIT Program Manager and comprised of representatives from the State designated information exchange (HealthInfoNet); the OIT representative (or designee) who serves on the OSC steering committee; the Director of the OSC; a representative from the statewide quality improvement association; a representative of the Maine Regional Extension Center; a MaineCare Member; and a representative from the Maine Primary Care Association.³²

The OMS standing committee will serve as an advisory committee to help accomplish the goals of the OMS HIT program. It is important to note that members of the OMS HIT standing committee are also members of the OSC steering committee.

This structure puts the standing and steering committees in a unique position to consider the broad policy goals of the Statewide HIT effort and how the OMS HIT program and its goals fit within the full HIT spectrum now and in the future. For example, the OIT representative who serves on the OMS HIT standing committee is also a member of Maine's MMIS (MIHMS system) steering committee. This cross-representation provides critical linkage between the OMS HIT effort and the MMIS certification

³² The OMS HIT standing committee, through reporting up to the OSC Steering Committee will have ample representation from stakeholders and groups. The OSC Steering Committee includes, as examples, representatives from the Maine Hospital Association, Maine Medical Association, Maine Department of Labor, colleges and universities, Maine citizens and others.

initiative which will undoubtedly be very valuable in the future and ensures integration across the inter-related initiatives.

The technical systems needed to implement the OMS HIT program are being designed and implemented by the State's OIT Office. Maine recognizes that the technical system design and development must run in concert with the program and policy development. Important coordination is accomplished through this integrated organizational framework design.

Although the OMS HIT Program Director provides an update to the OSC steering committee each month, beginning in May 2011, the OMS HIT Program Director will make an official report monthly to the full OSC HIT Steering Committee who will consider and advise the OSC Director on policy issues for the OSC and the OMS HIT Program.

FIGURE 10 – State of Maine HIT Structure

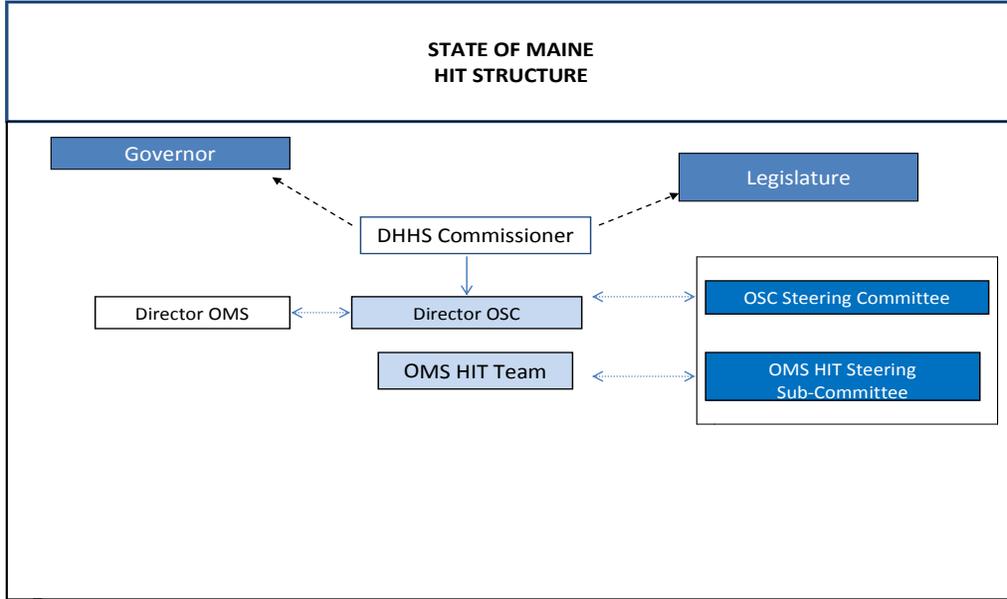
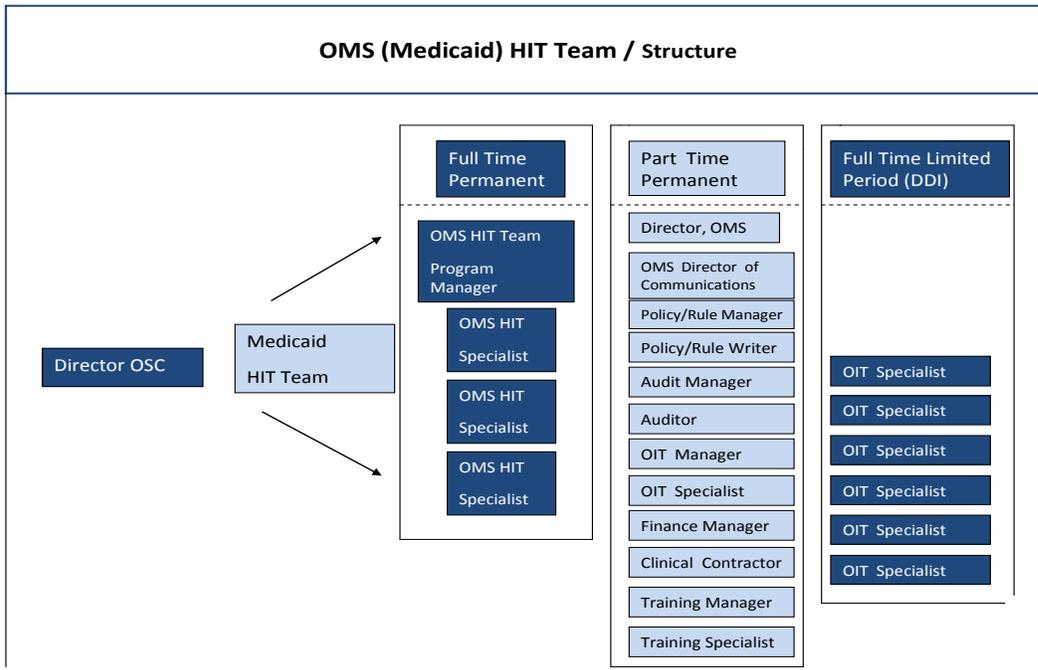


FIGURE 11 – OMS (Medicaid) HIT Team / Structure



As depicted in the charts, the OMS HIT Program Team is led by the fulltime permanent OMS HIT Program Manager and fulltime permanent HIT team specialists. Team membership also includes part-time permanent Department managers and professionals. For the DDI phase (April through October,

2011), the team also consists of full-time limited period OIT staff who are designing, developing, testing and implementing the technology necessary to operate the HIT program.

The OMS Program Manager will oversee the program and operations of the OMS HIT program. The Manager will coordinate and conduct outreach efforts and training, escalate issues to CMS for response and guidance, and other management activities, as well as the administrative activities such as measuring progress against planned goals and objectives, leading the process to update the SMHP and IAPD, and budgeting and planning activities. The primary responsibilities for the HIT specialists include answering and responding to provider inquiries regarding the EHR Incentive Program, reviewing and determining eligibility for the program, reviewing and processing EHR incentive payment requests, and tracking appeals and auditing activities.³³

The OMS HIT Program operates under a work-plan framework that was developed during the SMHP planning process.³⁴ The work plan guides biweekly HIT management team meetings of OMS managers, the OSC Director, OIT managers, representatives from finance, audit, policy, the Director of MaineCare Services, and the OMS communication's director to discuss the status of projects and ground level issues that need coordination.

Each month representatives of the management team meet with the MeREC to review communication's activities and the education and outreach work plans. The team develops joint communications and forums, reviews communication documents, and discusses new CMS and ONC education and outreach materials. The OMS HIT Program Manager was named as a member of the MeREC Steering Committee which meets monthly to discuss and plan activities, including the results of the MeREC efforts that month to sign up providers to adopt electronic health records and participate in the MeREC and Health Information Exchange. For example, the MeREC Steering committee recently reviewed, interviewed and selected vendors of certified EHRs that Maine providers may use. The latest MeREC Steering Committee meeting revolved around how to overcome the hurdle of some providers not wanting to participate in the EHR program because they are near retirement age or want to see what the requirements are before joining the HIT age.

In addition to the biweekly meetings, the Director of the OSC and the OMS HIT Program Manager meet at least three times each week to identify, discuss, and decide issues. These meetings serve as a forum to determine the agenda for the biweekly status meetings and which issues need to be pushed up to the OMS steering committee for further consideration. It also enables OMS to track the progress of its work and to meet program goals and objectives or identify potential problems early on for correction.

The HIT team also meets on day-to-day operations and program issues.

B2b. Privacy and Security

One of the most significant challenges facing HIT initiatives today is addressing the privacy and confidentiality issues raised by the public.³⁵ The HITECH Act requires more stringent and greatly enhanced privacy and security of patient health information. It strengthens the Health Insurance Portability and Accountability Act of 1996 (HIPAA) by adding new requirements for privacy and security

³³ A detailed State resource schematic is included in the State's IAPD.

³⁴ See Appendix B-3 for an example of the work-plan framework.

³⁵ 2009 Survey Report eHealth care Initiative HIE Survey

for health information and directly affects more entities, businesses and individuals in more diverse ways.³⁶

The underlying HIPAA law layered with the new HITECH Act requirements, require states to conduct a complete inventory of existing privacy and security plans and to make systems and practice improvements which are especially critical to HIT use. Maine viewed privacy and security practices at three levels:

- I. Personal health information that is currently collected electronically and via paper based methods represents an individual's medical history. This must be the most restrictive in terms of access and security and privacy controls. The consumer/individual must have ultimate control over the use and access of this information.
- II. General health information that is found in medical records and is shared among providers. Security and privacy controls must be in place for general medical record information that is controlled by providers. Use of this data should be used for decision-making purposes and so providers can better coordinate care. Since personally identifiable information is still linked to this data, Members must have the choice about what information is shared and who has access to it.
- III. Population health information that is collected and exchanged via an HIE. Other agencies will have access to this information for trending and analysis of general population health. Personally identifiable information is not tied to this data yet privacy and security are still important.

After inventorying and reviewing privacy and security standards and requirements, MaineCare developed the following vision, goal and activities to support its initiative:

Vision

Medicaid providers and Members trust and participate in HIT and electronic exchange of health information as a result of MaineCare's efforts which incorporate privacy and security solutions and processes in every phase of HIT development, adoption and use.

Goal

³⁶ The HITECH Act:

- Expands definitions of "business associates" to include persons/organizations that perform activities involving the use or disclosure of personally identifiable health information and those that transmit or access protected health information on a routine basis.
- Mandates that security standards that apply to health plans and health care providers will also apply directly to business associates.
- Establishes new security breach notice requirements
- Entitles individuals to receive electronic copies of health information
- Calls for regulations regarding the sale of electronic health records and protected health information

By 2016, MaineCare will build public trust and facilitate electronic exchange, access, and use of electronic protected health information, while maintaining the privacy and security of patients, providers and clearinghouse health information, through the advancement of privacy and security legislation, policies, principles, procedures and protections for protected health information that is created, maintained, received or transmitted.

Activities to Accomplish Goal

- Inventory existing privacy and security standards and practices including HIPAA and other Federal and State-specific laws to develop a comprehensive HIPAA and HITECH compliant program;
- Establish business best-practices for administrative, physical and technical privacy and security protections for all protected health information within the State and MaineCare HIT systems;
- Establish a process for MaineCare Members to have ultimate control over their health records through an opt-in and opt-out system which mirrors industry best-practices³⁷ and where MaineCare Members allow health care providers, plans (including Medicaid), and clearinghouses different levels of access to their health information;
- Collaborate the OSC initiative and submit legislation to allow MaineCare members the choice to permit access to mental health, substance abuse, HIV and other protected sensitive health information to their designated health care providers and the Health Information Exchange for the sole purpose of medical treatment and continuity of care. The proposed legislation must have strict privacy and security controls that align with the National Institute Standards and Technology (NIST) standards as defined by ONC in the Modifications to the HIPAA Privacy, Security and Enforcement Rules Notice of Proposed Rule Making (NPRM) as the industry standard for good business practices;
- Collaborate with the OSC and submit legislation to ensure that health care discrimination against MaineCare Members does not occur. The proposed legislation must include protection for members who opt-out of the HIE from being denied care as well as protection for providers who provide care for members who opt-out and, therefore, do not have comprehensive health information on the patient when making clinical decisions. (See

³⁷ Common best-practice policies to protect patient privacy, even beyond HIPAA are included in the 2009 Survey Report eHealth care Initiative HIE Survey which Maine reviewed to help prepare the privacy and security information in this SMHP.

below)

- Implement and continually perform quality review checks on systems and data to ensure that they meet industry best-practices for security and privacy of all health information, and make improvements where and when needed.

MaineCare has worked diligently in this area and will continue its work during SMHP implementation. For example: The OSC formed a Legal Working Group (LWG) in 2009 to address the legal and policy domain requirements in the State HIT and Medicaid HIT Program Plans. The LWG had representatives from the National Association of Mental Illness of Maine (NAMI-ME), HIV providers and advocates, the Maine Hospital Association, the Maine Medical Association, Maine Family Planning, the Attorney General's Office, HealthInfoNet, the Maine Civil Liberties Union, private health attorneys, and the Program Manager of the OMS HIT Program. The LWG analyzed Maine and other state's laws; policies and procedures that enable and foster information exchange within and outside the State; the use of existing or new trust agreements among parties that enable secure flow of information; and how the State addresses issues of non-compliance with Federal and State HIT laws and policies.³⁸

The LWG met for six months in 2009 and produced a draft report for the Legislature who recommended that the LWG continue its efforts and report back with proposed legislation. Throughout most of 2010 the LWG worked to draft a report to the Maine legislature which includes draft statutory language to improve Maine laws.³⁹ (The bill is scheduled for hearings and work sessions for May, 2011) MaineCare will continue to review, improve and keep current on all privacy and security laws through the implementation phase of the SMHP.

B2c. Communication, Education and Outreach

The HITECH Act envisions a health care system where individuals can exercise choices and make informed decisions about their health care providers and can allow providers to have access to a patient's "complete" medical record. Decision makers have access to the right information at the right time and the health care delivery system is more efficient and affordable. Maine understands that transforming health care systems to achieve these objectives takes a lot of communication, education and outreach across the State. The topic of public engagement was discussed at length at the HIT visioning sessions where the vision, goals, and activities were developed:

Vision

³⁸ Source: Maine Statewide Health Information Exchange Strategic and Operational Plans: A Strategy to Create an Infrastructure that Preserves and Improves the Health of Maine People, 3/25/2010

Communication, education, and outreach efforts helped build a high performing health information exchange system that has gained universal: 1) EHR and HIT adoption among MaineCare providers; 2) trust and participation of MaineCare Members; and 3) value for decision-makers.

Goal

For the period through 2016, MaineCare will promote State and National HIT efforts to improve health outcomes through electronic health information tools by developing and implementing comprehensive communication and training programs for State decision makers, staff, providers, citizens of Maine and stakeholders.

Activities to Accomplish Goal

- Understand the barriers to HIT and use the opportunities afforded by the HITECH Act to develop and implement strategies to these barriers;
- Coordinate and participate in the Maine Regional Extension Center (MeREC) efforts and forums that deliver health information technical assistance to providers to modernize work place culture and to improve health care practices through the adoption of certified EHR technologies;
- Develop and conduct a comprehensive and coordinated communication, education, and training strategy with provider associations, organizations, and other HIT initiatives,⁴⁰ that help providers understand the benefits of the HIT and exchange initiatives, and Meaningful Use;
- Develop and conduct training programs for State decision-makers, MaineCare management and State staff to educate themselves, providers and Members about the benefits of HIT;
- Develop and implement Member education on health information technology and the benefits of integrated care, and on their power to make decisions about access and the exchange of their health information.

One of the first activities was to understand potential barriers for providers to adopt HIT. Nationwide, a recent survey found very low use of EHRs in US hospitals.⁴¹ Among hospitals without an electronic health record, the most cited barrier to adoption is inadequate capital for purchase (74%) and the second is

⁴⁰ See the section on Coordination with other HIT Initiatives for details about the HIT initiatives.

⁴¹ Jha, Ashish, et al. "Use of Electronic Health Records in US Hospitals." *The New England Journal of Medicine* (March 26, 2009)

EHR maintenance cost (44%). Another study found the most frequently cited barriers to EHR adoption among physician practices⁴² are start-up financial costs (84%) and ongoing financial costs (82%).

As part of the “As-Is” Assessment, MaineCare in collaboration with the Office of the State Coordinator, commissioned a series of surveys of providers, with a particular emphasis on professionals who were listed in the CMS regulations as meeting the definition of an “eligible professional,” dental practices, and hospitals. Researchers from the Muskie School, Cutler Institute for Health and Social Policy at the University of Southern Maine, developed and distributed surveys in the spring of 2010. As part of the survey, Muskie asked the participants about barriers to adoption if they had not implemented EHR technology within their practices. Most of the responses about barriers mirrored the national survey results: The primary barrier was the cost to acquire EHR technology; second was cost to maintain EHR technology; and the third was a mix of return on investment concerns and internal knowledge/technical resources barriers.

On a parallel track, MaineCare knew that the public’s perceived barriers to HIT were of a more personal nature and dealt with privacy and security concerns. MaineCare’s visioning sessions with Members and advocates included privacy and security issues and the best means of educating the public about privacy and security safeguards and Maine’s data warehouse and exchange that had adopted opt-in/opt-out strategies for health information, particularly the practice of not exchanging or storing sensitive health information such as behavioral and mental health, substance abuse and HIV/AIDS records unless the patient specifically opted-in.

Once Maine understood the barriers as perceived by the providers and the public MaineCare was able to develop an “overcoming barriers” communications strategy. For providers, in terms of costs, it means education about the incentive payment programs offered as part of the HITECH Act. For the public, it means education around privacy and security laws, systems, and the benefits of integrated care.

Maine’s strategy for its SMHP is to leverage CMS and ONC guidance and education tools that provide a consistent and comprehensive framework for the HIT programs. MaineCare views the federal program information as being the foundation with Maine-specific information added to the foundation for those aspects of the HIT program that need to be dealt with at the state level. Relying on this approach will serve Maine well as it implements the SMHP because it will result in a program that is consistent with other state HIT programs where it needs to be, and yet recognizes the Maine-specific aspects of HIT initiatives.

The State knows that it will take a variety of communication, education and outreach methods to get the HIT points across. As part of its planning activities MaineCare:

- Developed an HIT webpage that is updated regularly and which includes a list-serve registration that sends a message to everyone on the list that new information has been posted. The site has links to the federal HIT program webpage and Maine-specific information such as power point presentations, fact

⁴² Steven R. Simon, et al. Correlates of Electronic Health Record Adoption in Office Practices: A Statewide Survey

sheets, frequently asked questions, MeREC and other organization information, calendar of events, OMS and OSC contact information, and other postings.⁴³

- In collaboration with the MeREC, developed a communication's and outreach strategy and plan that coordinates activities being conducted by the MeREC and MaineCare to advance the use of EHR technology systems and to help qualified health care providers select, implement and meaningfully use health information technology including electronic health records. This strategy and plan will continue to be updated with the implementation phase of MaineCare's HIT project.
- Coordinated with MeREC to reach out to independent providers as well as partnering with large health care systems to expand the use of health information technology in their affiliated practices. Specifically MaineCare participated in a series of four provider forums in late October and November. Presenters shared their experiences of adopting EHR technology in their practice and lessons learned.
- Participated in the Quality Counts⁴⁴ webinars that discuss HIT topics such as the cultural of health care practices, workflow analysis, workflow redesign, vendor selection, implementation optimization, meaningful use, quality improvement and quality coaching.
- Led discussions with provider groups and associations about the barriers, benefits, public engagement, and opportunities for incentive payments.
- Employed existing communication channels (such as MaineCare's website and Newsletter, *MaineCare Matters*).

MaineCare will continue these efforts during the implementation phase of the HIT Incentive Payment Program. In addition, Maine agrees with the provisions of the HITECH Act and CMS rules and guidance stressing the importance of an integrated communications and education strategy. Maine will use the comprehensive communication, outreach, and education tools developed by CMS and the ONC for states, providers, and the public. There are several other initiatives in Maine related to health information technology. The State believes that it is critical to coordinate and integrate communication strategies to take advantage of economies of scale, resources, and as important, to avoid fragmented programs that frankly, can be a barrier in and of itself, to health information technology. Maine's Communication, Education and Outreach activities are best described in the context of "HIT Initiative Coordination."

⁴³ http://www.maine.gov/dhhs/oms/HIT/hit_index.html. Also, see Appendix B-4 for examples of communication strategies.

⁴⁴ Described later in this Section.

B2d. HIT Initiative Coordination

MaineCare is committed to addressing the needs of underserved and vulnerable populations such as children, individuals with chronic conditions, Title IV-E foster children, individuals in long-term care settings and the aged, blind and disabled. To meet this commitment, MaineCare optimizes the coordination of HIT initiatives.

The major coordination points are with the following partners:

HealthInfoNet/MeREC	MaineCare has, and will continue to coordinate with Maine’s REC (who partners with the ONC and OSC), to aid in the adoption of EHRs and attaining demonstrated Meaningful Use performance.
Office of the State Coordinator	As part of the OSC organizational structure, the MaineCare HIT initiative is linked with the efforts of the OSC and developed its SMHP to fit within the larger State-wide HIT plan.
ConnectME Authority	MaineCare is coordinating with the ConnectME Authority, which is responsible for mapping and funding the development of broadband access across the state, to enable access to EHR and to share data in a secure manner.
Maine CDC and the State of Vermont	MaineCare is a partner with Maine’s CDC and Vermont on a newly awarded Children’s Health Insurance Plan Reauthorization Act (CHIPRA) grant that has a large HIT component.
DHHS Initiatives	MaineCare is coordinating with other Federally supported initiatives such as ICD-10, rural Maine Tele-health, and Health Care Reform initiatives.
Patient Centered Medical Home Project	MaineCare participates in a State-wide Patient Centered Medical Home project which has adopted HIT goals and activities.
Partnerships	MaineCare aligns and coordinates its quality measures and programs with Maine Quality Counts and the Maine Quality Forum; and views CMS a critical partner in a successful HIT efforts.

In Maine HIT Initiatives share governance structures (including people who are on the steering committee of the various initiatives), stakeholder relationships, legal and contractual agreements and communication efforts. For example, the OMS HIT Program and the CHIPRA Quality Measurement activities have aligned four CHIPRA core measures with proposed Meaningful Use measures A complete list of HIT-related grants, including a description of the grant product and how it supports the adoption of EHR technologies, may be found in the “As-Is” Assessment section of the SMHP and the Implementation

Advanced Planning Document (IAPD). To support and further this coordination, MaineCare's visioning activities arrived at a vision, goal and activities:

Vision

Increased coordination of federal, State and DHHS-specific HIT initiatives has produced efficient well-run integrated programs and improved quality of care and health outcomes.

Goal

By 2016, all federal, State and DHHS-specific HIT initiatives will be intrinsically linked through alignment and coordination of plans, governance, communications, systems, and the sharing of clinical quality measures to improve efficiency, health outcomes and satisfaction.

Activities to Accomplish Goal

- Use the inventory of initiatives that was conducted for the SMHP planning activities to ensure the MaineCare HIT Program vision and goals align with the other HIT initiatives and vice versa.
- Participate in planning and implementation efforts of the other initiatives, including communications, sharing and exchanging data and information, long-range goals, and governance structure and vice versa.
- Hold regularly scheduled meetings with the other HIT initiative groups with standing agenda items such as avoiding duplication of efforts, improving efficiencies, upcoming communications and education forums, sharing information, and systems updates that may provide common efficiencies and opportunities for other initiatives to participate in and benefit from.
- Through coordination with the HIT initiatives and stakeholders, plan and conduct State-wide HIT summits that bring together stakeholders, including providers and Members, to provide education on implementing and deriving benefits from HIT and electronic health records.
- Similar to the process to develop this SMHP, include other HIT initiatives and stakeholders in the annual (or as needed) SMHP and IAPD updates.
- Continue to have the OMS HIT Program Manager participate in the OSC HIT governance structure, including leading the standing OMS HIT committee and being a member of the OSC Legal Working Group.
- Fully integrate, share, and analyze the quality measures from all HIT initiatives and use the results to further improve program delivery and health outcomes.
- Conduct joint surveys and use other methods to gather provider, Member, public and decision-maker opinions and input to measure the success of coordination and integration of the HIT initiatives.
- Leverage the CMS and ONC support that is available for states to plan and implement successful HIT programs.

B2e. Infrastructure and Systems

The technical infrastructure and systems must support the implementation of the EHR Incentive Program and advance the long-term HIT vision. Maine has an OIT vision for all DHHS applications that has been reviewed and recognized by DHHS executive management as setting standards for OIT work. The vision is used to set direction and review proposed projects to measure their consistency with the OIT vision for DHHS applications. (DHHS Applications Governance Team, Applications Vision Statement. Adopted June 26, 2008.) The OIT technical requirements and system design to support the MaineCare's EHR Incentive Program and advance the long-term HIT vision provide the basis for Maine's HIT vision, goal and activities for interoperability:

Vision

Using HIT, MaineCare provides client-centered services that improve health outcomes, quality, patient safety, engagement, and care coordination, through an efficient and secure health care system that has eliminated duplication of data and has reduced costs.

Goal

By 2016, all Members will be cared for by providers who have access to, and exchange, health information in a secure system and use data and certified technology that support health care needs, promote healthy outcomes, and provide quality data for decision-makers.

Activities to Accomplish Goal

Create a single point of entry for providers and a common identifier to the State's systems for quality, cost efficiency, analysis and research purposes and ultimately connect to the Health Information Exchange by creating a two-way data flow to and from State systems such as:

- MIHMS- Claims Database
- IMMPACT 2- Web- based Immunization Information System
- HealthInfoNet – Maine's Health Information Exchange
- Create a simple, streamlined and automated process for Providers to report Meaningful Use criteria, quality measures and obtain EHR incentive payments;
- Make available all health information (including mental health, substance abuse, HIV and other protected health information, medications and diagnoses) to all MaineCare Members in an easy to understand format;
- Use a common individual identifier (e.g., Master Client Index) technology for continuity of care for individual MaineCare Members and for linking Member information with other Maine Departments such as Corrections and Education;
- Remove data silos from State systems to provide access to the data that is collected and managed commonly across DHHS;
- Coordinate the clinical quality measures gathered by DHHS to ensure CHIPRA, Meaningful Use, and all other clinical quality measures are

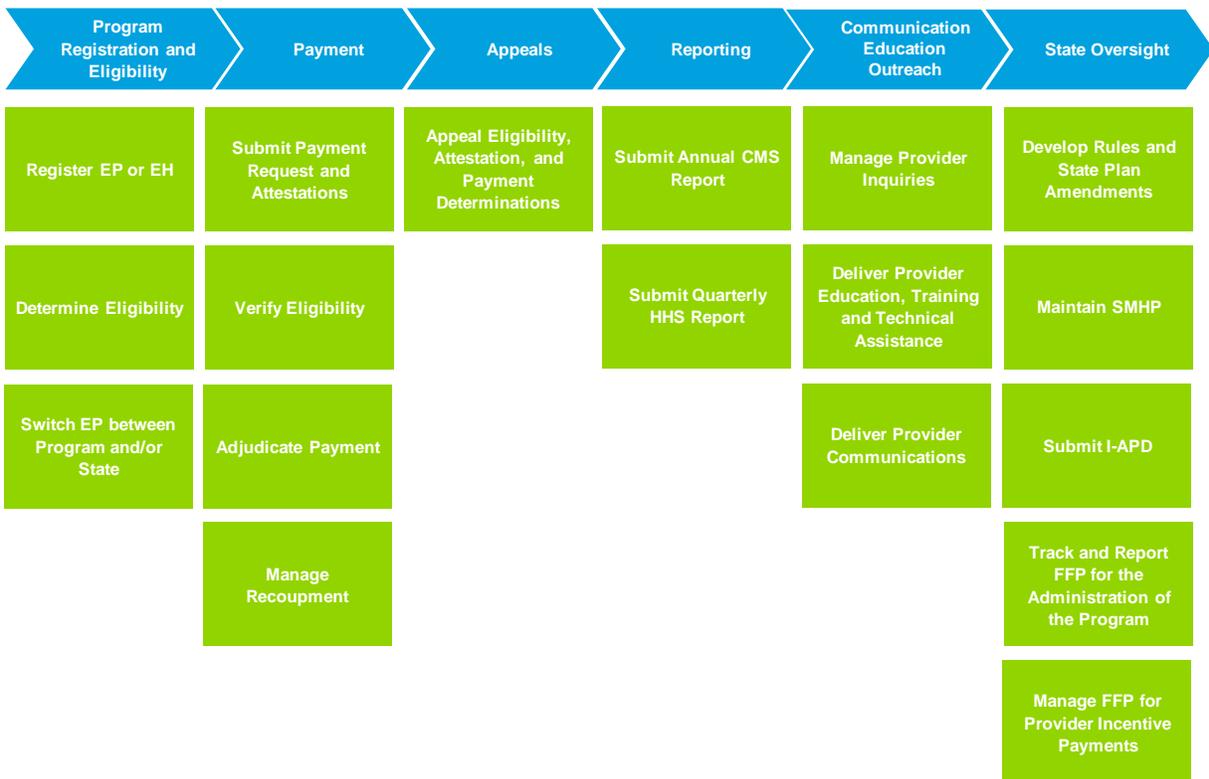
coordinated especially for populations with unique needs, such as children;

- Provide patients and families access to their health care data (clinical and administrative) through a Member portal;
- Collect and disburse data in a secure standardized manner to promote evidence-based protocols for clinical decisions.

SECTION C – ACTIVITIES NECESSARY TO ADMINISTER AND OVERSEE THE EHR INCENTIVE PROGRAM

This Section describes the activities necessary to administer and oversee the HIT and EHR Incentive Payment Program.⁴⁵ It is comprised of six processes and 18 sub-processes:⁴⁶

Figure 12. Diagram of EHR Incentive Program Processes and Sub-Processes



⁴⁵ MaineCare’s activities are based on the Federal regulation governing the Medicaid EHR Incentive Program, the guidance provided by CMS in the SMHP Overview Template distributed in April 2010 and the documentation provided by CMS regarding the National Level Repository (NLR). A table that contains a crosswalk of the questions that CMS indicated that should be included in the Activities Necessary to Administer and Oversee the EHR Incentive Program to this document may be found in Appendix C-1.

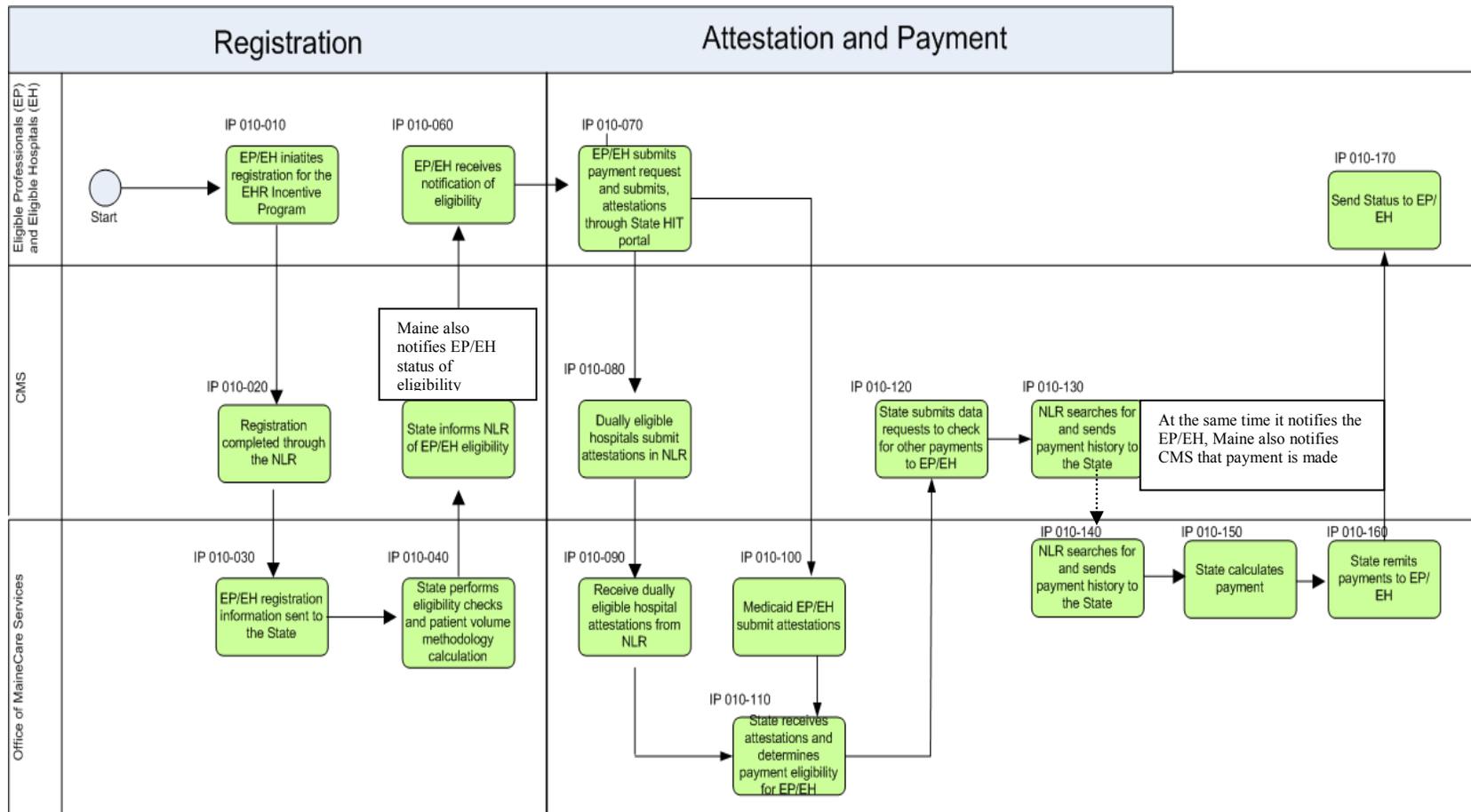
⁴⁶ See Appendix C-2 for more details about process flows.

Each of the six processes comprises a Part. The 18 sub-processes are described under the appropriate Part:

Part	Summary
1. Program Registration and Eligibility	<ul style="list-style-type: none"> • Provides an explanation of how Eligible Professionals (EPs) and Eligible Hospitals (EHs) submit and receive approval to register for the Medicaid EHR Incentive Program • Describes how the state will apply its eligibility methodology including the patient volume calculation • How Providers switch between programs
2. Payment	<ul style="list-style-type: none"> • Describes how EPs and EHs will request payment and attest to meeting eligibility and AIU requirements • Describes how OMS will verify eligibility • Details the payment calculation for EPs and EHs and procedures to generate and track a Medicaid EHR incentive payment once it has been approved
3. Appeals	<ul style="list-style-type: none"> • Details the procedures in place to allow EPs and EHs to appeal a determination made by the Maine Medicaid Program
4. Reporting	<ul style="list-style-type: none"> • Defines the reports and processes to conduct CMS and US Department of Health and Human Services required reporting
5. Communication, Education and Outreach	<ul style="list-style-type: none"> • Provides an explanation of the Maine Medicaid Program support mechanisms that will help EPs and EHs with technical assistance and eligibility questions related to the Medicaid EHR Incentive Program
6. State Oversight	<ul style="list-style-type: none"> • Defines the process that will be in place to ensure that no amounts greater than 90% FFP will be claimed for administrative expenses related to the administration of the program and the methodology for verifying such information is available and other state oversight processes

A high-level look at the application and payment process is shown here:

Figure 13. Registration, Attestation and Payment Process Flow for the EHR Incentive Program



Narrative Description of HIT Incentive Payment Program Process

The following steps describe in narrative form high level activities on how Maine will process provider requests for HIT Incentive Payments. (The steps are shown graphically in the process flows under each of the six Parts of this Section which show more detail.)

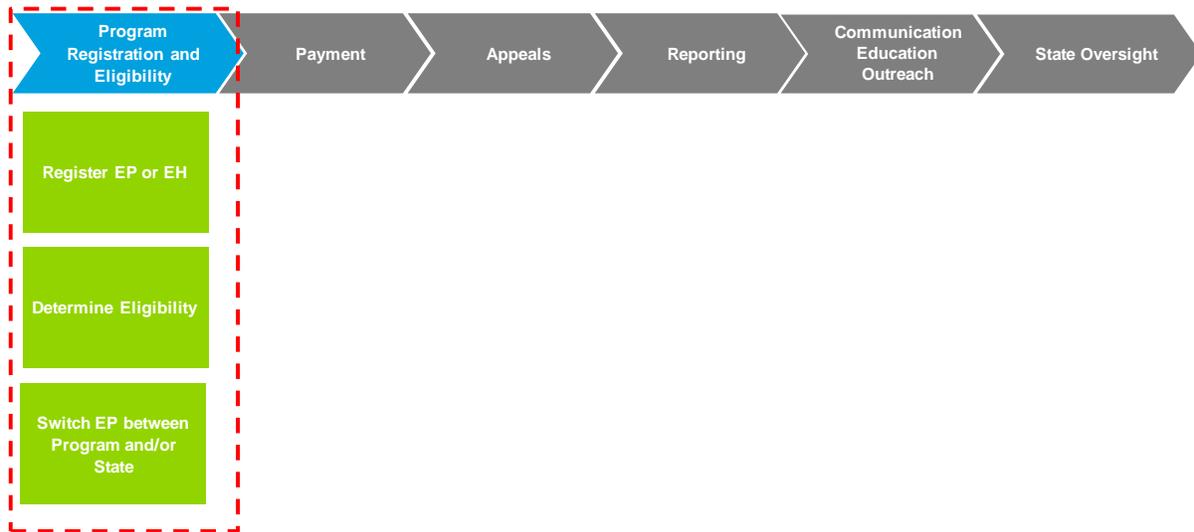
- Once the State is notified that a provider has registered with the NLR a MaineCare HIT Team Specialist (HIT Specialist) will contact the provider at the email address provided during the registration process. (See Eligibility for a description of the HIT Team including the help-desk)
- The HIT Specialist will work directly with the provider to explain the requirements of the Medicaid HIT Incentive Payment Program and the application process. (This email address will also be used to communicate with the provider about the status of the incentive payment request.)
- The preferred method for EPs and EHs to apply for an incentive payment is through an online portal (Depicted in the Payment Request and Attestation process flow). HIT Specialists will assist providers including extra help for those who do not have internet access and who need to submit a paper application.
- When the provider has completed the on-line application, the HIT Specialist will begin the verification/confirmation process.
- MaineCare will interface with the NLR to request the provider payment history to verify that: 1) an EP has not received a payment from another state's Medicaid EHR Incentive Program or from the Medicare EHR Incentive Program; or 2) an EH has not received a payment from another state's Medicaid EHR incentive Program. The interface will also include other historical information, like exclusions, that were documented during program registration or requests for payments. (This information will be stored by MaineCare allowing the system to identify the payment year of providers that have transferred into the Maine EHR Incentive Program and ensure appropriate payments are made to the provider.)
- When the NLR sends the provider information to MaineCare to verify that all providers and hospitals are properly licensed and qualified, an HIT Specialist will check MaineCare's provider enrollment portal. (For its new MMIS system, MaineCare used the CMS-1513 Re-enrollment forms which include disclosures related to ownership, control, and relationship information, including business transactions, to meet certification standards. In addition, MaineCare developed a questionnaire that providers are required to fill out to enroll in MIHMS that discloses criminal conviction information. MIHMS also receives criminal convictions information from licensing and other databases. The MIHMS provider re-enrollment process ensures that providers are properly licensed and qualified.)
- To complete the application, the EP or EH must attest to meeting all of the requirements of that payment year. (The Submit Attestation of Adoption, Implementation or Upgrade (AIU) of Certified EHR Technology and the Submit Attestation of Meaningful Use processes are discussed in more detail in this Section.)
- MaineCare will validate and determine the patient volume for EPs and EHs during the Determine Eligibility sub-process by checking the all-claims database and MIHMS claims system reports. For hospitals, Medicare cost reports will be used to verify the Medicaid patient volumes, and to

calculate the payment amount. For FQHCs, HRSA reports will be used to confirm “needy individual” patient levels. (MaineCare has selected the Encounter method per the Final Rule to calculate and confirm that the provider meets the Medicaid patient volume threshold.)

- MaineCare will be able to identify EPs who work at more than one site by requiring providers to list all of the addresses where they work. An HIT Specialist will confirm that multiple applications are not received for an EP by checking on-line systems for NPI, addresses and other data to ensure duplicate payments are not made.
- The HIT Specialist will confirm that the EP is not hospital based, by checking service codes used in hospital settings.
- The HIT Specialist will verify that the type of EHR technology that the provider attested to using is listed on the ONC list of certified EHR technology.
- MaineCare will also verify that the EP or EH has certified its application by signing the following statement which appears at the end of the OMS application: *“This is to certify that the foregoing information is true, accurate, and complete. I understand that Medicaid EHR incentive payments submitted under this provider number will be from Federal funds, and that any falsification, or concealment of a material fact may be prosecuted under Federal and State laws.”*
- The last step allows EPs and EHs to switch the EHR Incentive Program in which they participate. If an EP or EH wishes to change their registration information (e.g., address or other demographic information), MaineCare will direct the provider to make the change in the NLR registration module, as this is the single point of registration information for the program.
- Before any payment is made, the HIT Team Program Manager will send an electronic message to the audit manager that a file is “complete” and ready to be reviewed. (An audit manager and an auditor who have attended an HIT audit boot-camp this spring and participated in webinars and other trainings on HIT audit strategies have been assigned to perform the HIT audit functions.)
- The auditor will use the on-line systems to confirm the provider submission and the HIT Team’s work by reviewing key risk steps in the process. (See Audit Section for the risk factor grid and other details of the Audit review.)
- The audit manager will send an electronic message to the HIT Team Program Manager that the file has been reviewed and approved for payment. An HIT Specialist will note the record and send electronic notification to the DHHS finance section to process the payment through the AdvantageME system. CMS is notified of the approval (or denial) through the NLR system as is the EP or EH via the email address provided during the registration process.
- The payment request goes through the financial and accounting processes and payments are issued to the EP or EH.
- After provider payments are made, the payment information will be reviewed by the HIT team manager and sent to the audit manager for further review, as appropriate. (See Audit section for details on the Audit process and assurances against Fraud, Waste and Abuse.)

Section C. Part 1. Program Registration and Eligibility

Figure 14. Program Registration and Eligibility Processes and Sub-Processes



C1a. Registration

The first map in this process flow shows how providers register for the Medicaid Program; Incentive Program; the second map details how MaineCare will determine eligibility; and the third map details how EPs may make a one-time switch between the Medicaid and Medicare program.

Figure 15. Register EP or EH Sub-Process

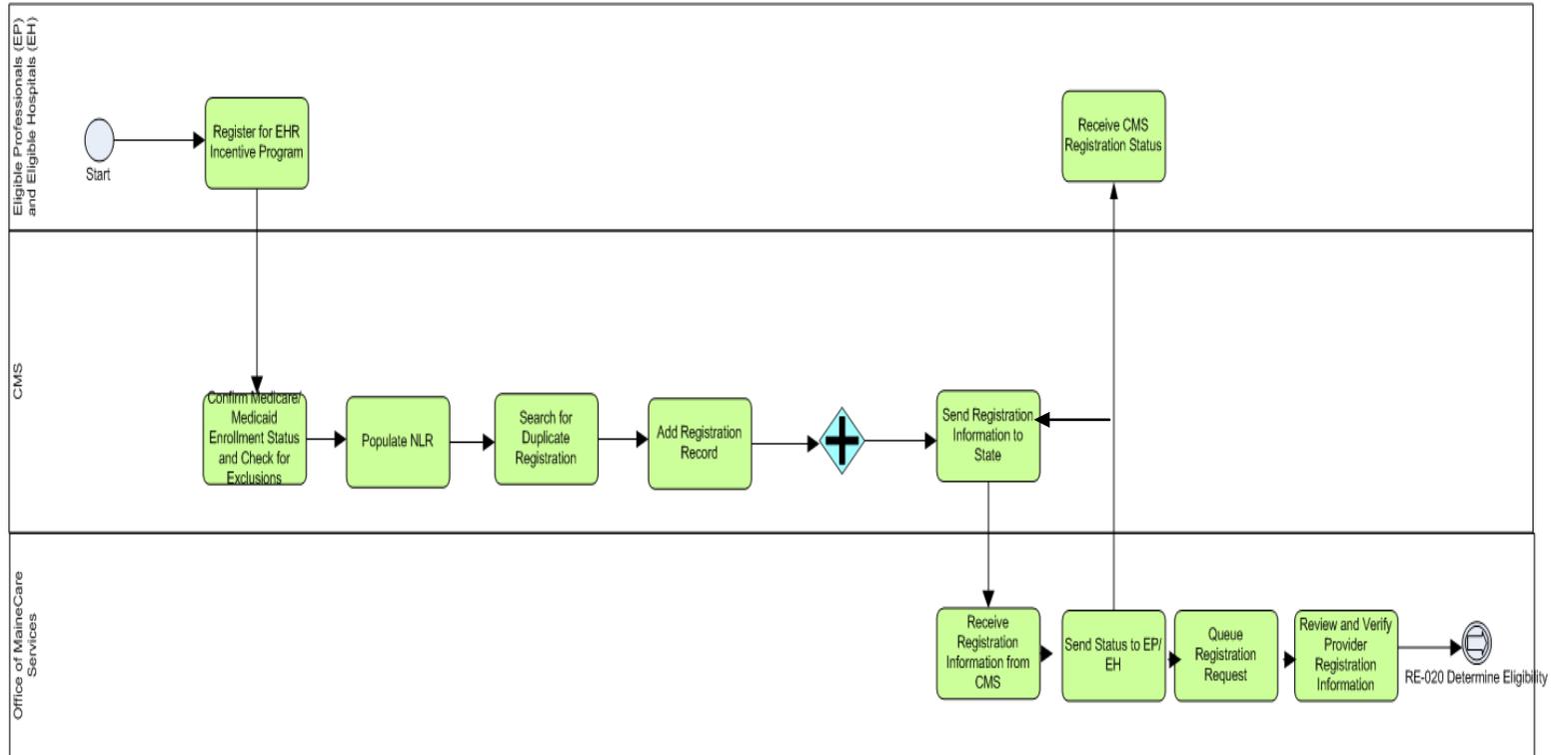
Program Registration and Eligibility

Register EP or EH

Determine Eligibility

Switch EP between Program and/or State

RE-010 Register EP or EH



Description: This sub-process shows the activities to register Eligible Professionals (EPs) and Eligible Hospitals (EHs) for the EHR Incentive Program. This includes EPs and EHs completing their registration for the program via the National Level Repository (NLR), the transmission of data from the NLR to the State, the State's eligibility methodology and determination, and notifying EPs/EHs of their eligibility status.⁴⁷

Resources: EPs/EHs, CMS, MaineCare Services

Proposed Technology to leverage: NLR, MIHMS, Online Portal

State Policy: The State should have a policy that enforces the CMS regulation as written in the Final Rule on the EHR Incentive Program.

CMS Regulation: See 495.10 in the Final Rule on the EHR Incentive Programs.

This is the point at which the Maine OMS HIT help-desk and the provider “intersect.”

1) Help Desk Functions and Tools

The help desk will be staffed Monday through Friday from 8:00 am to 5:00 pm by OMS HIT Specialists that have been trained and are able to provide detailed information on the MaineCare EHR Incentive Program including all eligibility requirements, how to register with CMS and then apply with MaineCare, and appeal processes. The help desk will also provide technical assistance to EPs and EHs who experience technical issues when submitting information to MaineCare.

In addition to the HIT help desk, providers may contact the MMIS provider help desk which operates Monday through Friday from 8:00 am to 7:00 pm. The MMIS help desk staff will be trained and have scripts. Providers may also contact the OMS HIT Team help-desk via email through the OMS HIT website. (Maine's IAPD includes more detail on training resources, which have been dedicated and built into the IAPD to help train the HIT Team Specialists, and MMIS help desk staff.)

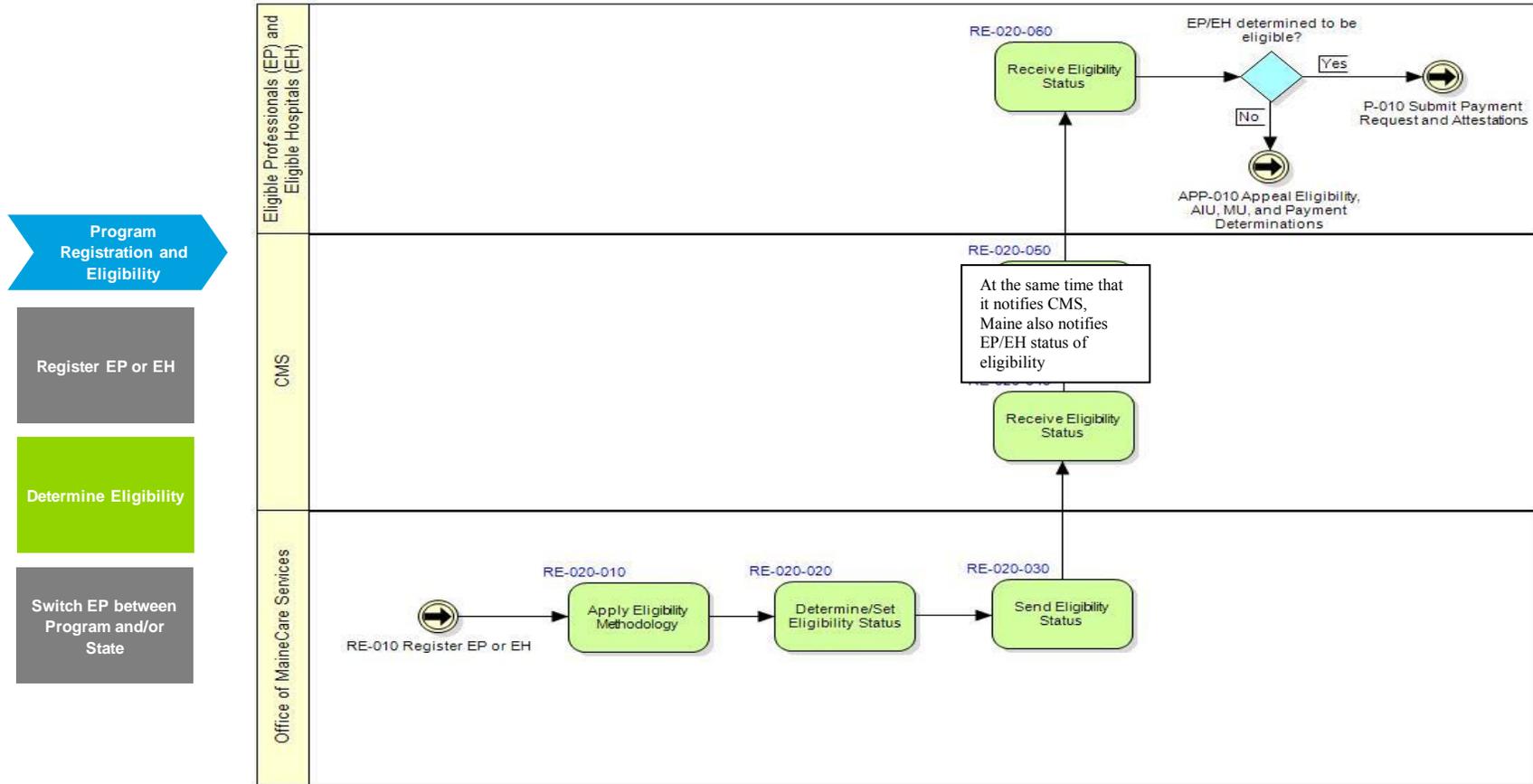
MaineCare will use the most current CMS HITECH/EHR Incentive Program Inquiry Toolkit as part of its resources to address questions received by the HIT help desk. If providers' questions cannot be answered by the help desk staff, the questions will be escalated appropriately to CMS' EHR Information Center. The State anticipates that these provider inquiries will be different from the typical help desk questions received, and will require more time to answer and a different skill set from the typical help desk resources.

This summer, prior to “go-live” expected in October, MaineCare will develop and adopt standard call center metrics and standards, such as Average Speed of Answer, Abandoned Calls, and other regularly measured metrics. The goal will be to answer telephone calls “live” or return messages within one business day. The same goal will be adopted for email contacts.

⁴⁷ See Appendix C-3 for further details of the process flow.

C1b. Determine Eligibility

Figure 16. Determine Eligibility Sub-Process



Description: This sub-process shows the activities to determine an Eligible Professionals (EPs) or Eligible Hospitals (EHs) eligibility for participation in the EHR Incentive Program. MaineCare will apply the State encounter methodology to calculate patient volume thresholds. Maine recognizes and will apply the different threshold requirements based on the type of EP. For example, for an EP to be eligible as an FQHC EP, the EP must practice predominantly in the FQHC and must meet a 30% needy individual patient threshold. Non-FQHCs, (other than pediatricians) must be non-hospital based (90% or less of their practice is done outside the hospital settings as described in the process flow documents included in this SMHP) and must meet the 30% Medicaid patient encounters threshold. Pediatricians must meet a 20% Medicaid patient encounter threshold. EHs (as described in the eligibility process flows, which include the few exceptions to the 10% threshold) must have a 10% Medicaid encounter threshold. Maine has systems and processes in place that will ensure that EPs and EHs meet all eligibility requirements defined in the Final Rule. Once their eligibility is determined, OMS will notify CMS and EPs and EHs of their eligibility status.⁴⁸

Resources: MaineCare Services

Proposed Technology to leverage: MIHMS, Online Portal

State Policy: The State should have a policy that enforces the CMS regulation as written in the Final Rule on the EHR Incentive Programs. The State will use the encounter method to determine the EP's Medicaid patient volume.

CMS Regulation: See 495.304 and 495.306 in the Final Rule on the EHR Incentive Programs.

⁴⁸ See Appendix C-4 Determine Eligibility for detail.

C1c. Switch EP or EH between Program and/or State Process Flow

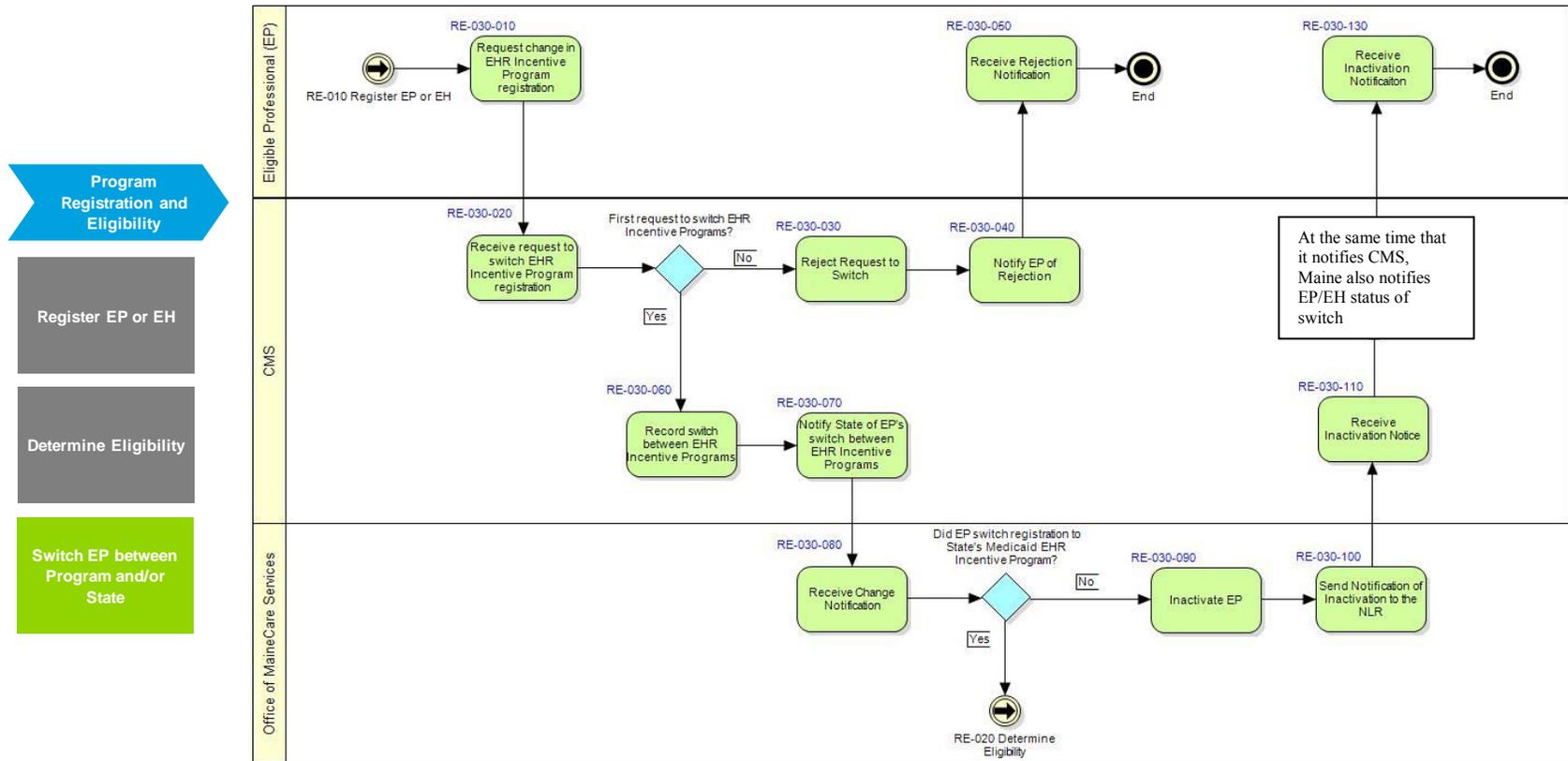


Figure 17. Switch EP between Program and State Sub-Process

Description: This sub-process shows the activities involved for an EP to switch their registration between EHR Incentive Programs. EPs are allowed to make a one-time switch between Incentive Programs (Medicare and Medicaid).⁴⁹

⁴⁹ See Appendix C-5 Switch EP for details.

Resources: EPs/EHs, CMS, MaineCare Services

Proposed Technology to leverage: NLR, MIHMS

State Policy: The State should have a policy that enforces the CMS regulation as written in the Final Rule on the EHR Incentive Program.

CMS Regulation: See 495.10 in the Final Rule on the EHR Incentive Programs.

Section C. Part 2. Payment

The following process maps demonstrate how requests for Medicaid EHR incentive payments are submitted by EPs and Hospitals and how those requests are processed by the Maine Medicaid Program. The process and sub-processes included in this section of the plan are:

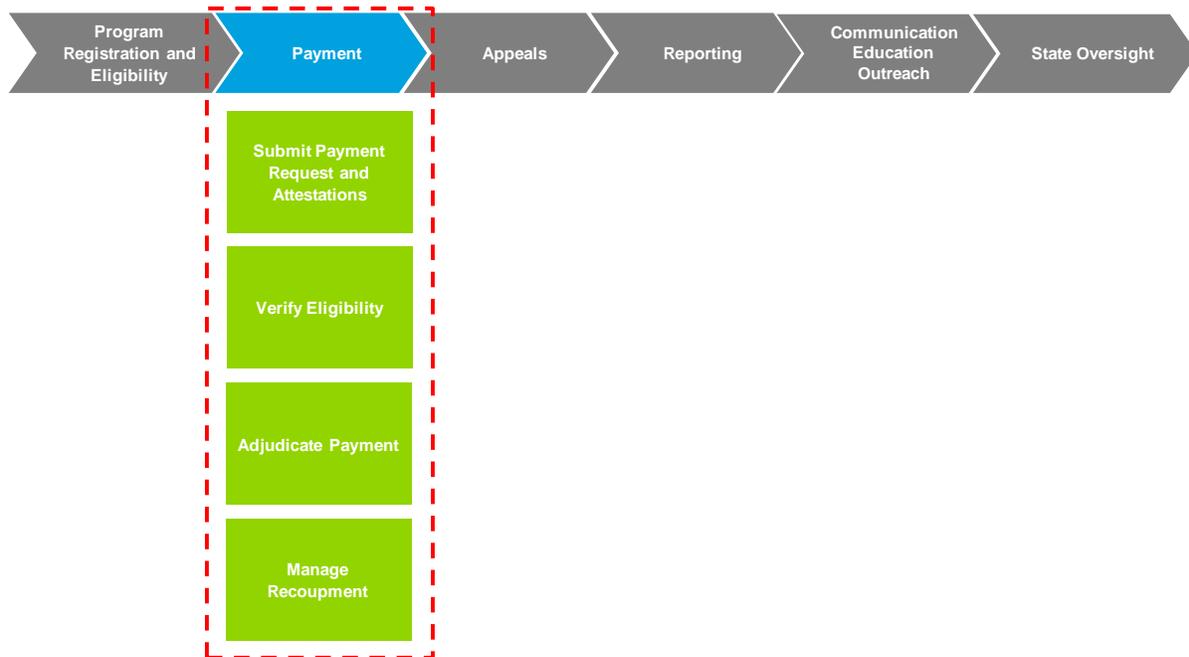


Figure 18. Payment Process and Sub-Processes

The payment process flow requires some additional explanation.

The Medicare and Medicaid Extenders Act of 2010 (Public Law No: 111-309), enacted on December 15, 2010, amended the HITECH. The amended section changes the definition and calculation of the “net average allowable cost.” As a result Maine will issue incentive payments to EPs and EHs as prescribed by the amended law.

For EHs, the payment will be calculated in the first year and will be issued in three annual payments: 50% Payment Year 1, 40% in Payment Year 2, and 10% in Payment Year 3. Prior to year 2016, payments can be made by the State to an eligible hospital on a non-consecutive annual basis. No hospitals may begin the Program (get incentive payments) for any year after FY 2016.

For EPs, payments will be made in annual payments over six years: Year 1, \$21,250; and Year 2 through Year 6, \$8,500 for a total of \$63,750. (These payment amounts reflect the changes under the “Extenders Act.”)

MaineCare will obtain the State Budget Authority to use the ARRA funds (100 percent FFP) to pay the Medicaid EHR incentive payments to EH and EPs. MaineCare will ensure payments are made in a timely manner by following all of the requirements of the Final Rule, the Medicaid State Directors Letter

released on August 17, 2010, and other rules and regulations, including:

- Notifying the NLR that an incentive payment (or ineligibility) has been made within five business days;
- Making payments within 45 days of providers completing all eligibility, AIU, and MU determination and verification checks and where a provider is registering or attesting to AIU or MU at the end of the year, make payment no later than 60 days into the CY for EPs or FFY for EH;
- Completing all provider eligibility and attestation of AIU and MU determination and verification processes in the 45-60 day period, prior to payment;
- Assuring the Medicaid EHR incentive payments are paid directly to the EP, employer or facility to which the EP has assigned payments, without any deduction or rebate. (In lieu of having the incentive payment issued directly to an EP, the EP may reassign the payment to their employer or entity with which the EP has a valid contractual arrangement that allows the entity to bill for the EP's services. This assign is accomplished by the EP including the TIN for the employer or entity when the EP registers. The employer or entity are notified that they can only accept incentive payments that have been reassigned voluntarily and are not allowed to retain more than five (5) percent of the Medicaid EHR Incentive Payment for costs unrelated to certified EHR technology. The Final Rule does allow an additional option of reassigning the payment to a State-designated entity that is registered with the Maine Medicaid Program as an entity promoting the adoption of certified EHR technology. The State does not have any State-designated entities so this option is not available in Maine, and the State recognizes that if it decided to designate entities, it would need to include this option in an updated SMHP.)
- Assuring CMS that under Maine's Manage Recoupment process, in case of an improper Medicaid EHR incentive payment, the State has a method in which it can recoup overpayment of monies made to EPs or EHs. MaineCare understands that it must repay to CMS all Federal financial participation received by providers identified as an overpayment regardless of recoupment from such providers, within one year of the overpayment, per section 6506 of the Affordable Care Act. (At this time, MaineCare does not have a Managed Care contract. If the State chooses to distribute the incentive payments through their Managed Care contract, the assurances and processes will be described in future iterations of the SMHP.)

C2a. Submit Payment Request and Attestation

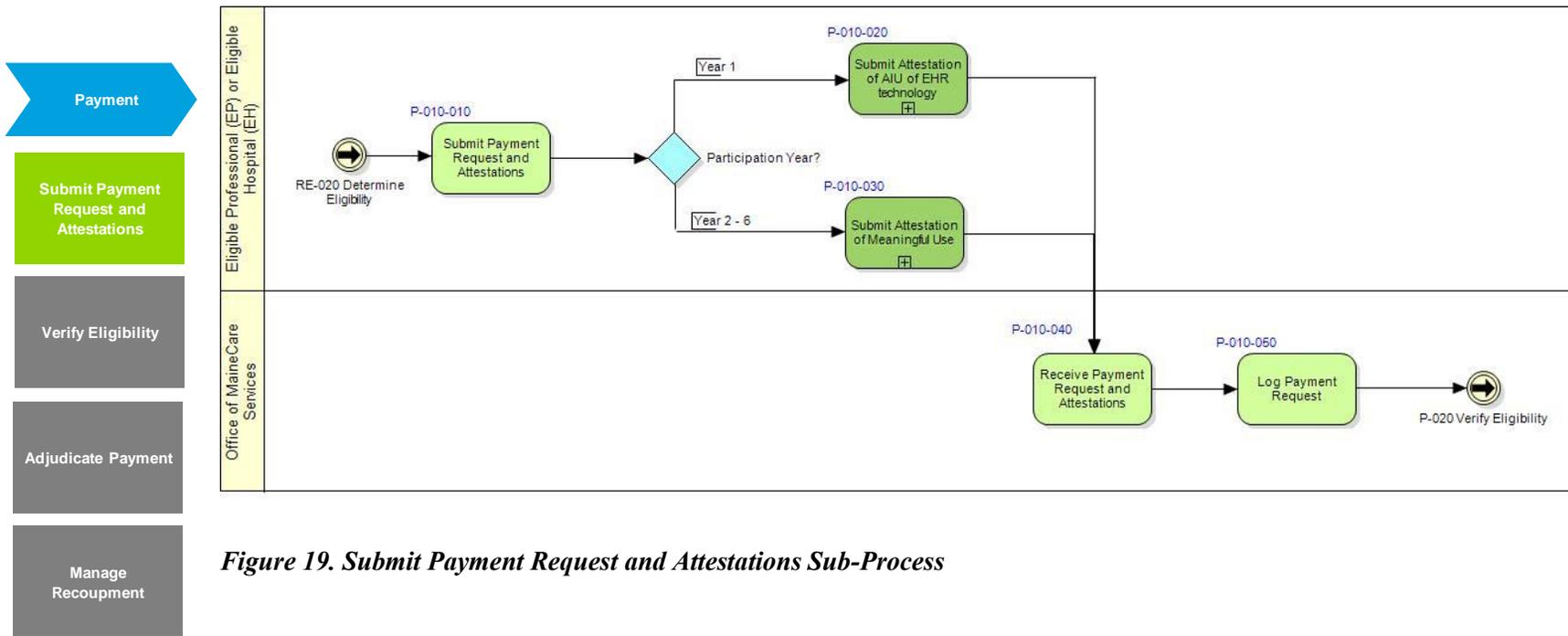


Figure 19. Submit Payment Request and Attestations Sub-Process

Description: This sub-process shows the activities for EPs and EHs to submit a payment request and provide their attestations of AIU and MU.⁵⁰

Resources: EPs/EHs, MaineCare Services, CMS

Proposed Technology to leverage: MIHMS, NLR

State Policy: The State will need to create a policy describing how EPs and EHs must provide their attestations of AIU and MU. The State should have a policy that enforces the CMS regulation as written in the Final Rule on the EHR Incentive Program.

CMS Regulation: Refer to 495.8, 495.312, 495.314 and 495.332 in the Final Rule on the EHR Incentive Programs.

⁵⁰ See Appendix C-6 Payment Request for detail.

Submit Attestation of AIU EHR Technology

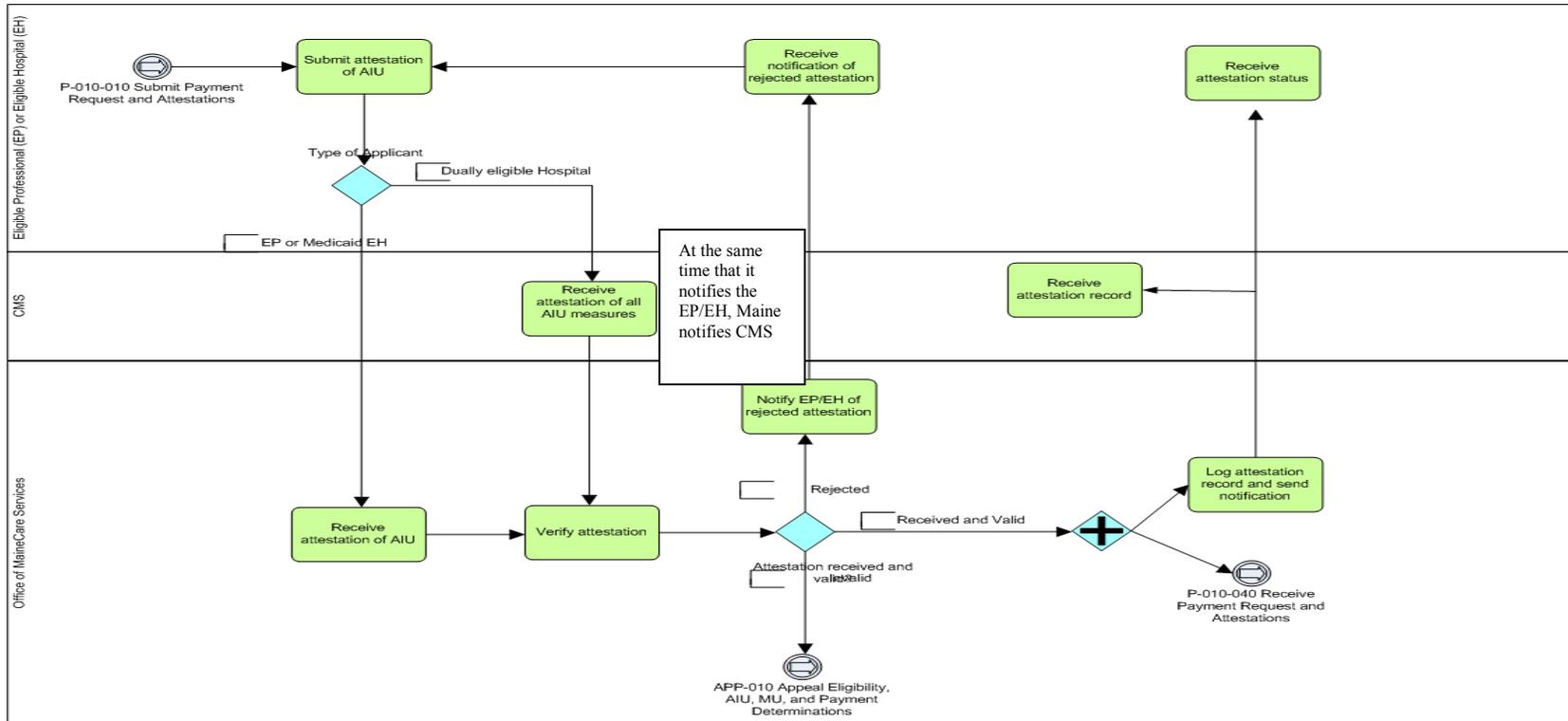


Figure 20. Submit Adoption, Implementation or Upgrade of Certified EHR Technology Attestations Sub-Process

Description: This activity describes the tasks involved in collecting attestations from EPs and EHs on the adoption, implementation, or upgrade (AIU) of certified EHR technology. Attestations of AIU are only required for the first year of participation in the EHR Incentive Program. EPs and EHs can begin attesting AIU of certified EHR technology from 2011-2016.⁵¹

Resources: MaineCare Services, CMS, EP/EH Proposed Technology to leverage: MIHMS, NLR

⁵¹ See Appendix C-7 Submit Attestation. Appendix C-8 is a placeholder for Attestation of Meaningful Use when CMS rules are in place.

C2b. Verify Eligibility Sub-Process

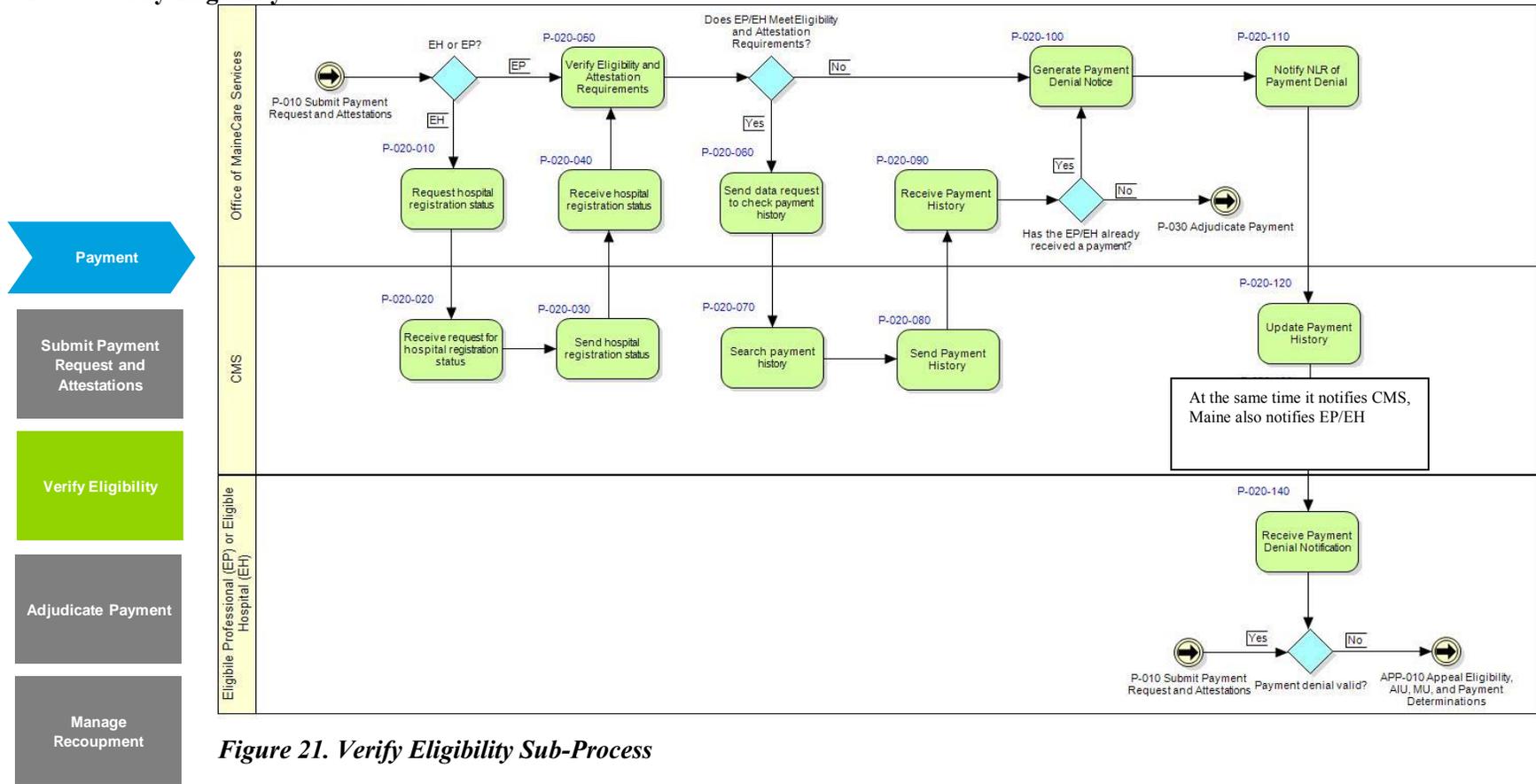


Figure 21. Verify Eligibility Sub-Process

Description: This sub-process describes the activities for verifying EP or EH eligibility and cross-checking attestations before making a payment to an EP or EH.⁵²

Resources: MaineCare Services⁵³

Proposed Technology to leverage: NLR, MIHMS

State Policy: The State should have a policy that enforces the CMS regulation as written in the Final Rule on the EHR Incentive Program.

State Policy: The State should have a policy that enforces the CMS regulation as written in the Final Rule on the EHR Incentive Program.

CMS Regulation: Refer to 495.312 and 495.332 in the Final Rule on the EHR Incentive Programs.

⁵² See Appendix C-9 Verify Eligibility Sub Process for detail.

⁵³ MaineCare Services is the primary Office within DHHS for the HIT Incentive Payment Program. Yet, as described in this document, there are several Offices within the Department that have critical functions under the HIT Incentive Payment Program, such as OIT and Finance.

C2c. Adjudicate Payment

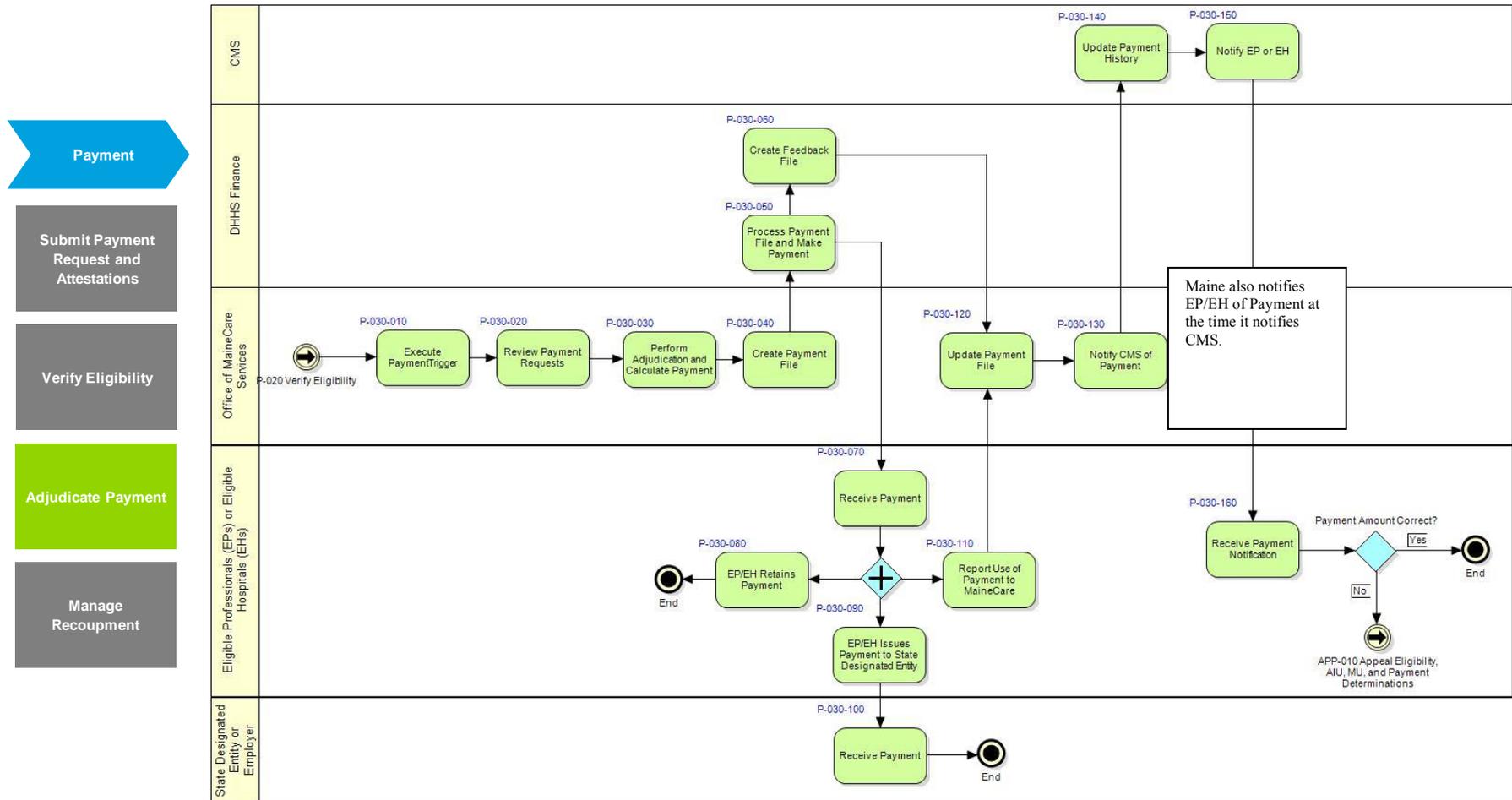


Figure 22. Adjudicate Payment Sub-Process

Description: This sub-process describes the activities for processing and making a payment to an EP or EH.⁵⁴

Resources: MaineCare Services, DHHS Finance, CMS, State Designated Entity

Proposed Technology to leverage: NLR, MIHMS, and AdvantageME

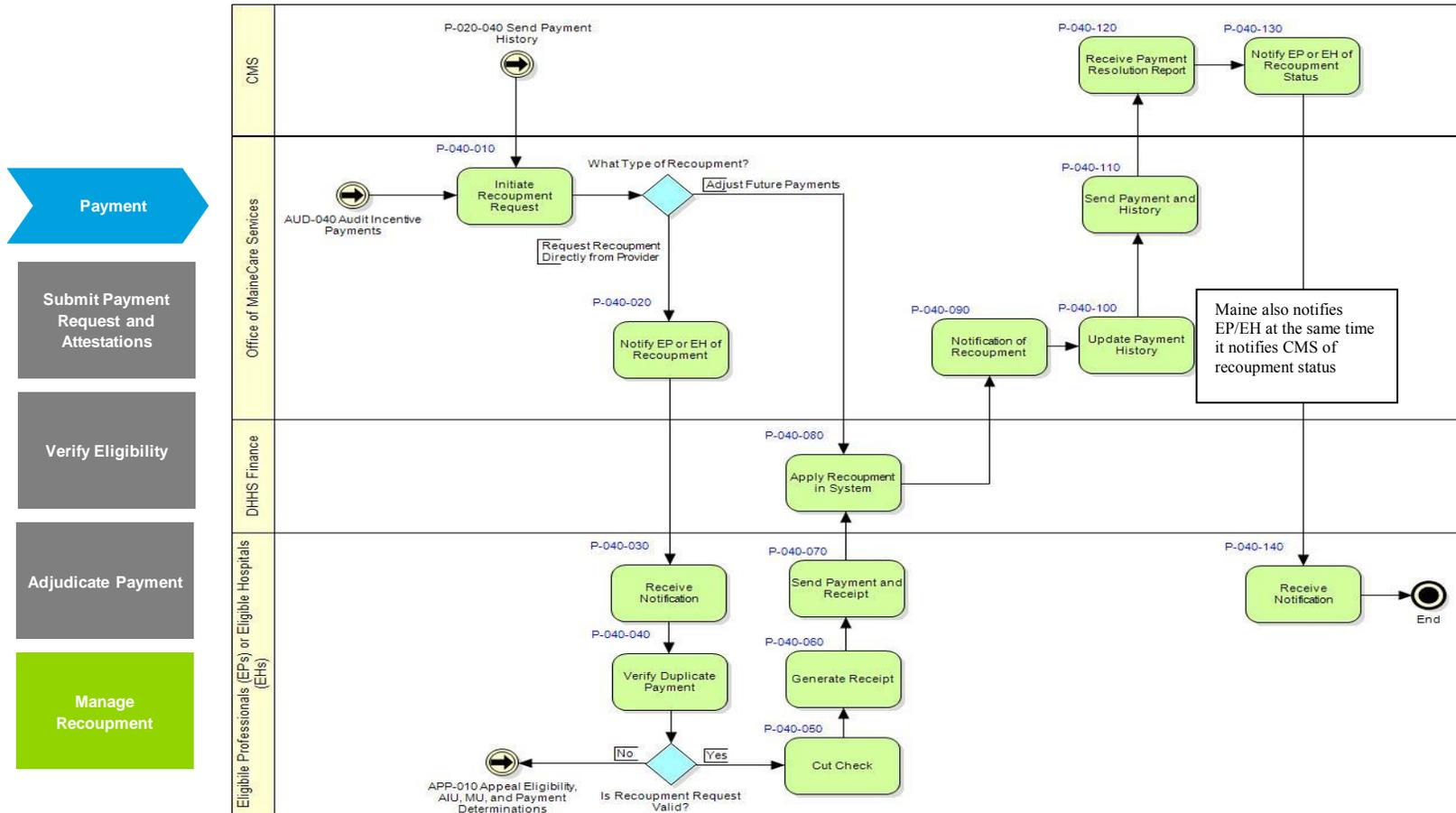
State Policy: The State should have a policy that enforces the CMS regulation as written in the Final Rule on the EHR Incentive Program.

CMS Regulation: Refer to 495.310, 495.312 and 495.332 in the Final Rule on the EHR Incentive Programs.

⁵⁴ See Appendix C-10, Adjudicate Payment

C2d. Manage Recoupment

Figure 23. Manage Recoupment Sub-Process



Description: This sub-process describes the activities involved in recouping incentive payments from EPs or EHs when a duplicate payment or overpayment is made. The recoupment of incentive payments is initiated by the discovery of an overpayment as the result of an audit or notification from the NLR.⁵⁵

Resources: MaineCare Services, DHHS Finance, CMS

Proposed Technology to leverage: NLR, MIHMS, and AdvantageME

State Policy: The State should have a policy that enforces the CMS regulation as written in the Final Rule on the EHR Incentive Program.

CMS Regulation: Refer to 495.312, 495.316, 495.332, 495.366, and 495.368 in the Final Rule on the EHR Incentive Programs.

Assumptions

Payments - Assumptions	
2	If the EP or Hospital is Medicaid certified there are no sanctions and the EP or EH is properly licensed.
3	EPs and EHs will not demonstrate Meaningful Use requirements during their 1st Payment Year, all will adopt, implement, or upgrade.
4	The aggregate hospital payment will be calculated in Payment Year 1, payments will be made based on the payment schedule documented in Section 5.2.
5	All acute care hospitals that qualify for Medicaid EHR incentive payments will participate in both the Medicare and Medicaid EHR Incentive Programs.
6	Hospitals that are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs will receive 1st payment from Medicaid for adopt, implement, or upgrade, then in payment year 2 will start to participate in the Medicare EHR Incentive Program and demonstrate Meaningful Use to CMS.
7	When referring to MaineCare services as proposed resources, this may include MaineCare business resources, OIT, or contractors.
8	Each EP and EH that wishes to participate in the EHR Incentive Program will have already received an NPI and TIN from CMS before registering and requesting a payment.

⁵⁵ See Appendix C-11, Manage Recoupment for details.

Section C. Part 3. Appeals

The following process map demonstrates how provider appeals are submitted, reviewed and processed. The process and sub-process included in this section of the plan are:

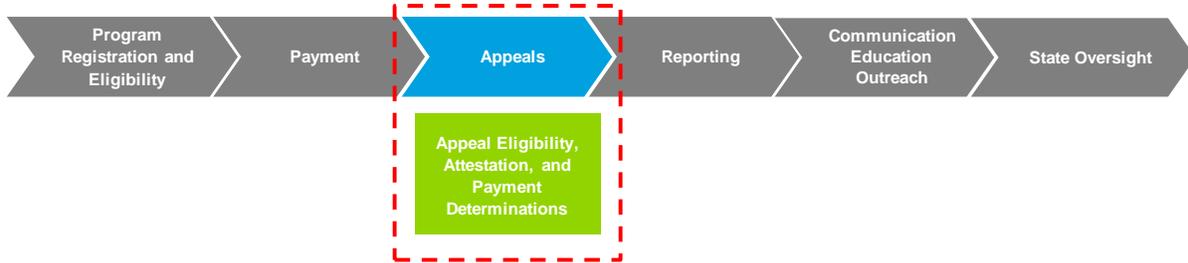
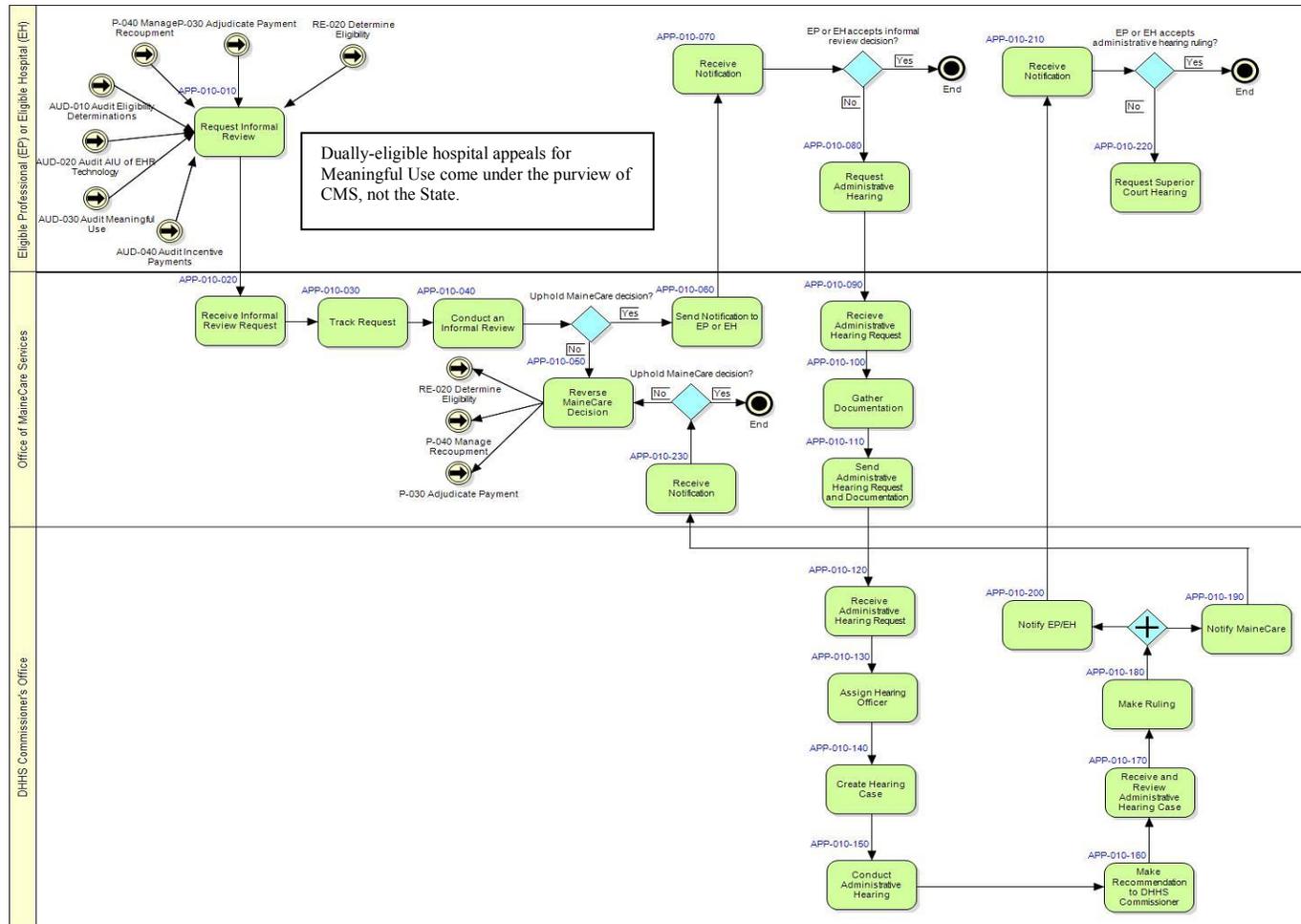


Figure 24. Appeals Process and Sub-Process

Consistent with the Final Rule, Maine’s appeals process for Medicaid incentive payments falls under the State’s Administrative Procedure Act. EPs and EHs are given the opportunity to appeal determinations of incentive payment amounts, eligibility determinations, and attestation demonstrations for the Medicaid EHR Incentive Program. There are several escalating steps to the appeal process. First, providers are able to ask for an Informal Review of an HIT decision. MaineCare reviews the decision and issues a written Informal Review response. The provider may appeal that decision and ask for an Administrative Hearing conducted by a DHHS hearings officer. The provider may appeal that written decision through Maine’s court system. (This is also the process that non-HIT appeals are conducted and is described in MaineCare rules.)

Dually-eligible hospital appeals of Meaningful Use are under the purview of CMS, not states. Appeals of this nature will follow CMS rules and regulations.



Appeals

Appeal Eligibility, Attestation, and Payment Determinations

Figure 25. Appeals Sub-Process

Description: This sub-process describes the method in which EPs and EHs may appeal eligibility determinations, adopting, implementation and upgrading (AIU) to certified EHR technology attestation determinations, incentive payments, and Meaningful Use determinations for EPs or Medicaid only EHs.⁵⁶

Resources: EPs/EHs, MaineCare Services, DHHS Commissioner's Office, Office of Administrative Hearings, DHHS Commissioner

Proposed Technology to leverage: None identified at this time

State Policy: The three-step process for Informal Reviews, administrative hearings, and court appeals are governed by MaineCare rules, the Maine Administrative Procedures Act and Administrative Hearing Regulations. The State should have a policy that enforces the CMS regulation as written in the Final Rule on the EHR Incentive Program.

CMS Regulation: Refer to 495.370 in the Final Rule on the EHR Incentive Program.

Assumptions

Appeals Process - Assumptions	
1	The same procedures will be followed for the following appeals related to the Medicaid EHR Incentive Program. (1) Incentive payment amounts (2) Provider program eligibility determinations (3) Demonstration of adopting, implementing, and upgrading, and Meaningful Use eligibility for incentives under this subpart (4) Audit findings

⁵⁶ See Appendix C-12 Appeals Sub-Process for details.

Section C. Part 4. Reporting

The following processes provide an explanation of the reporting mechanisms that will support MaineCare in administering the EHR Incentive Program. The process and sub-processes included in this section of the plan are:

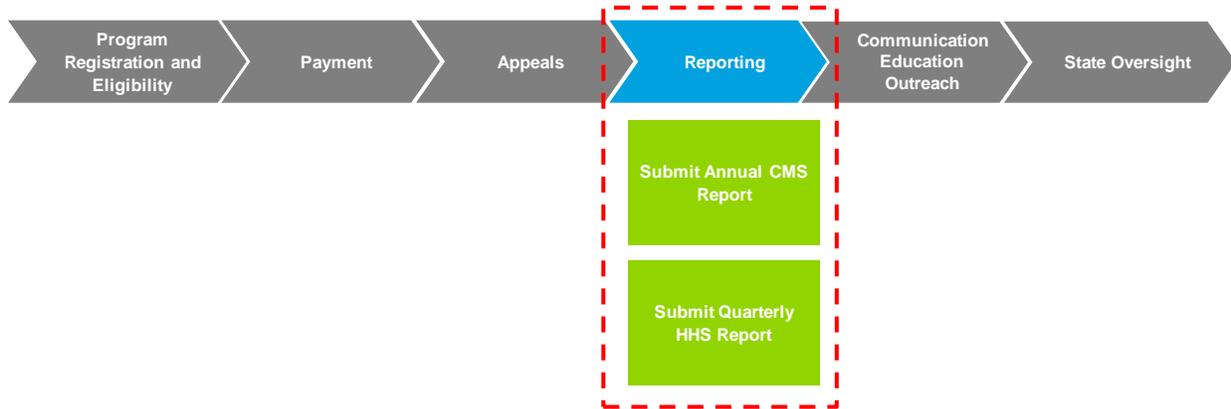


Figure 26. Reporting Process and Sub-Processes

MaineCare is responsible for tracking and verifying the activities necessary for a Medicaid EP or EH to receive an incentive payment for each payment year. The process below shows how the State will collect and report on provider Meaningful Use of certified EHR technology and other incentive program metrics for CMS. MaineCare will submit to CMS on an annual basis a report that contains the following:

1. Provider adoption, implementation, or upgrade of certified EHR technology activities
2. Aggregated, de-identified Meaningful Use data, such as:
 - a. Number, type and practice locations of providers who qualified for an incentive payment on the basis of having adopted, implemented, or upgraded to certified EHR technology.
 - b. Aggregated data tables representing the provider adoption, implementation, or upgrade of certified EHR technology.
 - c. Number, type, and practice location(s) of providers who qualified for an incentive payment on the basis of demonstrating that they are meaningful users of certified EHR technology.
 - d. Aggregated data tables representing the providers' clinical quality measures data.
 - e. Description and quantitative data on how its incentive payment program addressed individuals with unique needs such as children.

MaineCare is, also, required to submit to US DHHS on a quarterly basis a progress report documenting specific implementation and oversight activities performed during the quarter, including progress on implementing the State's approved Medicaid HIT Plan. MaineCare will work in coordination with the Office of the State Coordinator (OSC) to produce these reports in alignment to process R-020 as described in section 5.4.2.

Furthermore, MaineCare discussed the potential management reports that would enable the State to

manage the administration of the program in the most efficient and effective manner. MaineCare identified the management reports listed in the table below as potential reports that they would need to manage the program.

Potential EHR Incentive Program Management Reports
Number of EPs and EHRs registered in the NLR
Number of EP and EH records received from the NLR
Number of EPs and EHRs deemed eligible for the EHR Incentive Program
Number of EPs and EHRs deemed ineligible for the EHR Incentive Program, including reason for denials
Number of EPs and EHRs pending eligibility decisions
Number of EPs and EHRs providing attestations to the State
Number of dually eligible hospitals providing attestations through the NLR
Number of EPs and EHRs receiving an incentive payment
Average number of days from receipt of payment request by the State to payment being received by an EP or EH
Total dollar amount of incentive payments distributed to EPs and EHRs
Number and dollar amount of duplicate payments made to EPs and EHRs
Number and dollar amount of duplicate payments avoided
Number and dollar amount of recoupments received from EPs and EHRs
Number of EPs and EHRs in each participation year (year 1, year 2, etc.)
Percentage of eligibility determinations, attestations, and incentive payment audited
Number and type of provider appeals files
Number and type of provider inquiries received
Annual report containing analysis of program outcomes

While MaineCare has identified some of the management reports they may need to administer the program, the details regarding these reports will be defined this summer in the DDI phase, including the frequency, timeframes, schedule, type (ad hoc, canned, or other), and data source for the reports.

C4a. Submit Annual CMS Report

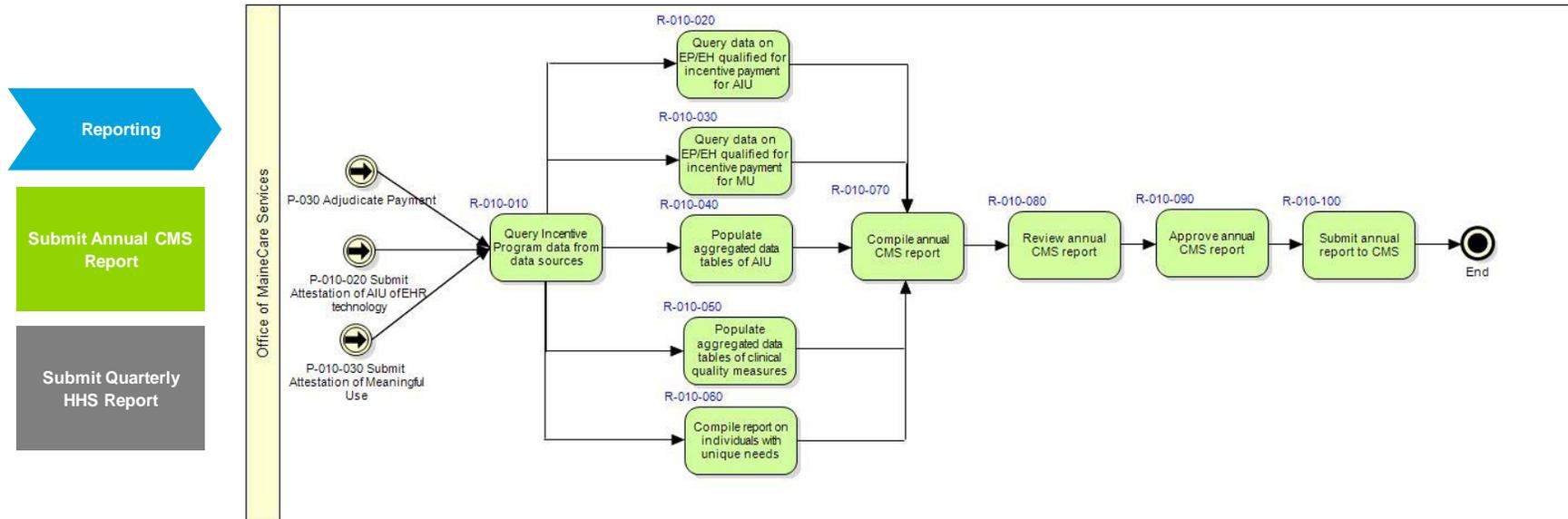


Figure 27. Submit Annual CMS Report Sub-Process

Description: This sub-process describes the reporting activities required to complete and submit an annual report on the EHR Incentive Program to CMS. Each State must submit to CMS an annual report of provider adoption, implementation, or upgrade of certified EHR technology activities, incentive payments to EPs and EHs, and aggregated, de-identified Meaningful Use data.⁵⁷

⁵⁷See Appendix C-13 Annual CMS Report for details.

The annual report must include, but is not limited to the following:

- The number, type, and practice location(s) of providers who qualified for an incentive payment on the basis of having adopted, implemented, or upgraded certified EHR technology.
- Aggregated data tables representing the provider adoption, implementation, or upgrade of certified EHR technology.
- The number, type, and practice location(s) of providers who qualified for an incentive payment on the basis of demonstrating that they are meaningful users of certified EHR technology.
- Aggregated data tables representing the provider's clinical quality measures data
- A description and quantitative data on how its incentive payment program addressed individuals with unique needs such as children.

Resources: HIT Manager, MaineCare Services

Proposed Technology to leverage: None identified at this time

State Policy: The State should have a policy that enforces the CMS regulation as written in the Final Rule on the EHR Incentive Program. CMS Regulation: See 495.316, 495.332, and 495.352 in the Final Rule on the EHR Incentive Programs.

C4b. Submit Quarterly HHS Report

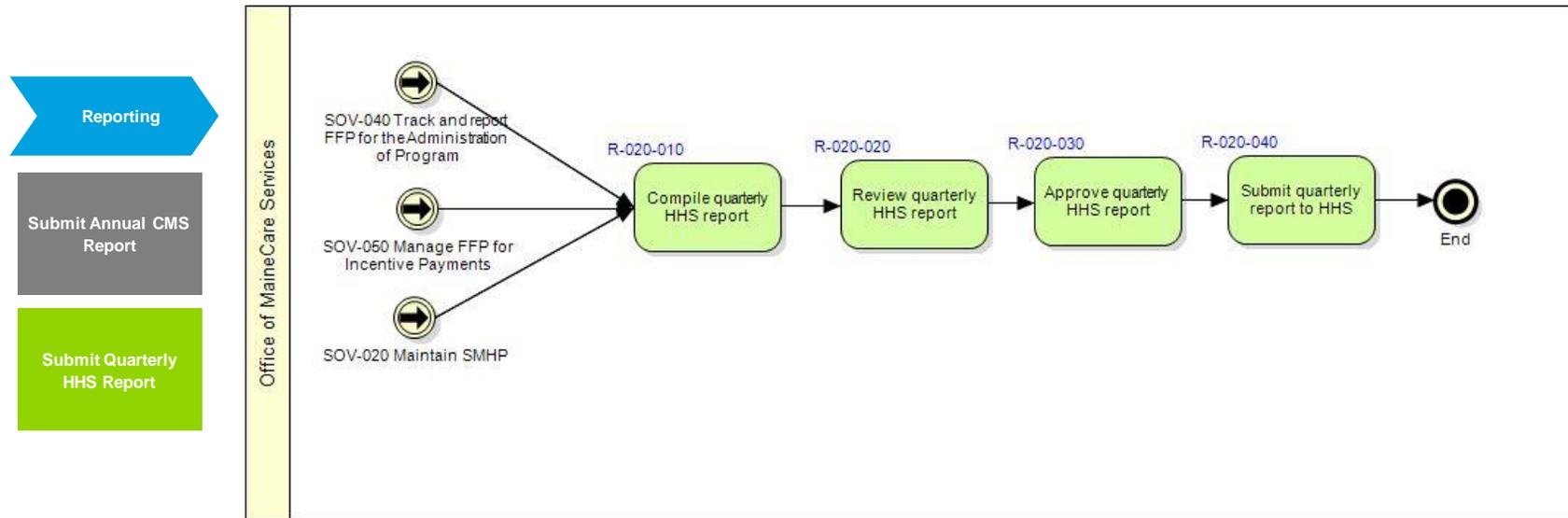


Figure 28. Submit Quarterly HHS Report Sub-Process

Description: This sub-process describes the reporting activities required to complete and submit a quarterly report on the EHR Incentive Program and HIT efforts to HHS. Each State must submit to HHS on a quarterly basis a progress report documenting specific implementation and oversight activities performed during the quarter, including progress in implementing the State's approved Medicaid HIT plan.⁵⁸

Resources: HIT Manager, MaineCare Services

Proposed Technology to leverage: None identified at this time

State Policy: The State should have a policy that enforces the CMS regulation as written in the Final Rule on the EHR Incentive Program.

CMS Regulation: See 495.332 and 495.352 in the Final Rule on the EHR Incentive Programs.

Assumptions for this Part: None

⁵⁸ See Appendix C-14 Quarterly HHS Report for detail.

Section C. Part 5. Communication, Education and Outreach

The following processes provides an explanation of the support mechanisms that will help EPs and EHs with technical and eligibility questions related to the Medicaid EHR Incentive Program. The process and sub-processes included in this section of the plan are:

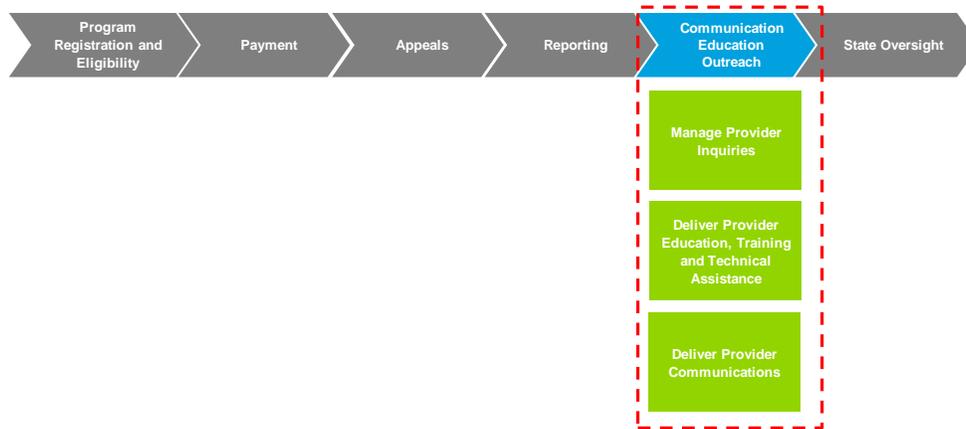


Figure 29. Communication, Education, and Outreach Process and Sub-Processes

As described in the Program Registration and Eligibility Part, MaineCare will operate a help desk for the EHR Incentive Program to answer inquiries from providers about the program. The help desk will have dedicated resources that are able to provide detailed information on the MaineCare HIT EHR Incentive Payment Program.

MaineCare will use the most current CMS HITECH/EHR Incentive Program Inquiry Toolkit for addressing questions received by the help desk. More complex questions will be referred to the HIT Program Manager or the CMS EHR Information Center. The State anticipates that these provider inquiries will be different from the typical help desk questions received, and will require more time to answer and a different skill set from the typical help desk resource.

The help desk will also provide technical assistance to EPs and EHs who experience technical issues when submitting information to MaineCare. The help desk will be able to quickly identify the issue and take steps to provide a resolution in a timely manner.

MaineCare will also engage in a communications and outreach campaign in coordination with the MeREC, and Provider and Hospital Associations. Using the tools and avenues provided the OSC, MeREC, Provider and Hospital Associations, and the Office of MaineCare Services, EPs and EHs will be given instructions on how to register for the Medicaid EHR Incentive Program, guidance on the eligibility requirements, and expectations on when and how they will be notified about the program. MaineCare will also use the email addresses provided by the EPs and EHs upon registering for the program to deliver targeted messages and provide one-on-one assistance with the program.

The recent placement of the OMS HIT Program with the OSC ensures collaboration and consistency that

Maine's EPs and EHs are given timely and correct information on the availability and operations of the process and especially the NLR system. MaineCare will use the most current Provider Inquiry Toolkit provided by CMS to ensure consistent messaging and information. The OSC, MeREC, Provider and Hospital Association and MaineCare have already begun the communication and outreach to engage EPs and EHs who are most likely to be eligible for Medicaid EHR incentive payments through targeted outreach activities. (The Provider Communication, Education, and Outreach and Communications processes are outlined below.)

MaineCare will use two parallel approaches for communication and outreach—the first is to conduct "pre-eligibility" efforts with providers who are expected to be at, or near, the Medicaid patient level thresholds while the second track will be an outreach program about HIT designed for providers who may not be as familiar with HIT or where there is more question about meeting the Medicaid patient thresholds. MaineCare is also developing an informational campaign for Maine's health care consumers on the promotion of HIE and EHR adoption. All of these activities will be thoroughly discussed in MaineCare's HIT reports.

C5a. Manage Provider Inquiries

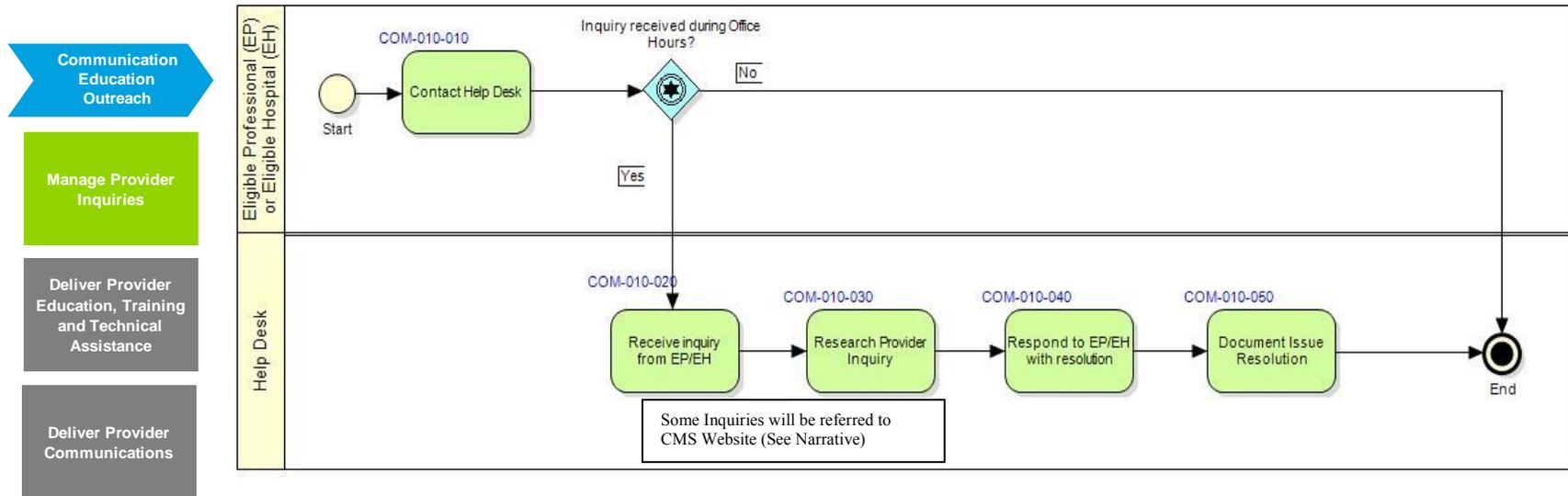


Figure 30. Manage Provider Inquiries Sub-Process

Description: This sub-process shows the activities involved to manage inquiries from EPs and EHs related to HIT and the EHR Incentive Program.

Resources: Help Desk

Proposed Technology to leverage: Interactive Voice Response (IVR)

State Policy: None identified at this time

CMS Regulations: None identified at this time

C5b. Deliver Provider Education, Training and Technical Assistance

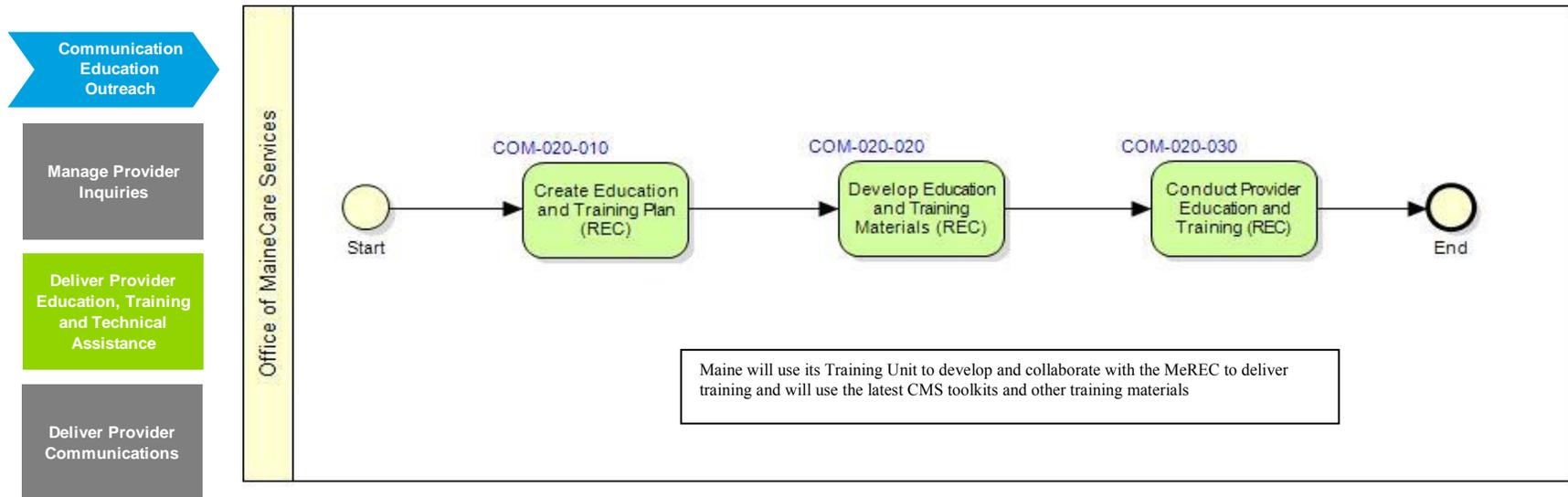


Figure 31. Deliver Provider Education, Training, and Technical Assistance Sub-Process

Description: This sub-process shows the activities that the State and MeREC will complete to provide EPs and EHs the training, education, and technical assistance they need to effectively implement EHR technology in their practice/hospital.⁵⁹

Resources: HIT Program Manager, MeREC, OMS Training Unit, OIT and other resources as needed.

Proposed Technology to leverage: Training modules, teleconference and videoconference tools and technology

State Policy: None identified at this time

CMS Regulation: None identified at this time.

⁵⁹ See Appendix C-15 Managing Provider Inquiries and Deliver Provider Education for detail.

C5c. Deliver Provider Communications

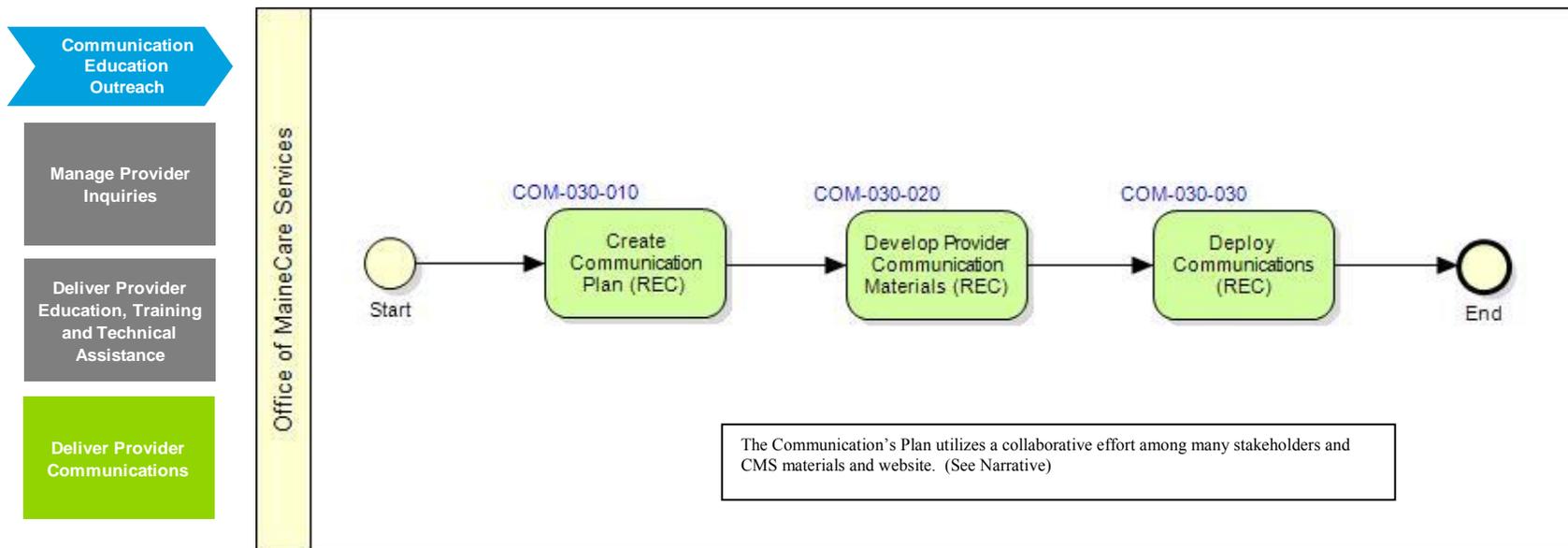


Figure 32. Deliver Provider Communications Sub-Process

Description: This sub-process shows the activities that the State and MeREC will complete to communicate with EPs and EHs regarding the Incentive Program, EHR technology adoption, and other HIT-related topics.⁶⁰

Resources: HIT Program Manager, MaineCare Director of Communications, MeREC, other resources as needed.

Proposed Technology to leverage: MaineCare website

State Policy: None identified at this time

CMS Regulation: None identified at this time

Assumptions: None

⁶⁰ See Appendix C-16 Deliver Provider Communications

Section C. Part 6. State Oversight

The following process maps demonstrate how MaineCare will monitor and oversee the administration of the EHR Incentive Program. The process and sub-processes included in this section of the plan are:

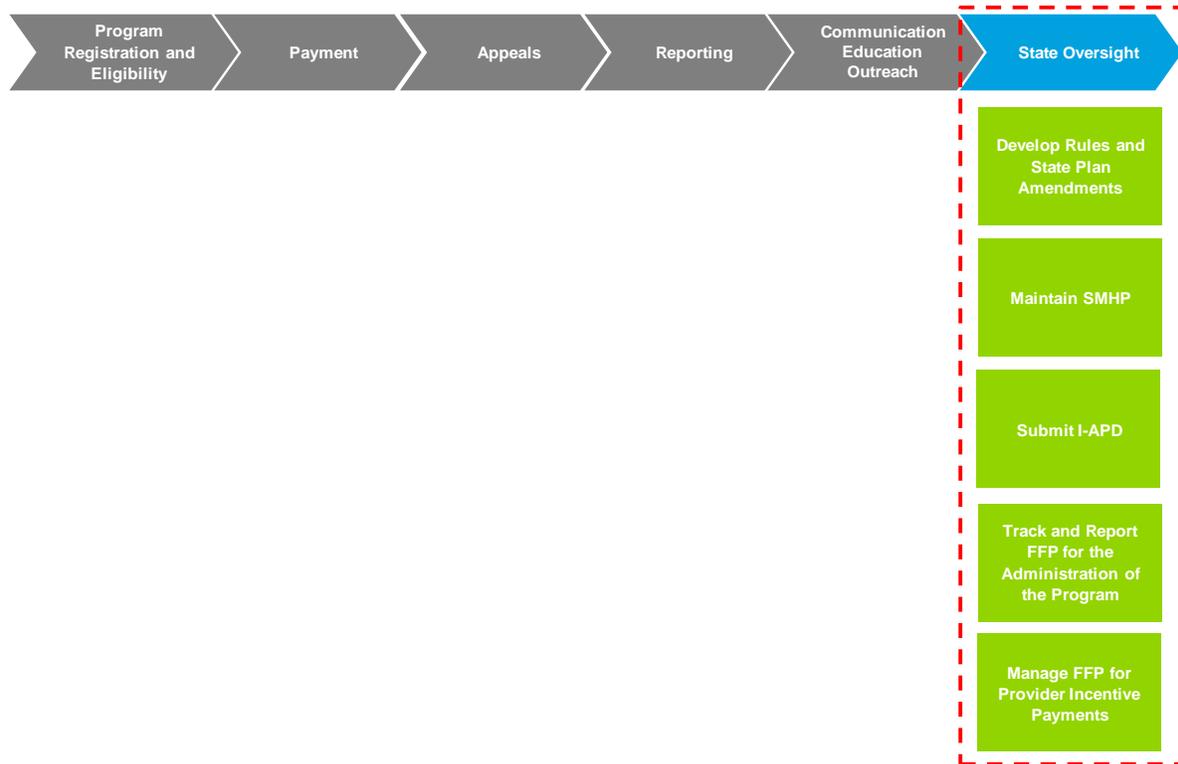


Figure 33. State Oversight Process and Sub-Processes

To get FFP, MaineCare must demonstrate to CMS’s satisfaction that MaineCare uses the funds provided to administer incentive payments to providers under this program; conducts adequate oversight; and pursues initiatives for the adoption of certified EHR technology to promote health care quality and the exchange of health care information.

For Part 1. Rules and State Plan Amendments, the CMS Final Rule made it clear that states do not need State Plan Amendments for the HIT Incentive Payment Program. Maine included the term “State Plan Amendments” in the sub-process title to assure CMS and readers that the State recognized that in some CMS programs State Plan Amendments are needed, but in the case of HIT, the Final Rule provision that no State Plan Amendments were needed.

MaineCare’s process to Develop Rules is a key element in conducting adequate oversight of the program. To administer the EHR Incentive Program, MaineCare will develop an EHR Incentive Program State rule according to CMS’ EHR Incentive Program Final Rule and subsequent regulations. Maine has an Administrative Procedures Act that governs State rulemaking. The process includes engaging stakeholders in the drafting of the rule; issuing a proposed rule with ample time for public and stakeholder comment; holding a public hearing on the rule; responding to comments; and issuing a final rule that has been approved by the Attorney General’s Office, the Commissioner of DHHS, Finance Division, OMS, and other offices. MaineCare’s Policy Division develops and oversees the rule and the rulemaking

process. The Policy Division has drafted a rule, which will be proposed in late spring and finalized in conjunction with MaineCare's go-live of the HIT Incentive Payment Program.

In terms of Part 2, SMHP and Part 3, IAPD, Maine understands that interaction with key stakeholders regarding the administration of the EHR Incentive Program is not a one-time affair. The successful adoption and implementation of HIT hinges on buy-in and participation from all stakeholders--from the Program Directors administering the program, OIT for technology planning and support, the providers adopting the technology and receiving the payments, Federal and State decision-makers, to the MaineCare Members that receive the benefits of coordination of care and lower health care costs. Therefore, MaineCare is committed to continued and ongoing collaboration with these stakeholders to revisit the processes and activities for administering the OMS HIT Program, including the EHR Incentive Payment Program. The SMHP will be reviewed and updated annually or as needed. MaineCare will maintain its SMHP including the four sub-activities which fall under this sub-process which include:

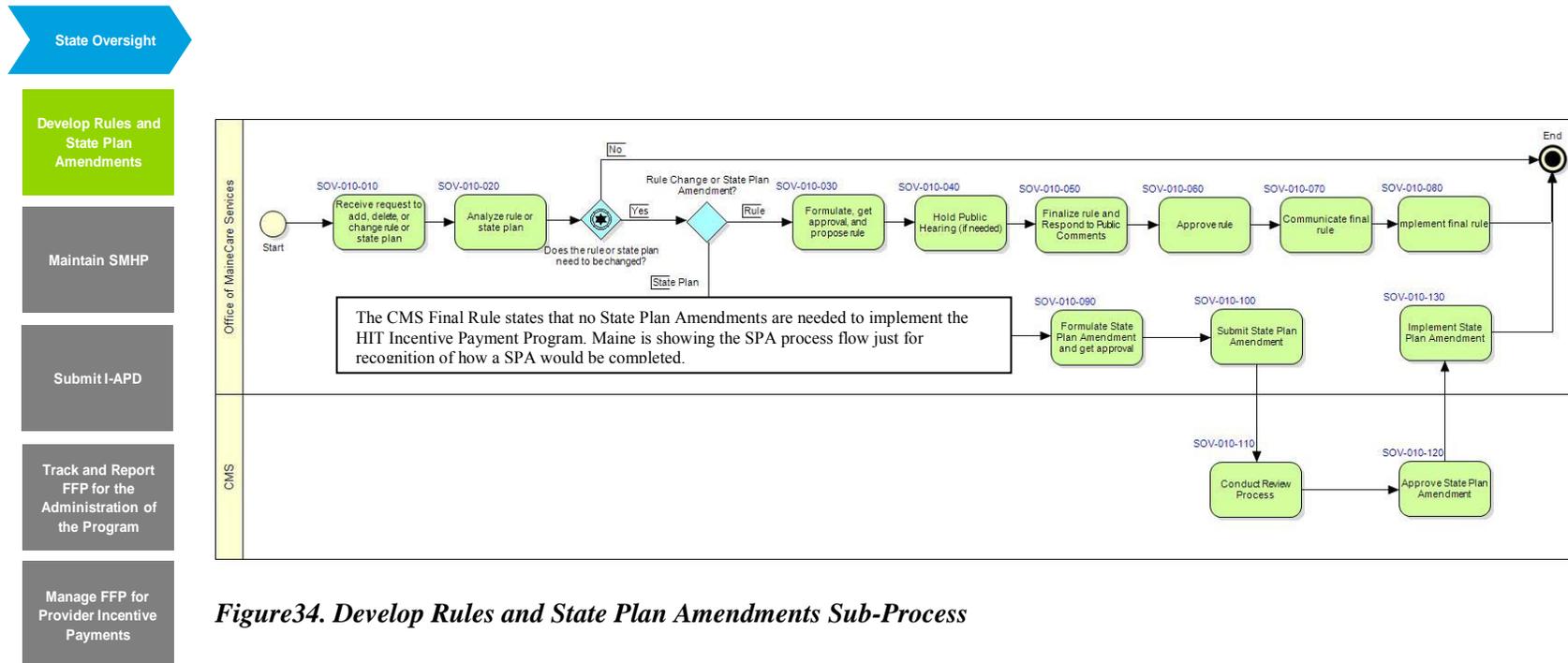
1. Revise HIT Landscape
2. Revise HIT Vision
3. Revise Meaningful Use Sustainability Plan
4. Revise Implementation Roadmap

MaineCare is responsible for updating and submitting a revised Implementation Advanced Planning Document on an annual basis (or as needed) to secure funding for its initiatives they are pursuing on an ongoing basis to encourage the adoption of certified EHR technology to promote health care quality and the electronic exchange of health care information.

In terms of Part 4 Track and Report and Part 5 Manage FFP, as stated in the Final Rule, FFP is available at 90 percent for State expenditures for administration activities for the OMS HIT Program, including support of implementing incentive payments to Medicaid EPs and EHS. MaineCare has implemented the Track and Report FFP for the Administration of the Program process to ensure that no amounts higher than 90 percent of FFP will be claimed by the State for administrative expenses in administering the HIT EHR Incentive Payment Program. To comply with the State Medicaid Director Letter dated August 17, 2010, MaineCare will submit quarterly budget estimate reports via Form CMS-37 electronically to CMS via the Medicaid and State Children's Health Insurance Program (CHIP) Budget and Expenditure System (MBES/CBES). On Form CMS-64, MaineCare will submit, on a quarterly basis, actual expenses incurred, which will be used to reconcile the Medicaid funding advanced to MaineCare based on the Form CMS-37. MaineCare will follow guidance outlined by CMS in the August 17th State Medicaid Director Letter Enclosure D for budget preparation, reporting of estimates, expenditures and timing of the grant award letter and retroactive requests for planning activities funded at 90/10 FFP.

As required under the Final Rule, the Manage FFP for Provider Payment process outlined below is the process MaineCare has put into place to ensure that no amounts higher than 100 percent of FFP will be claimed by the State for reimbursement of expenditures for State payments to Medicaid EPs or EHS for the certified EHR Incentive Payment program.

C6a. Develop Rules



Description: This sub-process shows the activities to create governance policies and guidelines to administer the EHR Incentive Payment Program.⁶¹

Resources: HIT Manager, Special Projects Unit, Policy Division

Proposed Technology to leverage: None identified at this time

State Policy: The State must make a Rule to administer, conduct oversight, and enforce the EHR Incentive Program. (No State Plan Amendment is required per CMS Final Rule.)

CMS Regulations: None identified at this time

⁶¹ See Appendix C-17 Develop Rules and State Plan Amendments

C6b. Maintain SMHP

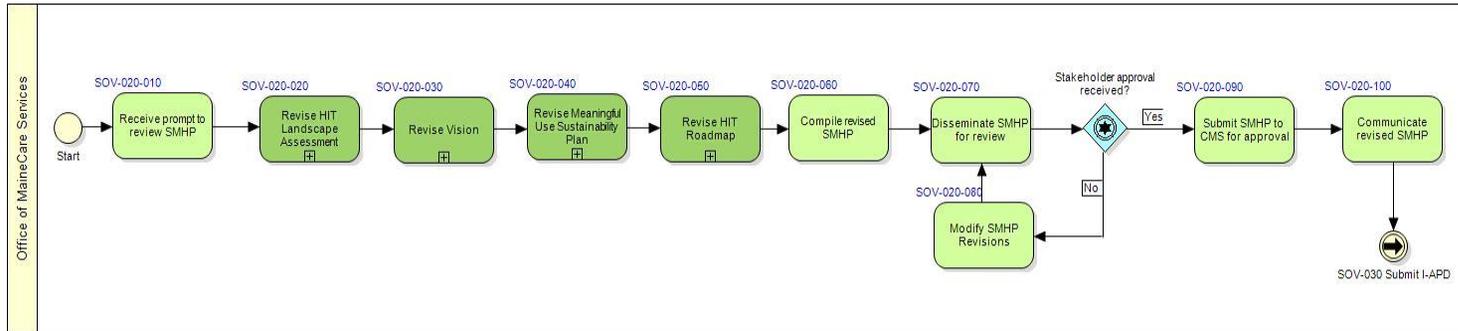


Figure 35 Maintain SMHP Sub-Process

Description: This sub-process describes the annual reiterative cycle for updating the SMHP to ensure that the HIT landscape assessment, vision, Meaningful Use sustainability plan, and roadmap reflect the current goals of MaineCare. The Meaningful Use sustainability plan refers to the need to update the SMHP to ensure that the stages of Meaningful Use criteria (i.e., Stages 1, 2 and 3) are being met.⁶²

Resources: Special Projects Unit, HIT Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, others as identified

Proposed Technology to leverage: None identified at this time

State Policy: The State should have a policy that enforces the CMS regulation as written in the Final Rule on the EHR Incentive Program.

CMS Regulation: Refer to 495.332 and 495.344 in the Final Rule on the EHR Incentive Program

⁶² See Appendix C-18 Maintain SMHP for detail.

1) Revise HIT Landscape Assessment

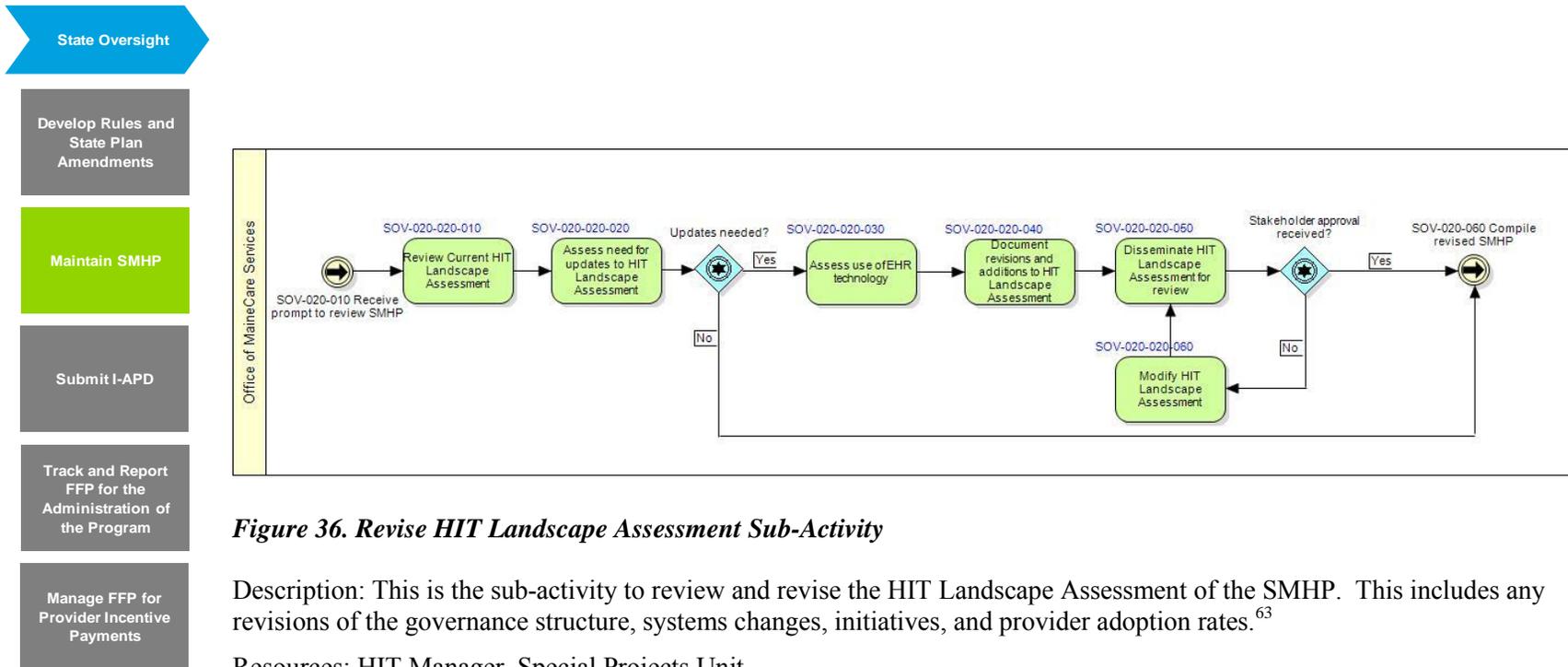


Figure 36. Revise HIT Landscape Assessment Sub-Activity

Description: This is the sub-activity to review and revise the HIT Landscape Assessment of the SMHP. This includes any revisions of the governance structure, systems changes, initiatives, and provider adoption rates.⁶³

Resources: HIT Manager, Special Projects Unit

Proposed Technology to leverage: None identified at this time

⁶³ See Appendix C-19 Revise HIT Landscape for detail.

2) Revise Vision

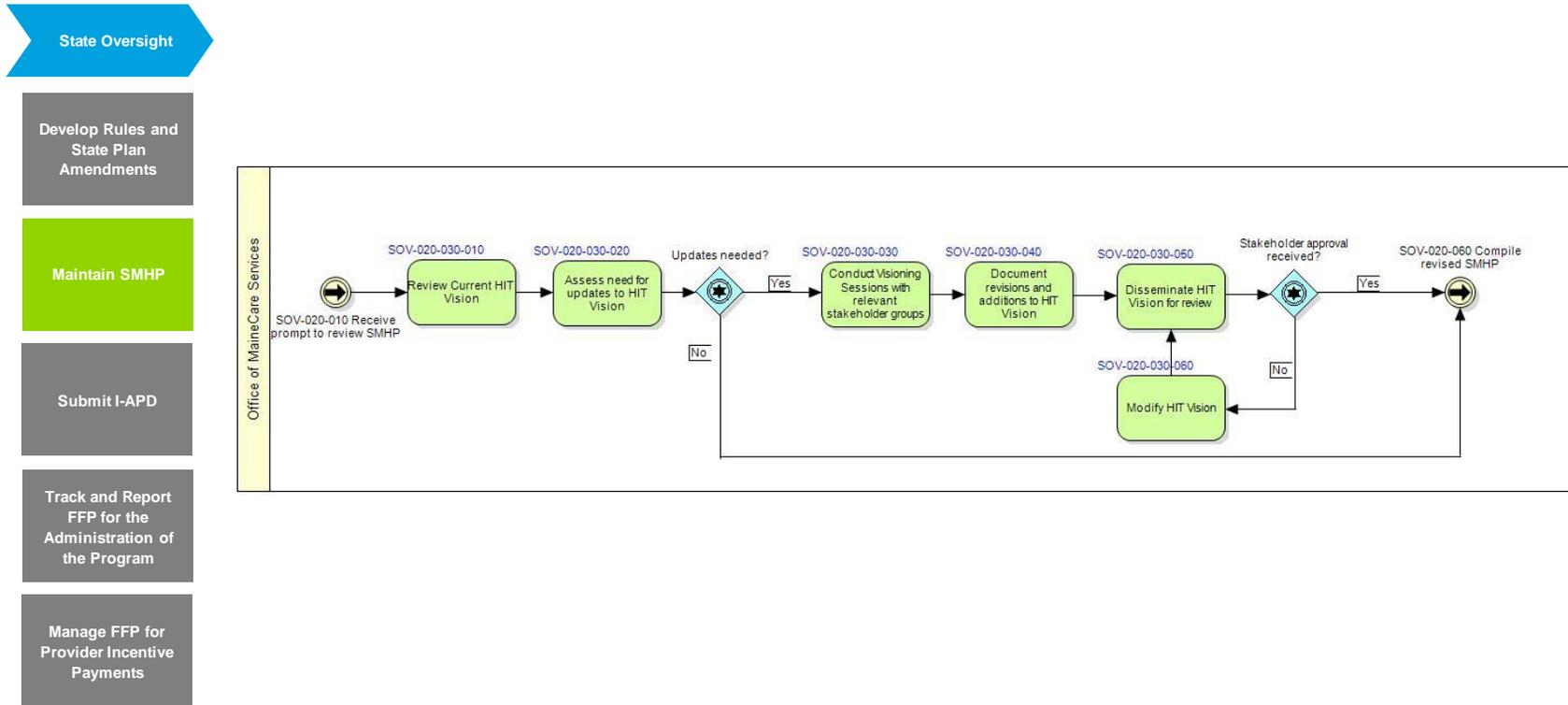


Figure 37. Revise Vision Sub-Activity

3) Revise Meaningful Use Sustainability Plan

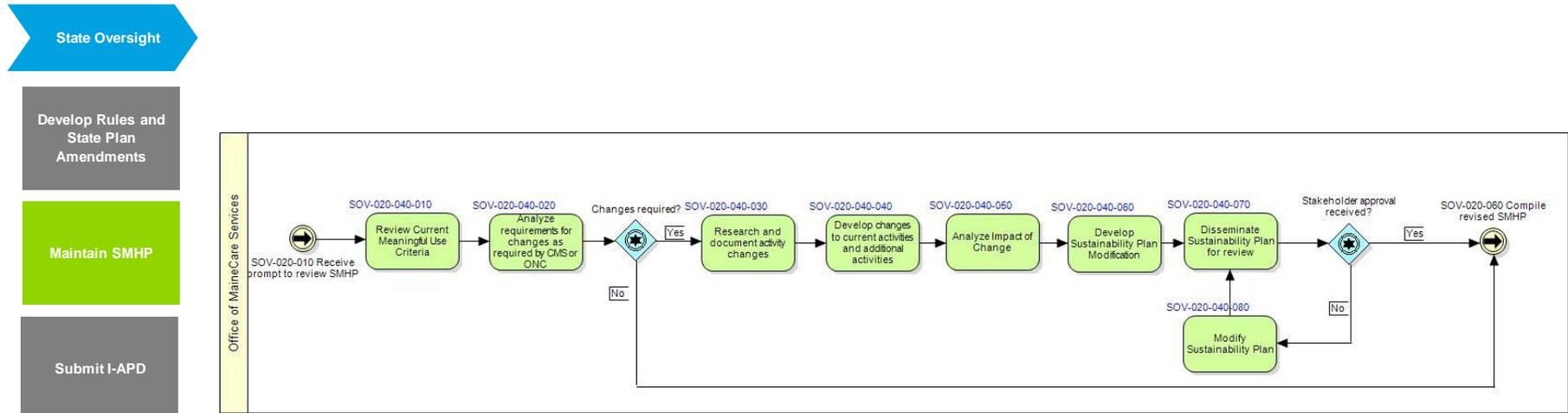


Figure 38. Revise Meaningful Use Sustainability Plan Sub-Activity

Description: This is the sub-activity to review and revise the Meaningful Use Sustainability plan, specifically how the State will change the standards for Meaningful Use attestations for the different stages of Meaningful Use. This includes review of the current Meaningful Use standards and meeting the requirements of the new stage. Maine recognizes that Meaningful Use is an iterative process and will include substantial documentation and information as CMS develops and publishes information about Meaningful Use.

Resources: HIT Manager, Special Projects Unit

Proposed Technology to leverage: None identified at this time

4) Revise HIT Roadmap



Develop Rules and State Plan Amendments

Maintain SMHP

Submit I-APD

Track and Report FFP for the Administration of the Program

Manage FFP for Provider Incentive Payments

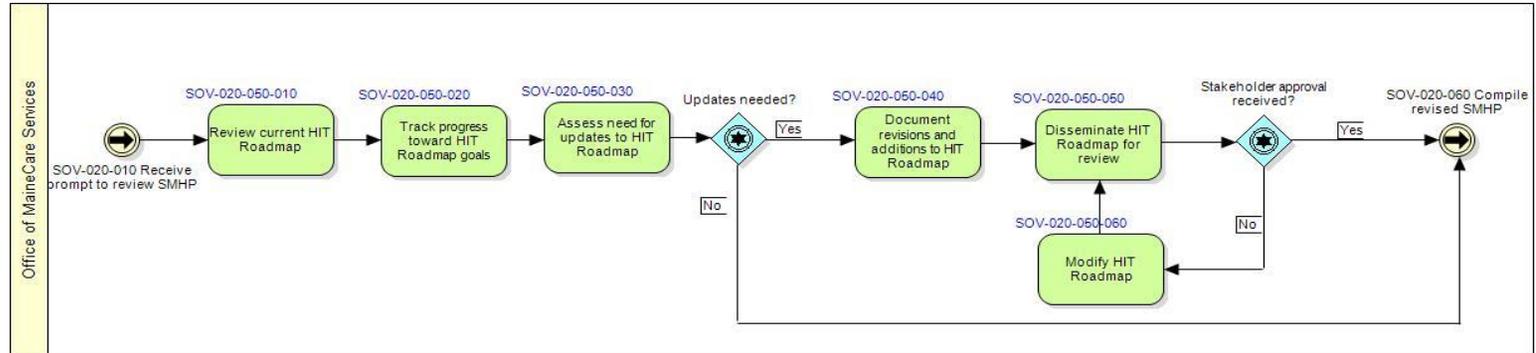


Figure 39. Revise HIT Roadmap Sub-Activity

Description: This is the sub-activity to review and revise the HIT Roadmap. This includes tracking progress toward Roadmap goals, assessing the need to revise the Roadmap, and modifying the Roadmap.⁶⁴

Resources: HIT Manager, Special Projects Unit

Proposed Technology to leverage: None identified at this time

⁶⁴ See Appendix C-20 Revise Roadmap

C6c. Submit IAPD

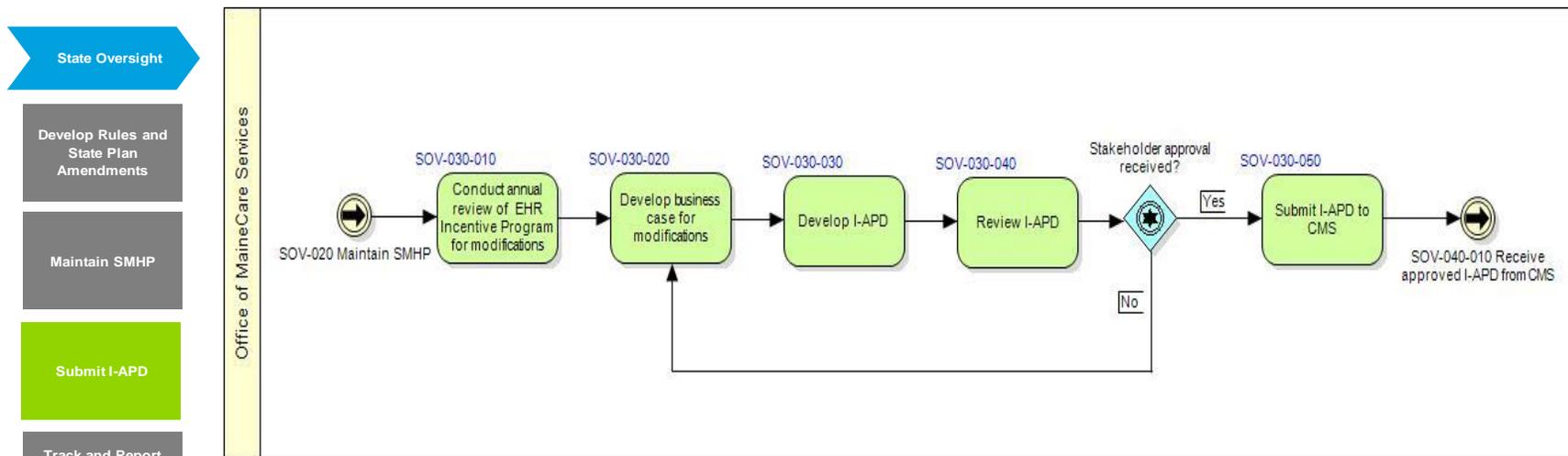


Figure 40. Submit IAPD Sub-Process

Description: MaineCare services must submit an Implementation Advanced Planning Document (IAPD) annually to request funding and enhancements from CMS for the administration and implementation of the EHR Incentive Program. This sub-process includes assessing the EHR Incentive Payment Program for modifications, developing the business case for needed modifications, developing the IAPD, reviewing the IAPD for stakeholder approval, and submitting the IAPD to CMS for approval. This is an iterative process that should be completed at least on an annual basis.⁶⁵

Resources: Special Projects Unit, HIT Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, others as identified

Proposed Technology to leverage: None identified at this time State Policy: The State should have a policy that enforces the CMS regulation as written in the Final Rule on the EHR Incentive Program.

CMS Regulation: Refer to 495.338, 495.340, 495.342, and 495.344 in the Final Rule on the EHR Incentive Program.

⁶⁵ See Appendix C-21 IAPD Sub-Process for detail.

C6d. Track and Report FFP for the Administration of Program

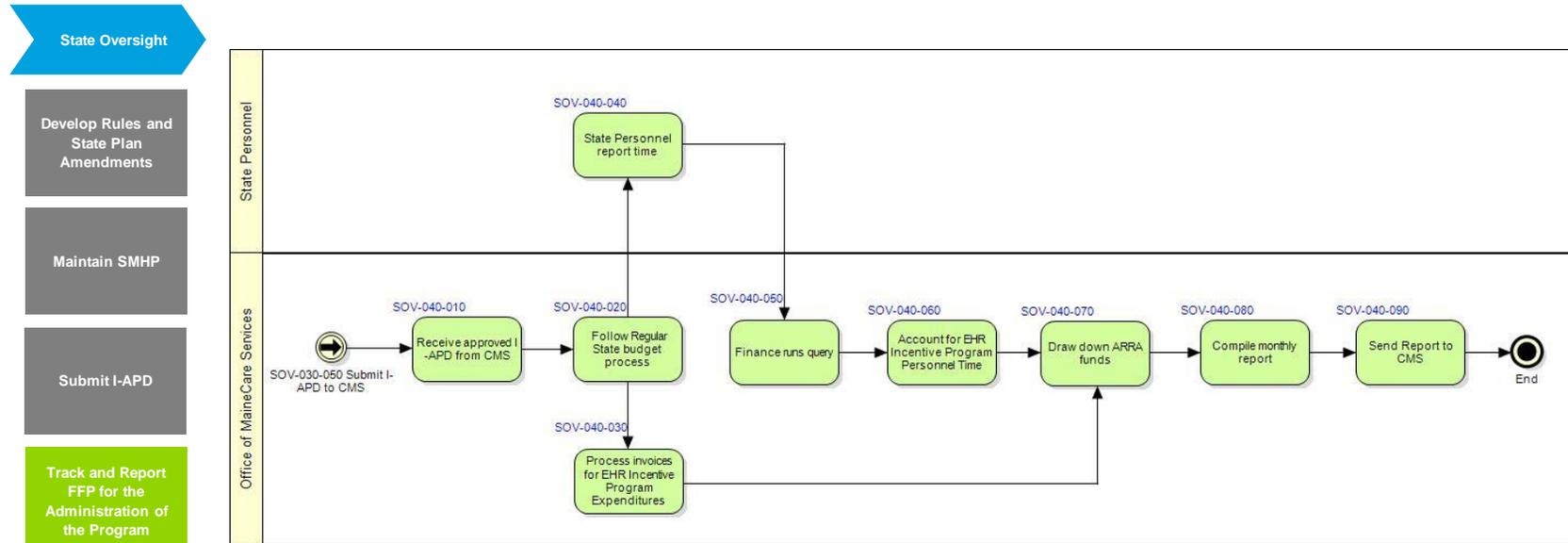


Figure 41. Track and Report FFP for the Administration of the Program Sub-Process

Description: This sub-process shows the activities that occur to manage FFP funds from CMS for the administration of the EHR Incentive Payment Program. This starts with the approval of the IAPD, managing state personnel time and costs, and reporting expenditures to CMS.⁶⁶

Resources: Finance and Accounting, HIT Manager

Proposed Technology to leverage: Medicaid Budget and Expenditure System, AdvantageME

State Policy: The State should have a policy that enforces the CMS regulation as written in the Final Rule on the EHR Incentive Program. The State will follow the statutorily defined State budget process.

CMS Regulation: Refer to 495.316, 495.318, 495.322, 495.324, and 495.366 in the Final Rule on the EHR Incentive Program.

⁶⁶ See Appendix C -22 Track and Report FFP for detail.

C6e. Manage FFP for Provider Payments

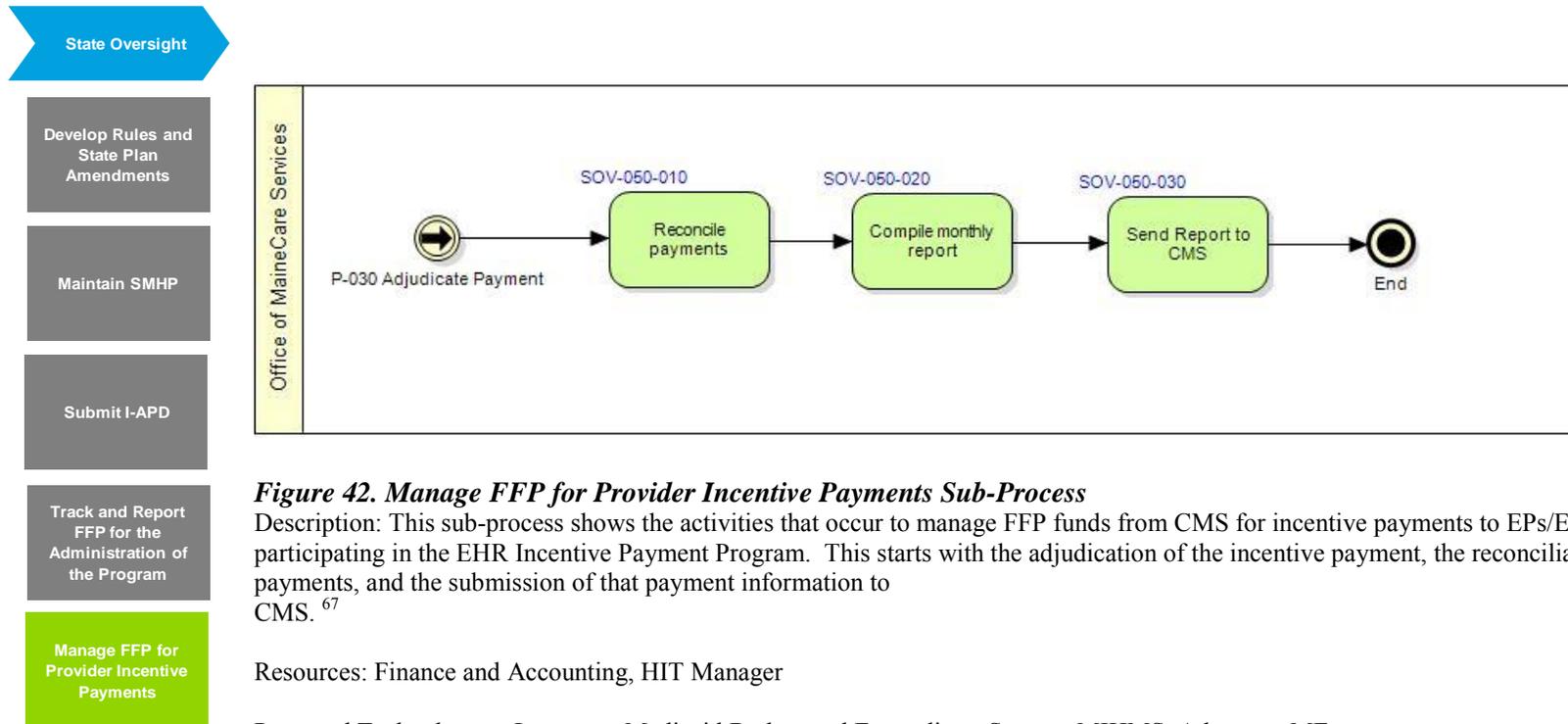


Figure 42. Manage FFP for Provider Incentive Payments Sub-Process

Description: This sub-process shows the activities that occur to manage FFP funds from CMS for incentive payments to EPs/EHs for participating in the EHR Incentive Payment Program. This starts with the adjudication of the incentive payment, the reconciliation of payments, and the submission of that payment information to CMS.⁶⁷

Resources: Finance and Accounting, HIT Manager

Proposed Technology to Leverage: Medicaid Budget and Expenditure System, MIHMS, AdvantageME

State Policy: The State should have a policy that enforces the CMS regulation as written in the Final Rule on the EHR Incentive Program.

CMS Regulation: Refer to 495.318, 495.320, and 495.366 in the Final Rule on the EHR Incentive Program.

⁶⁷ See Appendix C-23 Manage FFP for Provider for details.

SECTION D: STATE AUDIT STRATEGY



This Section describes MaineCare’s audit approach for the HIT and EHR Incentive Payment Program.

The Section is divided into four parts that illustrate how Maine will audit the HIT EHR Incentive Program to promote program integrity, prevent making improper incentive payments, and monitor the program for potential fraud, waste, and abuse.⁶⁸

The development of the State’s Audit Strategy for the EHR Incentive Program produced specific action items for the State to conduct to audit, control, and conduct oversight of the EHR Incentive Program. These action items, taking into consideration technology and human resources needed to complete the activities, are a crucial piece of the Implementation Roadmap and the Implementation Advanced Planning Document (IAPD) and are, therefore, a critical element to the overall SMHP.⁶⁹ There are several DHHS Divisions that have oversight authority over the OMS HIT Program.

DHHS HIT Oversight Responsibilities

DHHS, Office of State Coordinator (OSC)	<ul style="list-style-type: none"> Administration and Oversight of the State-wide HIT Program
DHHS, Office of MaineCare Services	<ul style="list-style-type: none"> HIT Program Manager— Administration and Oversight of the OMS HIT Program Policy Division--Draft State rules that govern and enforce the OMS EHR Incentive Program
DHHS, Audit Division	<ul style="list-style-type: none"> Audit eligibility determinations, attestations of AIU and in the future, Meaningful Use, of Certified EHR technology, and incentive payments
DHHS, Finance Division	<ul style="list-style-type: none"> Tracks and reports financial information on the HIT and Incentive Payment Program.

As stated earlier in the SMHP, the Department’s Division of Audit has assigned an audit manager and an auditor to the OMS HIT Program who have established relationships with the providers and hospitals and a deep understanding of the systems and practices being evaluated. The Audit manager attended an HIT

⁶⁸ Section D is based on the MaineCare Program’s assessment of the Federal regulation governing the Medicaid EHR Incentive Program, the guidance provided by CMS in the SMHP Overview Template distributed in spring 2010, and the interface control document provided by CMS regarding the National Level Repository (NLR). A table that contains a crosswalk of the questions that CMS indicated should be answered is found in Appendix D-1 along with a detailed acknowledgement and agreement with fraud prevention processes and requirements.

⁶⁹ Appendix D-2 is the audit strategy are the resource documents and activities used to conduct this assessment and plan.

audit boot-camp this spring. Both the manager and the auditor have participated in webinars and other trainings on HIT audit strategies.

Section C of the SMHP includes a summary of the activities of the incentive payment process. This Section D. includes each of the four Parts of the audit component of the incentive payment process and is intended to be read and understood in conjunction with Section C.⁷⁰

- Before any payment is made, the HIT Team Program Manager will send an electronic message to the audit manager that a file is “complete” and ready to be reviewed.
- Either the audit manager or the designated auditor will use the on-line systems to confirm the provider submission and the HIT team member’s work, and for hospitals, Medicare cost reports and the hospital payment calculation, and verification of the provider’s attestations to the CMS EHR reporting number via the API.
- The audit manager will send an electronic message to the HIT Team Program Manager that the file has been reviewed and approved for payment.
- After provider payments are made, the payment information will be reviewed by the HIT team manager and sent to the audit manager for further review, as appropriate. Audit will use standardized reports and tools in the evaluation and documentation of the audit process to ensure that all cases are evaluated according to the same criteria and findings are uniform for all auditors and EPs or EHs. The Audit Division has identified criteria that will be used to trigger desk audits.⁷¹

⁷⁰ In addition to this Section of the SMHP, the State’s IAPD discusses actions to achieve the goals and objectives of the SMHP and State and federal requirements.

⁷¹ These audit triggers are designed for the first year of operations of the HIT Program. As Meaningful Use measures and metrics are designed and implemented, Maine will modify its audit strategy accordingly.

<u>Trigger</u>	<u>Number of points</u>
First time that the provider has had contact with MaineCare	5
Low claims volume as shown on routinely produced MIHMS claims reports	1-5
Lack of use of the State HIE (HIN)	5
EPs or EHS identified by Program Integrity on audits of other programs. (fraud, waste and abuse)	1-5
Providers whose initial application was incomplete and required repeated contacts/untimely delays/incomplete information to OMS	1-5
Other Risk factors (works at multiple sites/high percentage of services performed in hospital, others TBD)	1-5
EHS whose first year Medicaid HIT payment is above \$500,000 ⁷²	5
TOTAL POINTS	

Providers who “score” a high number of “points” will trigger a desk audit, which depending on the results, may trigger an on-site audit. This spring and early summer MaineCare will work with the Audit Division to refine the grid, identify other risk factors, the point level which will trigger a desk audit, and establish random sample criteria and standards. MaineCare will also work with the Audit Division to identify the types of records (including contracts, receipts, and other legal documents) that providers and hospitals must keep and make available for desk or on-site audits to verify they meet the AIU requirements and that their EHR product has been certified by an Authorized Testing and Certification Body (ATCB) as designated by ONC.

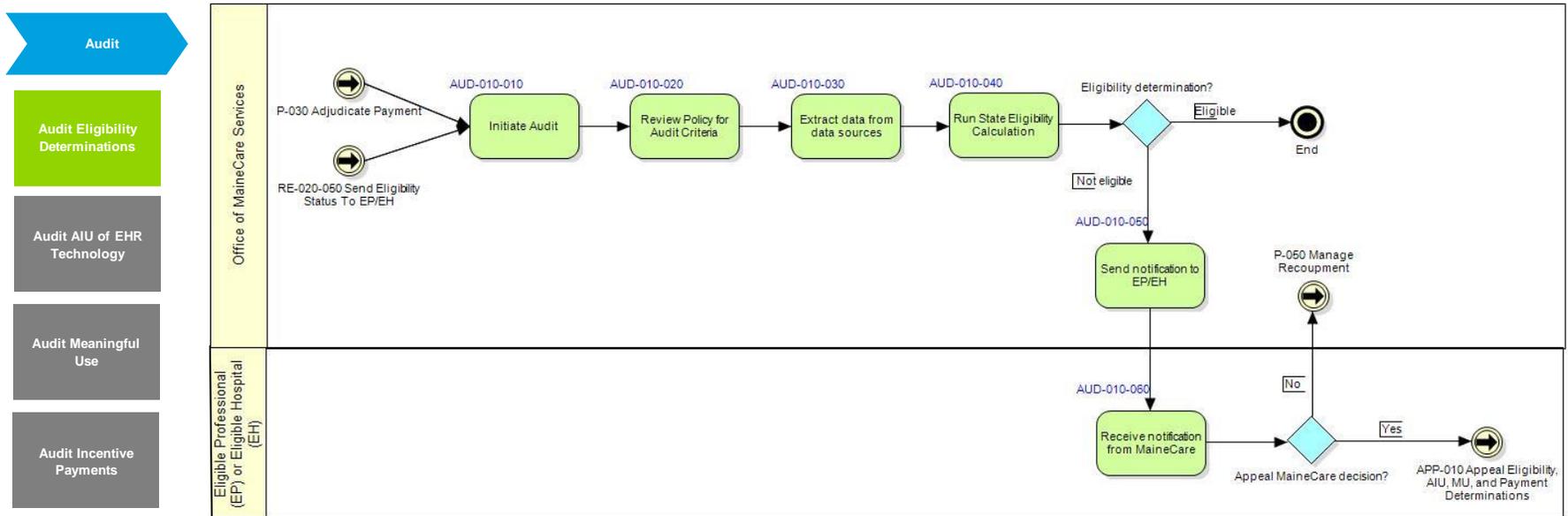
⁷² Maine has elected to pay hospitals over a three year period. Thus, \$500,000 equates to a total hospital payment amount of \$1,000,000. Based on the smaller volume that Maine hospitals have, \$1,000,000 is an appropriate audit threshold.

Section D. Part 1. Audit Eligibility Determinations

The following table displays the key information on the type of audit, resources and data sources used, whether the audit occurs pre-payment, post-payment, or both, and the timing of the audit.

Audit Eligibility Determinations			
Type of Audit	Resources/Data Sources	Pre- or Post-Payment	Timing of Audit
EP's or EH's eligibility	<ul style="list-style-type: none"> • MIHMS • State licensing registry • State sanction list 	<ul style="list-style-type: none"> • Pre-payment 	<ul style="list-style-type: none"> • Upon EP's or EH's submission of attestation information

Figure 43. Audit Eligibility Determinations Sub-Process



Description: This sub-process describes the activities required to audit eligibility determinations of EPs and EHs.⁷³ The process map details how MaineCare audits eligibility determinations.⁷⁴ To audit eligibility determinations, MaineCare Auditors will conduct manual lookups to verify the qualifications of the providers who request Medicaid EHR incentive payments. Those qualifications include that the provider is credentialed/licensed, not-sanctioned, not hospital-based, practicing predominantly, is eligible to receive Federal funds, and is an eligible professional or hospital. Resources to verify this information include the State licensing registries and sanction records. The MaineCare Auditor will verify that the EP or EH meets the patient volume requirements by verifying the calculation data.

A note about the hospital-based exclusion: Hospital-based professionals who provide more than 90% of their services in a hospital are not eligible for incentive payments. Maine will review physician claims for place service codes (POS) 21 (inpatient hospital) and 23 (emergency room, hospital) to substantiate that the professionals are not hospital based.

Resources: MaineCare Services

Proposed Technology to leverage: MIHMS

State Policy: The State should have a policy that enforces the CMS regulation as written in the Final Rule. The State will use the encounter method to determine EP/EH eligibility. The State has developed a risk-based trigger system for audits and still needs to determine the percentage of EPs and EHs that will be “randomly” chosen for audit each year of the EHR Incentive Program.

CMS Regulation: See 495.304, 495.306, 495.316, and 495.368 in the Final Rule on the EHR Incentive Programs.

⁷³ See Appendix D-3 for a detailed description of the audit eligibility processes and activities.

⁷⁴ These eligibility requirements can be found in Subpart D – Requirement Specific to the Medicaid Program, Section 495.304 and 495.306 in the Final Rule on the EHR Incentive Programs

Section D. Part 2. Audit AIU of Certified EHR Technology

The following table displays the key information regarding what type of audit is conducted, the resources and data sources used, whether the audit occurs pre-payment, post-payment, or both, and the timing of the audit.

Audit AIU of Certified EHR Technology			
Type of Audit	Resources/Data Sources	Pre- or Post-Payment	Timing of Audit
AIU of Certified EHR Technology	<ul style="list-style-type: none"> Documentation provided by the EP or EH (e.g., vendor contract) ONC Certified Health IT Product List 	<ul style="list-style-type: none"> Pre-payment 	<ul style="list-style-type: none"> Upon EP's or EH's submission of AIU attestation

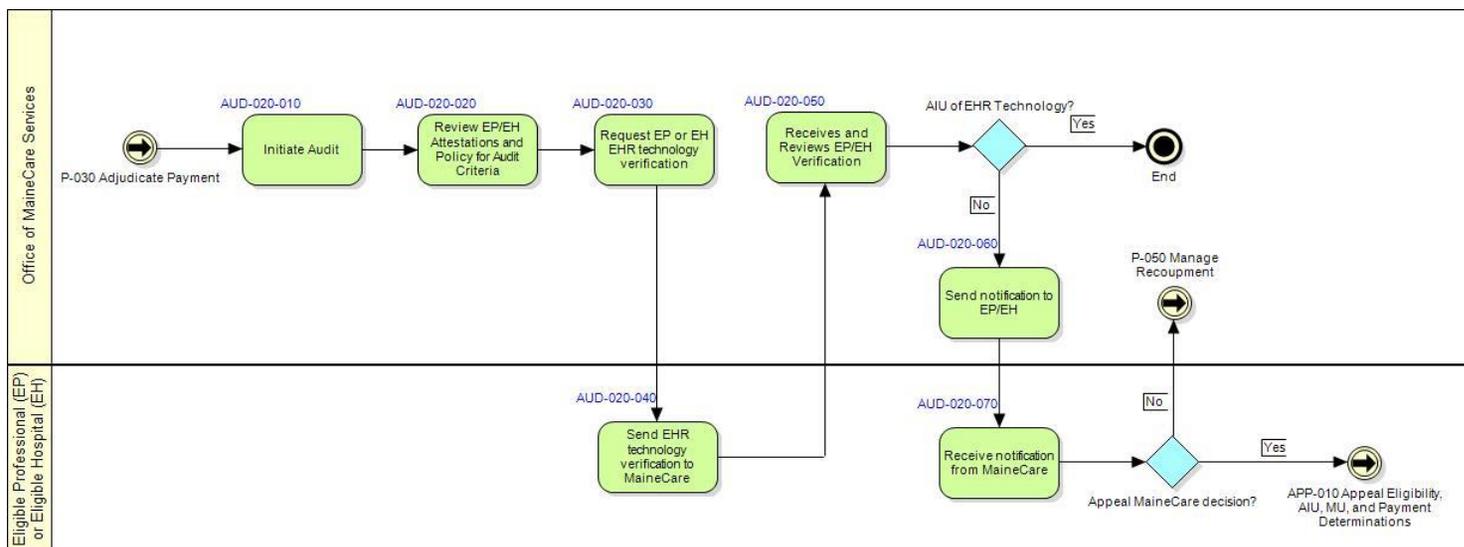


Figure 44. Audit AIU of Certified EHR Technology Sub-Process

Description: This sub-process describes the audit process to determine if EPs or EHs have adopted, implemented, or upgraded EHR technology. To audit attestations, MaineCare will verify that attestations provided by EPs and EHs are complete and accurate. In the first payment year, Medicaid EPs or EHs must demonstrate that during the payment year, they have adopted, implemented, or upgraded certified EHR technology to receive an incentive payment. (Dual Eligible hospitals fall under CMS oversight for Meaningful Use.) The MaineCare Auditor will verify the use of certified EHR technology by determining whether the EHR technology attested to by the provider is on the ONC's list of certified EHR technology prior to issuing an incentive payment to that provider. The State will use the ONC Web Service listing of all certified EHR technology to automate the pre-payment verification of providers' attestations regarding the certified EHR technology attested to by the provider. The State will communicate to providers that it is the EP or EH's responsibility to ensure that their application and attested to EHR technology is listed on the ONC Certified Health IT Product List.⁷⁵

Resources: MaineCare Services

Proposed Technology to leverage: ONC Web Service

State Policy: The State should have a policy that enforces the CMS regulation as written in the Final Rule. The State should also finalize the method the State will use to determine which EPs and EHs will be audited using a risk-based system and random audits. The State will have to establish what qualifies as proof of adopting, implementing, or upgrading certified EHR technology.

CMS Regulation: See 495.314, 495.316, and 495.368 in the Final Rule on the EHR Incentive Programs.

⁷⁵ See Appendix D-4, Auditing AIU, for more details.

Section D. Part 3. Audit Meaningful Use

Part 3, Audit Meaningful Use, is being held as a place-holder for Meaningful Use rules and guidance to be issued by CMS.

Audit Meaningful Use			
Type of Audit	Resources/Data Sources	Pre- or Post-Payment	Timing of Audit
Compliance with Meaningful Use Criteria	<ul style="list-style-type: none">• To Be Developed• Systems being Considered:• EHRs via the HIE (HIN)• MIHMS• MEPOPS• UHDDS• IPHIS• IMPACT2• PMP	<ul style="list-style-type: none">• Pre-payment	<ul style="list-style-type: none">• Upon EP's or EH's submission of MU attestation

Section D. Part 4. Audit Incentive Payment

The following table displays the key information regarding what type of audit is conducted, the resources and data sources used, whether the audit occurs pre-payment, post-payment, or both, and the timing of the audit.

Audit Incentive Payment			
Type of Audit	Resources/Data Sources	Pre- or Post-Payment	Timing of Audit
Incentive Payment	<ul style="list-style-type: none"> • MIHMS • AdvantageME 	<ul style="list-style-type: none"> • Post-payment 	<ul style="list-style-type: none"> • Upon remittance of payment to EP or EH

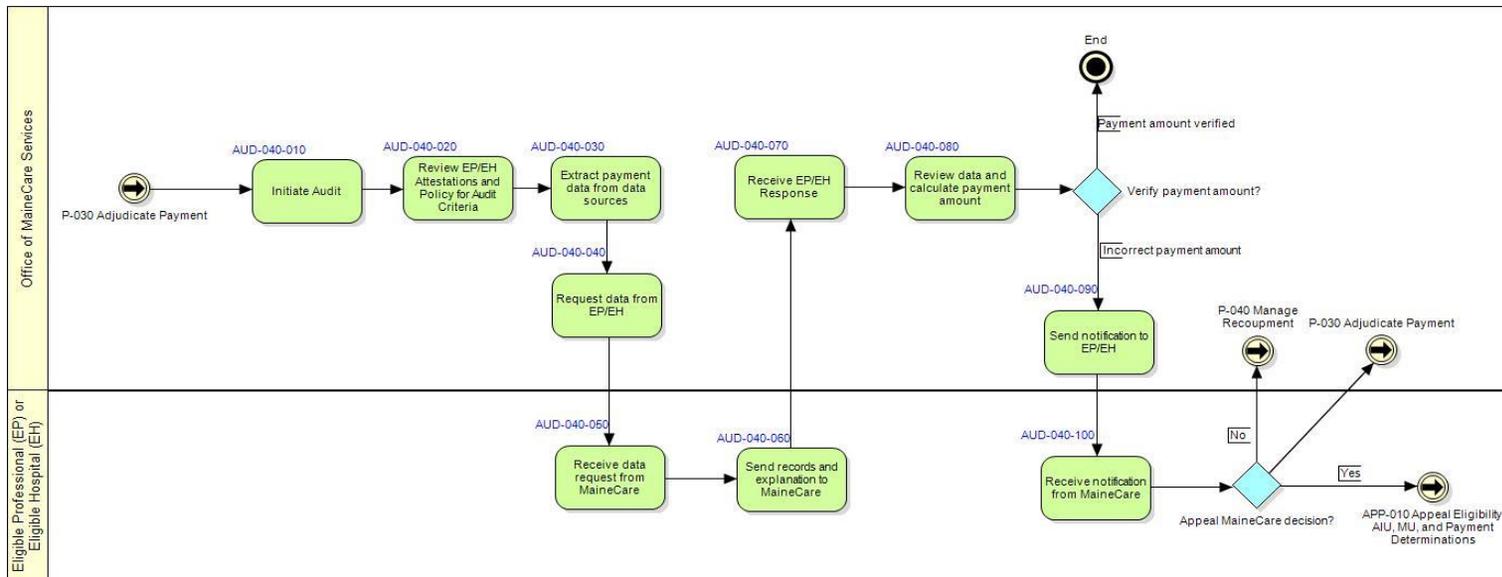


Figure 45. Audit Incentive Payment Sub-Process

Description: This sub-process describes how the State audits incentive payments to EPs and EHs. The Auditor will verify that any payments that have been issued were for the correct amount. This means that payments to Eligible Providers

must follow the six year period that Maine elected to use (\$21,250 first year; followed by five payments of \$8,500, for a total of \$63,750). Payments to hospitals are hospital-specific and based on the criteria in the CMS Final Rule and paid over a three year period (50% first year; 40% second year; and 10% third year).⁷⁶ The Audit process will also involve auditing the other requirements which are also conditions of eligibility for payment.⁷⁷

In the event that a duplicate payment or overpayment does occur, MaineCare understands that it must repay to CMS all Federal financial participation received by providers identified as an overpayment regardless of recoupment from such providers, within one year of the overpayment. MaineCare will initiate recoupment and remit those funds back to CMS. MaineCare will track the total dollar amount of overpayments in the Manage FFP for Provider Incentive Payments sub-process as part of the State Oversight processes. When incentive payments are processed and issued to EPs and EHs, DHHS Finance and MaineCare will record the payment in AdvantageME, the Medicaid payment system. Payments will be reconciled on a regular basis against the total amount of FFP received from CMS. Upon reconciliation, MaineCare and DHHS Finance will collaborate to identify any incidences of overpayment and recoup those payments from the provider, remitting the appropriate payment amount to CMS within one year.

Resources: MaineCare Services

Technology: AdvantageME, MIHMS

State Policy: The State should have a policy or State rule that enforces the CMS regulation as written in the Final Rule.

CMS Regulation: See 495.310, 495.312, 495.314, 495.316, and 495.368 in the Final Rule on the EHR Incentive Programs.

Events in this process:

P-030: Adjudicate Payment

APP-010: Appeal Eligibility, AIU, MU, and Payment Determinations

P-050: Manage Recoupment

⁷⁶ It is important to note that payments after the first payment year (that is, year two and beyond) will be based on the provider meeting Meaningful Use requirements.

⁷⁷ See Appendix D-5 for more detail on the auditing of the incentive payments.

SECTION E. GAP ANALYSIS AND ROADMAP

This section is the gap analysis and roadmap for MaineCare's hit electronic health record incentive payment program and long-term hit vision.⁷⁸ This Section is divided into two Parts: 1) Gap Analysis and 2) Roadmap.

Section E. Part 1. Gap Analysis

Each gap was evaluated based on its applicability with either administering the EHR Incentive Program or Long-term HIT vision. In some cases, gaps were found to be associated with both. In addition to associating the gap with the EHR Incentive Program and the long-term HIT vision, gaps were also categorized under *People, Process, or Technology*.

E1a. Key Questions

Key questions were developed to help identify the gap and how MaineCare might address the gap:

Key Questions

What are the identified gaps related to the CMS SMHP template?

How will current services and infrastructure impact program execution?

What changes to existing strategies and policies should be considered?

Do security and privacy policies strongly protect the many stakeholders?

What internal or external dependencies require consideration?

Are the right people and skill sets in place to perform effectively in these changing environments?

Will today's OMS governing structure be able to guide the EHR Incentive Program and long-term HIT vision to success considering other State-required programs and projects?

Are there opportunities missed as a result of technology limitations?

Can the technology support the EHR Incentive Program as well as the long-term goals and vision?

⁷⁸ See Appendix E-1 for a list of CMS questions.

E1b. Approach and Activities for the Development of the State’s HIT Roadmap

An understanding of the strategic plan and steps to take to make a successful HIT Program is a critical component of the SMHP. The table below outlines the inputs used to develop the State’s HIT Roadmap:

Inputs to Developing the State’s HIT Roadmap
The “As-Is” and “To-Be” sections of the SMHP to understand the State’s current assets and future goals
CMS’ EHR Incentive Program Final Rule , SMHP Template and State Medicaid Director’s Letters released on September 9, 2009 and August 17, 2010; and the “Extenders” Act
The Maine Office of the State Coordinator’s Strategic and Operational Plan to understand the State’s strategic HIT goals and objectives

These key inputs helped the State complete the following activities:

Activities to Develop the State’s HIT Roadmap
Conducted a series of interviews with MaineCare’s key HIT stakeholders to understand key opportunities and future wants for the administration of the EHR Incentive Program and support of their HIT vision
Identified gaps between the current “As-Is” Landscape and future “To-Be” Landscape
Assessed the implications of the gaps
Developed recommendations for activities to fill the gaps
Prioritized activities to fill gaps
Created, reviewed and finalized the State’s HIT Roadmap

Maine understands that the strategic planning activities to achieve the HIT vision must continue as the MaineCare program implements the EHR Incentive Program. While the State has developed a more detailed plan around the implementation of the EHR Incentive Program, it is expected that coordination with the MeREC, ongoing discussions to achieve the HIT vision, and strategic planning activities will continue and will be updated in the State’s future SMHP and IAPD submissions.

E1c. Gap Analysis Findings

Gaps were identified and categorized as *People, Process, or Technology* which are the major resource components.

Category	High-Level Examples of Gaps
People	<ul style="list-style-type: none"> • Training is required to increase the level of awareness and skill sets • Distribution of available resources may need to be evaluated for workload balancing

Category	High-Level Examples of Gaps
Process	<ul style="list-style-type: none"> Processes and workflows are needed to understand where modifications are required and efficiencies can be gained A review of policies is required to understand where existing policies need to be modified or new policies developed
Technology	<ul style="list-style-type: none"> Technology assets need to be evaluated to support requirements Infrastructure needs to be enhanced to support requirements

The findings of the gap analysis illustrated the largest number of gaps in the category of process. This was to be expected since the HIT with its EHR Incentive Payment Program is a new initiative and requires new processes to execute the program (e.g., audit and appeals processes). Other notable findings were the number of technology long-term vision gaps that extend beyond the initial six month implementation of the EHR Incentive Payment Program. Some of these technology gaps are yet to be fully understood due to the timeline to execute longer-term initiatives. But, as the EHR Provider Incentive Program matures, other required initiatives (ICD10, CHIPRA Quality grant, PBM implementation, data exchange with the HIE) will begin to compete for resources and budget.

In the short-term, areas of challenges were found to exist around the availability of resources to support the program.

It was also noted that while this program is new, there are many areas that already exist within DHHS that can be expanded without large re-investments of time or budget. Some of the areas include governance structures; the existence of a policy development process; training methods and teams to conduct the training; support and customer service models; a consolidated Office of the State Coordinator and OMS HIT Programs; and an OIT Office that oversees all IT projects and activities across DHHS and the State.

E1d. Gap Analysis Findings – What Works

Gap analysis findings illustrated that many functions are in place to support the EHR Incentive Program and long-term HIT vision. While these functions are in place, there still may need to be refinement of these functions.

Category	Functions Already in Place
People	<ul style="list-style-type: none"> DHHS management understands the importance of promoting health information technology to improve the quality of care for MaineCare Members. The SMHP and Medicaid HIT activities are being developed as part of the overall State HIT plan in coordination with the Office of the State Coordinator.

Category**Functions Already in Place**

- DHHS has had ongoing communication with stakeholders about the EHR Incentive Program, Meaningful Use, and engaged stakeholders in visioning activities.
- An organizational structure is in place to support the EHR Incentive Program. However, staff roles, workload, and skill sets must be evaluated to assess the ability of existing resources to support the HIT Program.
- The State understands the need to administer EHR Incentive Payments to hospitals and Eligible Providers as soon as possible, but also recognizes the need for proper planning and for the State infrastructure to be in place and tested.
- OIT is a centralized Office that supports State agencies and specifically DHHS' implementation of the EHR Incentive Payment Program and its long-term HIT vision.
- DHHS program and OIT technology leadership has been actively involved in the key initiatives within DHHS as well as other State programs.

Process

- Governance structures and committees exist across the Office of the State Coordinator and DHHS and are a good starting point for coordination across programs and initiatives that relate to or intersect with the EHR Incentive Payment Program and the long-term HIT vision.
- Maine FQHC's are receiving HIT/EHR funding from HRSA. Grants were used between the years of 2005 and 2008. Remaining grant money has been received for projects for years 2008- 2011.
- Maine has established programs, such as the Patient Centered Medical Home, with a vision of providing better coordinated care. These programs should be leveraged to help achieve the long-term HIT vision.
- Data collaboration discussions have started with neighboring New England states (e.g., CHIPRA project with Vermont). This collaboration directly supports the Federal government's vision to promote the exchange of patient information across state borders. This collaboration should continue recognizing that maturity models for neighboring states may vary.
- The State has a solid understanding of the potential level of participation in the EHR Incentive Program and provider adoption of EHR technology through survey collection and analysis. Additional survey and analysis will be required as further stages of Meaningful Use are defined.

Category	Functions Already in Place
	<ul style="list-style-type: none"> Well-defined and foundational processes are in place to develop policy and procedures for MaineCare. New policies will need to be developed and should follow existing DHHS processes. The Office of the State Coordinator has established a legal working group (LWG) to understand required security controls to secure and manage the exchange of patient information between participating health care entities. One of the focus areas under consideration by the LWG is discussion regarding inclusion of behavioral health and/or HIV diagnoses into the HIE. Currently, patients presenting with these diagnoses are excluded from the exchange.
Technology	<ul style="list-style-type: none"> The OIT vision focuses on provider-centric processes designed to avoid duplication in applications and data sharing. The management of confidential information is appropriately monitored through standardized controls and data use agreements that limit access to authorized individuals. This activity should be continued as data is further exchanged among business partners and the health information exchange. DHHS has implemented MIHMS which has moved to a stabilization phase. This system can be considered in the future to further support the EHR Incentive Payment Program Planning is underway to build the broadband access across Maine. This initiative and work will support the implementation of health information technology and provide the infrastructure for health information exchange.

E1e. Gap Analysis Findings – Gaps and Recommendations

This Part identifies the gaps and provides recommendations for the SMHP Roadmap.⁷⁹ The tables below represent the gap findings, implications and recommendations for the EHR Incentive Program and long-term HIT vision categorized by People, Process and Technology. Check marks denote whether the gap should be addressed in the EHR Incentive Program or long-term vision. If appropriate, the gap may need to be continually managed and resolved in the short and long-term and as such, will be noted in both the EHR Incentive Payment Program and vision columns. The year the gap should be addressed and/or monitoring on an ongoing basis is noted in the “calendar year” columns.

Figure 46. Gap Analysis

⁷⁹For complete definitions of the terms used in this Gap Analysis, see Appendix E-2.

No	Category	Gaps	Implications	Recommendations	EHR Incentive Program	Long-term HIT Vision	2011	2012	2013	2014	2015	2016
1	People	<p>Provider Outreach. Based on the Muskie survey, initial results show approximately 50% of eligible professionals that responded to the survey indicated that they are either not participating or are unsure about participation in the EHR Incentive Program.</p> <p>Providers may not understand the program or are not aware of the program which is causing the low interest.</p>	Low participation is contrary to the goals of the Federal government to promote adoption of HIT and increase the sharing of data to improve coordination of care and population health.	Formulate provider outreach strategy to include education, training and communication in coordination with the MeREC and leverage existing CMS developed materials about the EHR Incentive Program to promote participation. Use the Provider Associations and OMS communication channels to aid in provider outreach and communication.	X	X	X	X	X	X	X	X
2	People	<p>Resource Planning: Program Oversight and Long-Term Planning. The State will need to make sure it has the resources devoted to this Program to meet EHR Incentive Payment Program implementation and continue long-term HIT visioning activities.</p>	Lack of resources devoted to this program may jeopardize completion of implementation activities and stall progress towards achieving the long-term HIT vision.	To understand what the true gaps in resources and available skill set, DHHS should conduct a resource analysis. The review should include staff volumes, current roles and responsibilities and work load balancing.	X	X	X					
3	People	<p>Resource Planning: Operations. While there is an organizational structure in place that may be able to support the EHR Incentive Program (e.g., Appeals Unit; Provider Contact Center), there are insufficient staff resources and skills to operate the functions of the EHR Incentive Payment Program and HIT vision.</p>	The number of knowledgeable resources to execute the Incentive Payment Program is critical, including resources knowledgeable in answering program specific questions including detailed questions on Meaningful Use. May jeopardize subsequent year implementation.	Perform a resource analysis to understand what resource availability and skills exist within MaineCare to administer the EHR Incentive Payment Program and identify what additional resources are needed.	X		X					
4	Process	<p>Governance. Closer coordination is required between MaineCare HIT activities and the MeREC for project coordination</p>	Lack of coordination will result in duplicate work, inconsistent messages to providers, and misalignment of goals, objectives, and vision.	Establish more formal coordination ties, including meetings with standing topics for discussion and understanding of roles and responsibilities for each group, and work plans with assigned responsibilities with built in accountability controls.	X	X	X	X				

No	Category	Gaps	Implications	Recommendations	EHR Incentive Program	Long-term HIT Vision	Calendar/Program Year					
							2011	2012	2013	2014	2015	2016
7	Process	Privacy and Security: New HIPAA Requirements. There is a possible disconnect between Privacy and Security policy mandates and the day-to-day management of Member information on protected patient information under the newly updated HITECH HIPAA program requirements.	<p>Failing to manage HIPAA and HITECH-mandated Privacy and Security can lead to a rise in complaints, enforcement actions, lawsuits, or monetary fines.</p> <p>Implications:</p> <ul style="list-style-type: none"> • Policies: <ul style="list-style-type: none"> – Lack of access to Participant PHI such as enrollment data, accounting of disclosures or marketing information is inconsistent with Federal law and could result in loss of funding – Misrepresenting the purpose for collection PHI does not comply with Federal law • Procedures: <ul style="list-style-type: none"> – Failure to adequately train personnel on privacy laws on how to protect data jeopardizes compliance • Practice: <ul style="list-style-type: none"> – Disclosing, sharing or selling PII/PHI to third parties contrary to HIPAA privacy policy breaches security – Misrepresenting the security protection of PII/PHI violates Federal law 	<p>Conduct a formal and comprehensive Privacy and Security audit across all of DHHS to assess to determine any vulnerability for potential privacy breaches of member information. The audit should not only include process, but the technology that support, tracks and monitors access to member data. The audit should include a review of program processes, operations processes, technology, and on-going staff training.</p> <p>Also, the audit should be focused on enterprise-wide security and privacy systems (e.g., user identification and authentication, privacy and security of systems and confidential health data, and auditing of data use and release).</p> <p>Continue efforts on resolving “opt-in” and “opt-out” issues for behavioral health and /or HIV diagnoses into the HIE resulting in better alignment of privacy and security policies across the state.</p>			X	X				

No	Category	Gaps	Implications	Recommendations	EHR Incentive Program	Long-term HIT Vision	Calendar Year					
							2011	2012	2013	2014	2015	2016
8	Process & Technology	Resource Planning and Technology: Managed Care. The current DHHS organization, processes, and MIHMS system are not configured to support a “Managed Care” initiative, if adopted.	HIT and Meaningful Use criteria greatly would contribute to a “Managed Care” initiative. If resource planning, processes, and technology are not coordinated and implemented if a type of Managed Care effort is implemented, desired outcomes may not be realized.	HIT and Meaningful Use criteria should be included if the State decides to implement a type of “Managed Care.”		X	X	X	X			
9	Technology	Technical Solution. The technology solution to support the EHR Incentive Program has not yet been determined.	CMS may not approve the SMHP if a systematic approach to managing the EHR Incentive Program is not identified which could delay program implementation.	Review potential technology solutions against requirements and processes developed as part of the SMHP.	X		X					
10	Technology	Interfaces for Meaningful Use. Requirements for building provider interfaces are not established for how providers and hospitals will submit data for Meaningful Use compliance.	The provider community will need to understand the access and integration requirements with the State as soon as possible in order to begin preparing to meet CMS specifications.	When Meaningful Use requirements and standards are defined by CMS, Maine will need to define the State’s required interfaces and systems where Meaningful Use data will be stored. Security implications as well as limited data manipulation by the Providers should also be considered as requirements are developed.	X	X		X				
11	Technology	Medicaid Data Exchange with HIE. Medicaid data is not being sent to the HIE. HIN currently collects data about individuals that may be MaineCare Members. However, without an interface between HIN and MIHMS, the individual cannot be identified as a MaineCare Member..	Medicaid is an important payer and stores critical clinical information about Members. Not sharing this information with the HIE provides an incomplete picture of a person.	Begin discussions with HealthInfoNet regarding sharing of Medicaid data with the HIE in 2011, including planning design, and development of the interface. Focus should be on implementing reusable services that allow DHHS to contribute to and benefit from regional, Statewide, and health information exchange.		X		X				

No.	Category	Gaps	Implications	Recommendations	EHR Incentive Program	Long-term HIT Vision	Calendar Year					
							2011	2012	2013	2014	2015	2016
12	Technology	<p>ePrescribing. Expand ePrescribing functionality.</p> <p>MaineCare is in the process of replacing its current Pharmacy Benefit Management Program (PBM) and has included this function as a base requirement.</p> <p>Also, data coming from Surescripts, HIN's ePrescribing data exchange is static and needs to move towards being dynamic to provide a complete data set for Medicaid providers.</p>	If ePrescribing functionality is not implemented, MaineCare may not be able to determine Provider compliance with prescribing Meaningful Use criteria.	Monitor this specific function as part of the PBM implementation.		X		X				
13	Technology	<p>Data Exchange. Information and data is not exchanged across state borders. HIE strategies calls for greater emphasis on interoperability "participation of many members of the health team" including across state borders.</p>	Will not meet Federal strategic objectives and encouragement to exchange data across state borders.	<p>Continue coordination with bordering state initiatives (Vermont, New Hampshire, and Massachusetts specifically) to understand the level of maturity of these states to exchange data.</p> <p>Leverage New England States Consortium Systems Organization (NESCSO) to further this topic.</p>		X		X	X	X	X	X
14	Technology	<p>Provider Access to Data. Providers do not have access to health information from State systems for care coordination including MIHMS claim data, IMMPACT 2, and HIN.</p>	Will not meet Federal strategic objectives for coordinated care and quality outcomes.	As the State continues its long-term HIT visioning, discuss the priority of this gap.		X			X	X	X	X
15	Technology	<p>DHHS Program and Provider Access to Member Data. Programmatic silos exist across DHHS programs and Providers because a Master Provider Index does not exist. Utilizing a Master Provider Index that is in alignment with MaineCare provider numbers would allow for better understanding of MaineCare-specific and statewide provider practices.</p> <p>Currently, there is no alignment between MIHMS and HIN rendering providers. The ability to align rendering providers, via a</p>	Coordination of providers may not be fully realized.	Using initial results from visioning activities and "As-Is" assessment, review programs with systems that support providers and explore the option of solutions such as a Master Provider Index. Begin addressing this in 2011, including planning, design and development of the interfaces.		X		X	X	X	X	X

		Master Provider Index, within MIHMS and the HIE, ensures that billing and rendering providers are identified within the HIE.											
16	Technology	All Payer/All Claims Database. While Maine is in a unique position with the All Payer, All Claims database, data is not up to date for analysis purposes and gaining access to the data (with proper security) is difficult.	MaineCare may not be able to use data available on the claim form for Meaningful Use auditing, analysis and longer-term vision goals.	Conduct a study to understand the current barriers with the All Payer/All Claims database and develop recommendations.	X	X	X						
17	Technology	Master Patient Index. Implementing a Master Patient Index will allow for better coordination of care for MaineCare Members. This will also address security and privacy concerns regarding the exchange of personal health information.	Coordination of care for MaineCare Members may not be fully realized.	Prioritize Strategic Projects such as implementing a Master Patient Index. Begin addressing this in 2011, including planning and high-level requirements.		X		X	X	X	X	X	X
18	Technology	Exchange of clinical information between DHHS and HIN. Clinical information between DHHS, MECDC and HIN is not being exchanged.	Coordination of care for MaineCare Members and program coordination may not be fully realized.	Develop a workgroup, with involvement from provider, technical, consumer advisory groups and the State to address sharing clinical information for payers.		X		X	X	X	X	X	X

Section E. Part 2. State's HIT Roadmap

The State's HIT Roadmap provides a graphic and narrative pathway of how MaineCare will implement the EHR Incentive Payment Program and the activities that will be taken to achieve the long-term HIT vision.

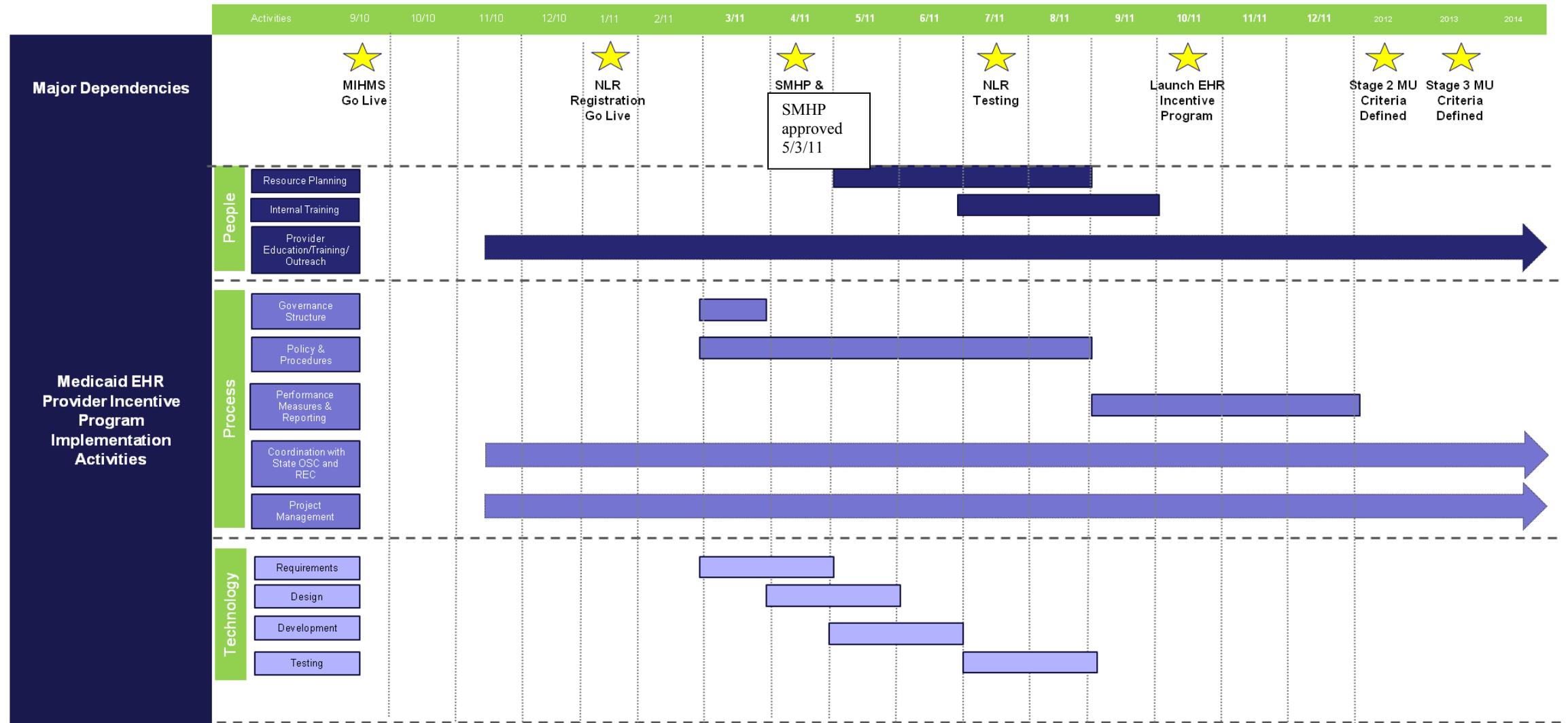
E2a. State's EHR Incentive Program Implementation Plan

MaineCare must address the gaps and activities to implement the EHR Incentive Program. Maine is targeted to be part of CMS' NLR Testing Group 5 and launching its EHR Incentive Program in fall 2011.

The State EHR Incentive Program Implementation Plan and the Maine HIT Long-Term Vision Roadmap are provided on the following pages. Each illustration represents a point of time and will change as the EHR Incentive Program and long-term HIT vision evolves. DHHS will continually validate the recommended milestones and activities and report on them in updated SMHP and IAPD documents.

The first illustration found on next page is the State's EHR Incentive Program Implementation Plan and provides the recommended major activities under the categories of People, Process and Technology over the next six months. Each of the twelve activities is associated with sub activities. An initial draft of these projected activities and sub activities follows the implementation plan.. Once CMS releases Stage 2 and 3 Meaningful Use criteria, Maine will re-evaluate its HIT Program.

Figure 47. MaineCare EHR Incentive Program Implementation Plan



EHR Incentive Program Implementation Activities

People	Resource Planning	▪ Evaluate Incentive Program resource support demands
		▪ Pursue near-term opportunities to re-balance staff assignments based on findings
		▪ Forecast staffing and skill sets required to support the program
		▪ Selectively hire and train in key areas for pressing program needs
	Internal Training	▪ Build incentive program training plan
		▪ Create curriculum materials and training schedule
▪ Train identified resources		
Provider Education/Training/ Outreach	▪ Collaborate / coordinate with REC/HIN/Medicare RO to create communication plan, messages, message vehicles, materials, timing	
	▪ Deliver consistent and timely messages to identified stakeholders	
	▪ Measure effectiveness	
Process	Governance Structure	▪ Re-evaluate current governance structures across MaineCare/DHHS
		▪ Create a collaborative approach to decision making by eliminating redundant structures and/or processes
		▪ Identify participants; roles and responsibilities; execute
		▪ Execute updated structure
	Policy and Procedures	▪ Create an inventory of policy and procedures documents impacted by the Incentive Program
		▪ Develop strategy to update policies
		▪ Update and approve
		▪ Determine areas requiring training
	Performance Measures & Reporting	▪ Establish metrics in line with CMS and State requirements to measure Incentive Program effectiveness
		▪ Determine the process and the reports required for program status
		▪ Determine stakeholder distribution lists to report status
	Coordination with State ONC HIT efforts	▪ Determine current communication processes between MeREC/OMS
▪ Determine points of intersection and gaps		
▪ Build collaborative strategy and plan to coordinate relevant initiatives		
Project Management	▪ Review current project management methods across DHHS	
	▪ Develop project management best practices, tools, team	
	▪ Execute formalize project management processes	
Technology	Requirements	▪ Determine and collect data and information from stakeholders
		▪ Analyze collected information to refine implementation plan strategy
		▪ Understand data challenges and gaps (e.g., business/OIT)
		▪ Document findings; recommendations; report out
	Design	▪ Establish design sessions; participants; materials
		▪ Prepare process straw models; policies and procedures
		▪ Determine integration, application (MIHMS and other); report impacts (business and OIT) and requirements
		▪ Document final business and technology design requirements
	Development	▪ Identify build resources (e.g., business and OIT)
		▪ Create timeline
		▪ Conduct build activities
		▪ Validate/sign off final build by stakeholders
	Testing	▪ Develop test plan and scripts
		▪ Test (workflow; application interfaces)
		▪ Obtain user acceptance
		▪ Conduct training

E2b. State's Long-Term HIT Vision Roadmap

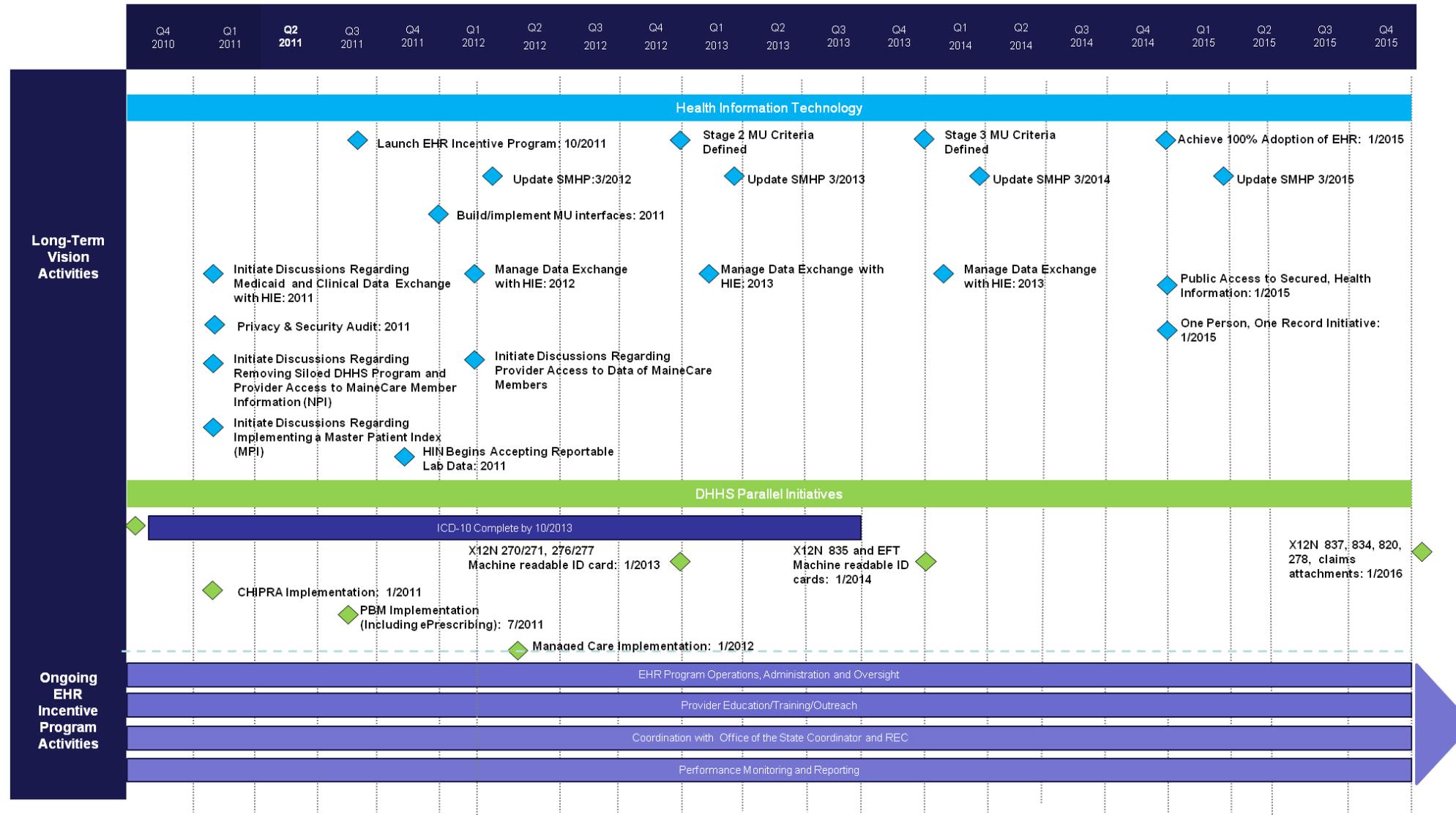
MaineCare's HIT Long-Term HIT Vision Roadmap identifies the gaps associated with achieving the long-term HIT vision and also graphically presents other parallel DHHS initiatives that must be kept in consideration as the HIT activities are planned and implemented. MaineCare will work closely with a variety of stakeholders including the OSC, HIN and the Maine Provider Associations to communicate about statewide HIT adoption efforts and initiatives.

The illustration on the following page outlines the specific HIT long-term initiatives by a preliminary start date extending to 2014. These are initiatives that MaineCare has currently in its portfolio of projects to complete over the next three to four years. DHHS parallel activities are noted below and include the planned implementations of: CHIPRA, Pharmacy Benefit Management, Managed Care, HIPAA X12N/5010 and ICD-10. Both the 5010 and ICD-10s must be completed by January 1, 2013 and October 1, 2013 respectively and are mandated by CMS.

The major planned initiatives represented in this illustration may not represent an exhaustive list and as its portfolio of projects is re-prioritized, updates will be necessary. DHHS will revisit the long-term HIT roadmap during the implementation phase and will provide an updated long-term HIT roadmap as a result of the implementation phase activities. The ongoing visioning during the implementation phase will detail out specific measures and goals to assure that project timelines are achievable and shorter term goals and objectives are defined.

Finally, the long-term EHR Incentive Program initiatives are noted at the bottom of the graphic including EHR Incentive Program administration, outreach, coordination with the MeREC, and performance monitoring and reporting.

Figure 48. MaineCare HIT Vision Roadmap



Assumptions

The State's EHR Incentive Program Implementation Plan and HIT Roadmap – Assumptions

- 1 Leadership within DHHS will support the initiatives within the State's EHR Incentive Program Implementation Plan and HIT Roadmap. Additional consideration should be taken to maintain DHHS and executive leadership support through management changes.
- 2 There will be a coordinated approach between MaineCare, Office of the State Coordinator, and the MeREC to collaborate on initiatives and avoid the duplication of efforts. Initiatives undertaken to implement the EHR Incentive Program will include participation from MaineCare staff, providers, hospitals, and provider associations.
- 3 The Implementation Plan and HIT Roadmap assume the budget will be available to support the program changes and enhancements as indicated. The Implementation Plan and HIT Roadmap represent a point in time and will be reviewed and revised annually at minimum to align with budgetary considerations. The Implementation Plan and HIT Roadmap may change to address budgetary priorities.
- 4 MaineCare will have incremental changes to the EHR Incentive Program Implementation Plan as processes go-live. It is expected that the first focus will be outreach and registration, followed up provider attestation and verification of eligibility, providers and finally capturing Meaningful Use data.
- 5 MaineCare/DHHS will launch the EHR Incentive Program in Quarter 3 of 2011 but is dependent upon IAPD approval and testing with the NLR in July 2011.
- 6 CMS will have the required infrastructure for the National Level Repository completed and tested by January 3, 2011. MaineCare will be ready to test with the NLR in July 2011.
- 7 An eligible hospital (EH) and/or eligible professional (EP) will be able to register through the CMS NLR portal by January 3, 2011.
- 8 MaineCare will leverage technology applications that exist today and those provided by CMS.

CONCLUSION

While Maine has positioned itself well for a successful implementation of the Medicaid HIT vision and Incentive Payment Program there is much work to be done. Maine appreciates the partnership and collaboration it shares with its federal partners, CMS and the Office of the National Coordinator. Without a close partnership and frankly, the federal funding available to promote electronic health records which in turn will provide better health outcomes and more cost-efficient health care, along with patient involvement and improved integration of health care, Maine would be hard pressed to achieve the positive results that health information technology brings. The HIT program has also brought closer integration, collaboration and economies of scale for Maine's Information Technology, telehealth, broadband, and related initiatives. We look forward to these continued partnerships.

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APPENDIX A-1

Footnote 5

SMHP Template CMS Crosswalk

MaineCare used guidance provided by CMS in the CMS SMHP template distributed to State Medicaid Agencies in spring 2010.

Question Number	CMS Guidance	“As-Is” Landscape Section
1.	What is the current extent of EHR adoption by practitioners and by hospitals? How recent is this data? Does it provide specificity about the types of EHRs in use by the State’s providers? Is it specific to just Medicaid or 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, etc.)?	Section A, Part 5.
2.	To what extent does broadband internet access pose a challenge to HIT/E in the State’s rural areas? Did the State receive any broadband grants?	Section A, Part 6o
3.	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.	Section A, Part 6
4.	Does the State have Veterans Administration or Indian Health Service clinical facilities that are operating EHRs? Please describe.	Section A, Part 6
5.	What stakeholders are engaged in any existing HIT/E activities and how would the extent of their involvement be characterized?	Sections A and B.

Question Number	CMS Guidance	“As-Is” Landscape Section
6.	Does the SMA have HIT/E relationships with other entities? If so, what is the nature (governance, fiscal, geographic scope, etc) of these activities? <i>CMS indicated that this question may be deferred.</i>	Section A, parts 1, 6 and 7, Section B
7.	Specifically, if there are health information exchange organizations in the State, what is their governance structure and is the SMA involved? How extensive is their geographic reach and scope of participation? <i>CMS indicated that the first part of this question may be deferred but States do need to include a description of their HIE geographic reach and current level of participation.</i>	Section A, Part 7
8.	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.	Section A, Part 3, Section C, Parts 1 and 2
9.	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 extension centers (RECs) assisting Medicaid eligible providers to implement EHR systems and achieve Meaningful Use?	Section A, Part 7, Section C, part 5
10.	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.	Section A, part 1
11.	What other activities does the SMA currently have underway that will likely influence the direction of the EHR Incentive Program over the next five years?	Section A, Parts 6, 7, and 8

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Question Number	CMS Guidance	• “As-Is” Landscape Section
12.	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.	Section A, Part 8
13.	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.	Section A, part 6a, Section A, Part 7
14.	What is the current interoperability status of the State Immunization registry and the Public Health Surveillance reporting database(s)?	Section A, Part C4
15.	If the State was awarded an HIT-related grant, such as a Transformation Grant or a CHIPRA HIT grant, please include a brief description.	Section A, part 6a

Footnote: 7**Health Information Technology Executive Steering Committee (HITSC)**

Health Information Technology Steering Committee (HITSC)	
James Leonard, State HIT Coordinator, Chair	David Winslow, Vice President, Finance, Maine Hospital Association
Devore Culver, Chief Executive Officer, HealthInfoNet	Kevin Lewis, Chief Executive Director, Maine Primary Care Association
Karynlee Harrington, Executive Director, Dirigo Health Agency	Lisa Letourneau, M.D., MPH, Executive Director, Quality Counts
Alan Prysunka, Executive Director, Maine Health Data Organization	John Edwards, Ph.D., Psychologist and IT Projects Manager, Aroostook Mental Health Center
Tony Marple, Director, MaineCare	Nancy Kelleher, State Director, AARP
Steven Sears, M.D., State Epidemiologist, Maine CDC	Katherine Pelletreau, Executive Director, Maine Association of Health Plans
Jim Lopatosky, Associate CIO-Applications, OIT	David Tassoni, Senior Vice President of Operations, athenahealth, Inc.
Melanie Arsenault, Director, Bureau of Employment Services, Maine Department of Labor	Catherine Bruno, FACHE, Vice President and Chief Information Office, Easter Maine Health care Systems
Barry Blumenfeld, M.D., Chief Information Officer Maine Health	Tom Hopkins University of Maine System
Paul Klainer, M.D. Internist and Medical Director, Knox County Health Clinic	Dr. Barbara Woodlee, President, Kennebec Valley Community College
Sandy Putnam, RN, MSN, FNP, Nursing Coordinator, Virology Treatment Center, Maine Medical Center	Perry Ciszewski, an individual representing the State's racial and ethnic minority communities

Health Information Technology Steering Committee (HITSC)

Julie Shackley, President/CEO,
Androscoggin Home Care and
Hospice

Philip Saucier, Esquire, an
individual with expertise in health
law or health policy

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HEALTHINFONET

HIN is a public/private partnership engaging a variety of stakeholders including health care providers, health plans, consumers, employers, State government, public health and HIT vendors. HealthInfoNet (HIN) is a key collaborator in statewide HIE and HIT efforts. Since 2005, the State of Maine has been developing electronic health information exchange capacity. These efforts have resulted in the formation of HIN, a 501c (3) corporation that has been designated as the statewide HIE organization. HIN is a private / public partnership with nineteen board members, three of which represent State government. In 2008, HIN began a Statewide demonstration project sharing an extensive clinical dataset from multiple sources. HIN will continue the close collaboration between the vendor and participating providers that was started during the Demonstration Phase. This collaborative process continues to create a strong sense of ownership and commitment in HIE participants, and will be leveraged by HIN and the State HIT Coordinator to develop a private/public sustainability model for statewide HIE. HealthInfoNet (HIN) is governed by a Board of Directors with an Executive Committee, and standing committees that support the HIN activities.

HealthInfoNet (HIN) is the designated Health Information Exchange (HIE) entity for the state of Maine. HIN is an independent, nonprofit 501c(3) organization whose mission is to create an integrated statewide clinical data sharing infrastructure that will provide a secure data sharing network for public and private health care stakeholders in Maine.

HealthInfoNet Board Composition

Committee	Committee Responsibilities
State Government	Maine DHHS, Commissioner Maine DHHS, Director of MaineCare Governor’s Office of Health Policy and Finance, Director Office of the State Coordinator, State HIT Coordinator
Health Care Providers	Small Rural Hospital, President/CEO Southern Maine Integrated Delivery Network, CIO Rehab/Home Health, President Northern Maine Integrated Delivery Network Executive Vice President Family Medical Clinic, President and CMO Western Maine Integrated Delivery Network, CMO Practicing Physician
Health Plans	Cigna Health care, Market Service Leader

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Committee	Committee Responsibilities
Patient/ Consumer Organizations	National Alliance for the Mentally Ill, Executive Director State Senator
Health care Purchasers/Employers	Private Research Laboratory, COO Former State Senator/Businessman Large Northern Business, Retired Director
Public Health Agencies	Maine Center for Disease Control and Prevention, Director Private/Public Health Consultant
Health Professional Schools/Universities	Not represented at this time
Clinical Researchers	Not represented at this time
Other Users of HIT	IT Venture Investment Company, Director
HIT Vendors	Represented through contractual relationships

The HIN Board provides a knowledgeable group of individuals with HIE expertise to build upon the ongoing HIE experience and efforts of HIN.

HIN Standing Committee Composition and Responsibilities

- **HIN Finance Committee**

This committee is comprised of members with experience and expertise in financial matters, chaired by the HIN Treasurer and with the HIN Chief Executive Officer (CEO) as an ex-officio member. This Committee is responsible for developing the HIN's financial policies, assisting the CEO in developing annual budgets and reviewing HIN's financial statements and for other related duties as may be prescribed by the Board from time to time. This Committee will continue to serve as a HIN standing committee but members of the committee will also serve on the OSC Financial Accountability and Sustainability Planning Committee. It is planned that the new committee will address the budget requirements for the statewide HIE, develop a sustainability plan for long term financing, and coordinate the funding of the HIE with monies awarded to other ARRA programs.

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- **Consumer Advisory Committee**

The membership of the HIN Consumer Advisory Committee is comprised of citizens, consumer advocates, consumer organizations, legal experts, health educators, privacy officers, public health professionals, and interested parties with experience and expertise in consumer participation and privacy protection in health information technology systems. The Committee is chaired by a member of the HIN Board. The Committee has been responsible for reviewing and advising on all policies and procedures related to the confidentiality of the HIN clinical data and the privacy protection for patients. The Committee has addressed HIPAA, State law requirements as well as other Federal and State guidelines

and initiatives, and public health data laws. This committee has been instrumental in the development of the opt-out provision for patient participation in HIN. Today, a number of key consumer advocacy organizations represent the interests of their respective constituencies on the HIN Consumer Advisory Committee. These organizations include the Family Planning Association of Maine, Legal Services for the Elderly, Maine Center for Public Health, the Maine Civil Liberties Union, Maine Disability Rights Center, the Maine Health Management Coalition, the Maine Network for Health, the National Alliance for the Mentally Ill and the and the University of New England Health Literacy Center. The OSC and the HITSC identified the need for a Privacy, Security, and Regulatory Oversight Committee that would be responsible for addressing the legal and regulatory issues for the statewide HIE, support the harmonization of state and Federal law, draft legislative recommendations as needed and where appropriate develop/recommend regulatory roles for OSC and the Governor's Office in regard to the sustainable business functions to support HIE statewide. The Consumer Committee is a shared function of both OSC and HIN with a focus on advising both the policy and operational areas and working closely with the Privacy, Security, and Regulatory Committee.

- **Technical and Professional Practice Advisory Committee (TPPAC)**

The membership of this committee is comprised of Chief Information Officers (CIO), Chief Medical Directors, IT experts, and practicing clinicians. All members have experience and expertise in the implementation and use of health information technology, clinical data sets, and/or public health information systems. Committee members also represent providers and clinical practices with varying degrees of electronic medical record system use including non-users. This Committee serves as the technical advisory body to the HIN Board and works closely with the HIN staff to manage the statewide HIE deployment. It is expected that this committee will remain as a standing committee of the HIN with a working relationship with the OSC Technical Architecture Committee focusing on Public Information Technology interoperability with HIN.

- **HIE Initiatives**

HealthInfoNet (HIN), acting as the designated statewide HIE organization, has completed a 24-month Statewide demonstration project to facilitate sharing extensive clinical datasets among select Maine providers and hospitals. The data elements being shared include prescription data, laboratory data, dictated and transcribed reports,

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problem lists, and allergy lists. The demonstration project ended in June 2010 and HIN is now focused on engaging all health care providers in the exchange by 2015.

Footnote: 9

MITA Vision, Goals, and Objectives	Alignment with HIT
Design and implement new systems	
Improve quality and efficiency of Health Care Delivery	✓
Improve member and population health	✓
Environment- flexibility, adaptability, rapid response to program/technology changes	
Enterprise view- technologies aligned with Medicaid business processes/technologies	
Coordinate with public health and other partners to integrate health outcomes	✓
Establish systems that are interoperable with common standards	✓
Timely, accurate, usable, and accessible data	✓
Use of performance measures	✓
Adopt data and industry standards	✓
Promote reusable components	
Efficient and effective data sharing	✓
Provide member focus	✓
Support interoperability, integration, and open architecture	✓
Promote good practices (e.g. Capability Maturity Model)	
Business-driven enterprise architecture	
Commonalities and differences co-exist	
Standards first	

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Table summarizing the MITA Business Assessment including the MITA Business Area, the capability maturity model level, and high level findings:

MITA Business Area	Level	High-level findings
Member Management	2	<ul style="list-style-type: none"> • Applications are initiated via a paper process • Data Hub exchanges eligibility data from disparate systems and MIHMS • MIHMS maintains comprehensive member information for multiple programs
Provider Management	3	<ul style="list-style-type: none"> • Provider enrollment is consistent across Medicaid enterprise • National Provider ID and other HIPAA data standards are used • Verifications of licenses, certifications, etc. are performed on-line
Contractor Management	2	<ul style="list-style-type: none"> • AdvantageME is used to manage and store vendor information • AdvantageME provides self-service (payment status) to vendors • DHHS Allocation database contains RFP and contract data
Operations Management	2	<ul style="list-style-type: none"> • Claims processing functionality is rule-based and highly automated • QNXT functionality creates capitation payments, premium assistance payments, and Electronic Funds Transferred (EFT) transactions based on established parameters • HIPAA standard transactions are used throughout operational processes
Program Management	3	<ul style="list-style-type: none"> • Comprehensive suite of tools supports efficient and effective management and monitoring of financial transactions (FFP, accounts receivable & payable) • Development and maintenance of benefit packages is facilitated by table driven structure • Pre-defined and customizable reports address management needs

MITA Business Area	Level	High-level findings
Care Management	2	<ul style="list-style-type: none"> • Manual and automated processes are used to establish and monitor compliance • Candidates are determined based on needs and received services
Program Integrity Management	2	<ul style="list-style-type: none"> • State-of-the art utilization review system monitors providers and members • MITA data and interface standards are used
Business Relationship Management	3	<ul style="list-style-type: none"> • Standard agreements are used to establish the relationship • Business rules are consistently maintained and enforced • Security is maintained in conformance with HIPAA

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**EHR INCENTIVE PROGRAM – ADMINISTRATION AND OVERSIGHT AREAS
DEFINITIONS AND REQUIREMENTS**

EHR Incentive Program administration and oversight areas	Definition and Requirements
Verifying Eligibility	The process should ensure that each Eligible Professional (EP) and Eligible Hospital (EH) meets all provider enrollment eligibility criteria upon enrollment and re-enrollment to the Medicaid EHR incentive payment program. These criteria include meeting the patient volume threshold and being a non-hospital based EP.
Program Registration	The process should allow EPs and eligible hospitals to sign up for the Medicaid EHR Incentive Program and verify that the EP or EH has not registered for the Medicaid EHR Incentive Program in any other state.
Tracking Attestations	The process should verify that all provider information including eligibility, NPI, TIN, Meaningful Use, and efforts to adopt, implement, or upgrade are all true and accurate.
Payment Process	The process should ensure that there is no duplication of Medicare and Medicaid incentive payments to EPs. The process must also ensure that EHR incentive payments are made for no more than 6 years and that no EP or EH begins receiving payments after 2016. Additionally the process should verify that all hospital calculations and incentives are paid correctly.
Audit Process	The process should verify incentive payments, provider eligibility determinations, and the demonstration of efforts to adopt, implement, or upgrade EHR technology, and Meaningful Use eligibility related to the EHR Incentive Payment Program.
Reporting Requirements	The process should fulfill all reporting needs as required by CMS and the State.

EHR Incentive Program administration and oversight areas	Definition and Requirements
Tracking Expenditures	The process should verify that no amounts higher than 100 percent of FFP will be claimed for reimbursement of expenditures for State payments to Medicaid EPs for the EHR Incentive Payment Program, and that no amounts higher than 90 percent of FFP will be claimed for administrative expenses in administering the certified EHR Incentive Payment Program.
Appeals Process	The process should allow for a provider to appeal based on the criteria in the Final Rule regarding eligibility, Meaningful Use, and payment.
Provider Questions	The process should facilitate the receipt and timely response to questions from EPs and EHs.
Provider Communications	The process should facilitate communication between EPs and EHs and the Medicaid agency.

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Comprehensive List of Technology Assets mapped to EHR Incentive Program Administration and Oversight Areas

EHR Incentive Program Administration and Oversight Areas										
Asset	Verifying Eligibility	Program Registration	Tracking Attestations	Payment Process	Audit Process	Reporting Requirements	Tracking Expenditures	Appeals Process	Provider Questions	Provider Communications
MIHMS	X	X	X	X	X	X	X	X	X	X
Provider Portal	X	X						X	X	X
Prior Authorization										
Third Party Liability										
Care Management			X							
PRIMS										
MEPOPS			X							
DW/DSS	X		X			X				
J-SURS					X					
Contact Manager		X							X	X
DataHub										
ACES										
EIS										
MACWIS										
MAPSIS										
MECARE										
Provider Management System (PMS)										
AdvantageME				X						
Case Mix Quality Assurance Application										
Minimum Data Set v 2.0 (MDS 2.0)										
Outcome Assessment Information Set (OASIS)										
All-Payer Claims Database	X									
UHDDS										
IPHIS			X							
IMMPACT 2			X							
ABLES										
ALICE										
BioNumerics										
Blood Lead Master Database										
CAREWARE										
Childlink										
CSHN										
COCASA										
Daycare Database										
EARS										
EBC										
EDRS										
EPHTN										
HIV DBMS										
Induced Abortion (IA)										
MBCHP										
Maine Cancer Registry (MCR)										
OHP Sealant										
PHN Referent Survey										
CareFacts										
STARLIMS										
STD MIS										
VACMAN										
ASPEN		X								
CNA Registry										
PHN Database										
DSAT										
DTxC										
LOC Database										
MYDAUS										
MEDITECH			X							
NEDSS										
Substantiation										
TDS										
Organ Donation										

Maine

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HIE Related Services																								
Asset	Diagnostic Results Reporting	Laboratory Results	Consultations / Transfers of Care	Eligibility & Claims Exchange	Medication Management (ePrescribing)	Care Coordination	Community Resource Management	Quality Reporting	Public Health	Consumer Empowerment / Access	Research	Provider	Patient Identifier	Record Locator	Audit Trail	Cross-Enterprise User Authentication	Integration Engine (Data Transformation)	Patient Consent Management	Clinical Portal	PHI De-identification	Terminology Service	Clinical Decision Support	Advance Directives Management	
MIHMS			X									X		X						X				
Provider Portal				X								X												
Prior Authorization																								
Third Party Liability			X																					
Care Management						X													X			X		
PRIMS				X			X											X						
MEPOPS			X	X										X										
DW/DSS							X	X		X				X								X		
J-SURS																								
Contact Manager																								
DataHub				X										X										
ACES				X										X										
EIS				X										X										
MACWIS				X										X										
MAPSIS				X										X										
MECARE				X										X										
Provider Management System (PMS)												X												
AdvantageME																								
Case Mix Quality Assurance Application				X			X																	
Minimum Data Set v 2.0 (MDS 2.0)	X						X						X	X						X		X		
Outcome Assessment Information Set (OASIS)	X						X					X	X							X		X		
All-Payer Claims Database				X		X	X				X	X	X	X						X				
UHDDS				X		X	X				X	X	X	X						X				
IPHIS		X					X	X		X										X				
IMPACT 2	X						X	X		X	X			X						X	X		X	
ABLES	X	X					X			X										X				
ALICE	X	X					X			X										X				
BioNumerics		X					X			X														
Blood Lead Master Database	X	X					X			X										X				
CAREWARE	X	X					X	X					X							X				
Childlink	X	X					X			X										X				
CSHN			X			X																		
COCASA	X	X					X													X				
Daycare Database	X	X					X			X										X				
EARS						X	X																	
EBC							X			X														
EDRS	X	X					X													X				
EPHTN							X			X										X				
HIV DBMS					X		X			X														
Induced Abortion (IA)							X													X				
MBCHP				X			X					X												
Maine Cancer Registry (MCR)							X	X		X														
OHP Sealant				X			X																	
PHN Referent Survey							X	X		X														
CareFacts							X	X		X													X	
STARLIMS							X			X														
STD MIS							X	X																
VACMAN							X	X																
ASPEN													X											
CNA Registry													X											
PHN Database													X											
DSAT						X		X																
DTXC						X																		
LOC Database				X		X																		
MYDAUS							X			X														
MEDI TECH						X		X																
NEDSS								X																
Substantiation						X																		
TDS						X	X			X	X										X			
Organ Donation						X																		

HIE RELATED SERVICE DEFINITIONS

HIE –Related Service	Definition
Diagnostic Results Reporting	A mechanism for facilitating the delivery of patient diagnostic results (e.g., radiology and pathology reports) for use in clinical care
Laboratory Results	A mechanism for facilitating the delivery of patient lab results for use in clinical care
Consultations / Transfers of Care	The mechanism(s) enabling information flows between requesting and consulting clinicians, often used during transfers of care occurring when a patient is discharged and transferred from one health setting to another
Eligibility & Claims Exchange	A mechanism to allow providers to electronically check patient eligibility status, submit and process claims transactions, and view claims history
Medication Management	A mechanism for maintaining and exchanging medication history, medication formularies, and prescription information (e.g. ePrescribing)
Care Coordination	Mechanisms that enable clinical summary exchange (e.g. referrals/discharges, disease management) across provider settings for individual patients
Community Resource Management	A mechanism for facilitating real time resource utilization and availability
Quality Reporting	Process and mechanism to measure, aggregate, and report on hospital and clinician quality and use of quality measures to support clinical decision-making, accountability, and transparency
Public Health	A set of services that fulfill various state and Federal public health and chronic disease management practice requirements – such as biosurveillance, predictive modeling, health risk assessment, and case management – by leveraging and aggregating data available through an HIE entity
Consumer Empowerment/Access	A mechanism enabling consumers access to their health information through a personal health record or patient portal

HIE –Related Service	Definition
Research	A mechanism that provides authorized individuals the ability to query either a centralized repository or multiple data sources to produce a de-identified report for an approved research project
Provider	A set of services that enhance a provider’s ability to deliver care, move between delivery settings, and comply with regulatory requirements (e.g., regulatory reporting, secure provider messaging, credentialing)
Patient Identifier	A methodology and related services used to uniquely identify an individual person as distinct from other individuals and connect his or her clinical information across multiple providers using an Enterprise Master Patient Index (EMPI)
Record Locator	A mechanism for identifying and matching multiple patient records together from different data sources
Audit Trail	Tracks when, where, and what data was accessed and who accessed the data through an HIE entity
Cross-Enterprise User Authentication	A mechanism for identifying and authenticating clinical system users to validate their right to access clinical information based upon privacy rules, patient consent, and individual user and organizational roles
Integration Engine (Data Transformation)	A mechanism for facilitating the intake of data in multiple formats in real time through the use of an integration engine, which transforms the data into a useable format
Patient Consent Management	A process for defining levels of patient consent and for tracking those consents and authorizations to share personal health information through an HIE entity
Clinical Portal	A web-based service offered to providers for accessing, viewing, and downloading clinical data available from data sources connected to an HIE
PHI De-identification	A mechanism for removing demographic and other person-identifying data from personal health information and other health care data so that they can be used for public health reporting, quality improvement, research, benchmarking, and other secondary uses

HIE –Related Service	Definition
Terminology Service	A service that ties together technology, nomenclature, data-element, or coding-transactions standards across disparate systems, normalizing (among others) HIPAA-standard transaction sets including HL7 and ANSI, LOINC, SNOMED CT, RxNorm, IDC, NCPDP, HCPCS, CPT, and document terminology
Clinical Decision Support	Distributes standardized clinical rules that can be incorporated into EHR systems or e-Prescribing systems in support of clinical decision making at the point of care
Advance Directives Management	Maintains and exchanges a patient’s legal documentation such as a living will, durable power of attorney for health care, etc.

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**REVIEW OF ASSETS NOT BEING USED
FOR OMS HIT PROGRAM AT THIS TIME.**

Care Management

Care Management is part of the MIHMS system and focuses on the health needs of the individual including the plan of treatment, targeted outcomes, and the individual’s health status. Care Management requires the need to collect necessary health care data to manage the health outcomes of Maine citizens. The Care Management function facilitates both case management and disease management within MIHMS. The fiscal agent performs the following tasks:

- Perform prior authorization of medical services.
- Provide support to determine efficient and effective care.
- Evaluate and assign levels of care for members in institutional settings.
- Assist with the implementation of External Quality Review Organization (EQRO) protocols.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ✓ Tracking Attestations 	<ul style="list-style-type: none"> ✓ Care Coordination ✓ Clinical Portal ✓ Clinical Decision Support

Pharmacy Benefit Management

Pharmacy claims adjudication processing for MIHMS occurs under the State’s existing PBM contract with GHS. Actual pharmacy claims payment processing occurs within MIHMS. This allows for a centralization of DHHS claims payment utilizing the financial solution application. Adjudicated pharmacy claims from GHS are extracted and transferred to MIHMS. When the financials processing occurs these claims are selected along with the medical, dental, and institutional claims.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
✓ Tracking Attestations	✓ Care Coordination
	✓ Clinical Portal
	✓ Clinical Decision Support

Maine Point of Purchase System (MEPOPS)

The Maine Point of Purchase System (MEPOPS) is a point of purchase system for pharmacy providers. This system processes Medicaid prescription drug claims by assessing a number of factors, including eligibility. GHS manages this application, which provides pharmacy claims information to MIHMS.

The MEPOPS application is in the process of being replaced. MaineCare has released a request for proposal for a new Pharmacy Benefit Management (PBM) program application. The new system will be implemented by July 2011. The anticipated capabilities of the new PBM system include:

- Maintain interfaces with POS system and reporting applications
- Provides real-time access to both beneficiary and provider eligibility
- Supports online real-time summary information including number and type of providers, beneficiaries, and services
- Available 24 hours a day, 7 days a week, 365 days a year
- Prior Authorization must be compliant with Federal and State regulations
- E-prescribing solution that would work with Prior Authorizations and POS
- Fully automated PRO-DUR system that meets Federal DUR regulations
- Fully functional RETRO-DUR system that meets Federal DUR regulations
- Implementation of Medication Therapy Management Program
- Transmit adjudicated claims to the Data Hub for the MMIS system
- Pharmacy help desk available to providers for clinical and technical support

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
✓ Tracking Attestations	✓ Eligibility and Claims Exchange
	✓ Record Locator
	✓ Medication Management

Prior Authorization (PA)

Prior Authorization applications are part of the MIHMS system. When specific program benefit services are needed by a member, the service can be designated as requiring a PA. Claims that are submitted

without establishing a PA will be denied. Providers have an interest in ensuring that a PA has been established for services they are providing. They can request PAs using the Provider Portal, paper requests, or by calling customer service representatives.

Utilization and quality management define those aspects of the MIHMS system that provide for a measure of cost control and improve the quality of Medical Care through the avoidance of inappropriate treatment regimens. The state has various options to deal with utilization which represents a progression of control related to the severity of member condition. The basic level would include the restriction of benefits by associating the need for Prior Authorization (PA) to a benefit. A more aggressive control would be Care Management which would provide specific treatments for certain high risk members, based on criteria defined by the State.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	➤ No alignment identified at this time

Third Party Liability

Third Party Liability (TPL) information is information related to other insurance coverage that would apply to members who are also eligible for Medicaid. This information is obtained from various sources including CMS, Employer databases, and Medicare and is maintained in the administrator database. Adjudication edits are configured to include the TPL information for consideration as to claim payment and payment amount. The TPL information is also supplied to GHS for consideration in Pharmacy processing.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	✓ Eligibility and Claims Exchange

Pharmaceutical Rebate Information Management System (PRIMS)

The Pharmaceutical Rebate Information Management System (PRIMS) solution is an automated system designed to track the invoicing and collection of rebates from drug manufacturers. The invoices, generated quarterly, are based on the quantities of drugs dispensed by providers to eligible clients and paid for by the Department. PRIMS generates an invoice for each manufacturer stating the unit type, quantity of units used, and the expected total rebate amount for each National Drug Code (NDC) for the billing quarter. As manufacturers make payments to the State, PRIMS provides for the logging, allocation, and reconciliation of those payments for each NDC.

The table below details alignment of PRIMS with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	✓ Quality Reporting ✓ Clinical Portal ✓ Medication Management

Systems Related to MaineCare (Not MIHMS)

DataHub

The DHHS DataHub integrates eligibility data from a variety of sources including ACES, EIS, MACWIS, and MAPSIS and feed that data to MIHMS. Full production of the DataHub went live on August 1, 2010. The DataHub facilitates the data exchange between the state eligibility systems and MIHMS to send member eligibility data to MIHMS for claims processing. In addition, other feeds that currently pass through WELFRE have been migrated to the DHHS Data Hub.

The table below details alignment of DataHub with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	✓ Eligibility and Claims Exchange ✓ Record Locator

Automated Client Eligibility System (ACES)

ACES is the client eligibility system developed by Keane Inc. to support the operational needs of the Office of Integrated Access and Support (OIAS). ACES supports the welfare programs of DHHS including MaineCare, Temporary Aid for Needy Families (TANF), Food Stamps, and others. The system records client information, determines eligibility for multiple programs, issues benefits, notifies clients and performs tracking and reporting functions. The system is web-based and is used statewide in 16 district offices over the State’s wide area network to record client information and determine eligibility for benefits. It also supports several interfaces with State and Federal agencies to collect additional information used in verification and benefit determination. ACES is the system of demographic record for MaineCare members.

The table below details alignment of ACES with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ➤ No alignment identified at this time 	<ul style="list-style-type: none"> ✓ Eligibility and Claims Exchange ✓ Record Locator

Enterprise Information System (EIS)

Enterprise Information System (EIS) is a web-based case management application that supports case management for five populations: Mental Health, Adults with Cognitive and Physical Disabilities, Children’s Services, Substance Abuse, and Elder Services. EIS contains eligibility, member, and provider data for each of these populations. EIS contains six key elements: assessments, plans, notes, reportable events, client tracking, and prior authorizations.

EIS interfaces with MIHMS. EIS tracks where services are taking place and MIHMS tracks where claims are being paid. EIS process and pays claims directly to providers for Mental Health members on the state grant program through APS; all other claims are processed and paid through MIHMS.

The Office of Adults with Cognitive and Physical Disabilities (OACPD) works with Resource Coordinators to manage waiver clients and send claims to MIHMS. Mental Health works with providers to capture information from APS, the care management vendor.

The table below details alignment of EIS with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ➤ No alignment identified at this time 	<ul style="list-style-type: none"> ✓ Eligibility and Claims Exchange ✓ Record Locator

Maine Automated Child Welfare Information System (MACWIS)

Maine Automated Child Welfare Information System (MACWIS) provides the case management system for the Bureau of Child and Family Services (BCFS) casework staff, Title IV-E eligibility determination for children in the Department's care, licensing functions for foster care placement services, placement services payment processes for children in the Department's care, miscellaneous bills processing for DHHS, and intake and assessment processes for child abuse and neglect reporting and mandatory Federal Reporting. MACWIS was designed as a casework management system that allows for the gathering of case specific information on child welfare cases. Much of the information that is collected is for Federal reporting requirements that are directly related to the allocation of Federal funds. The system also contains all the Bureau's licensing, Title IV-E eligibility determinations, miscellaneous bills and child welfare payments, resource management, child welfare contracts, and central intake work. MACWIS serves over 1000 users with over 80,000 transactions processed daily, over 5 million dollars in payments per month, and operates 24 hours a day, 7 days a week, 365 days a year. Information recorded in MACWIS is also used for tracking of the following strategic goals for the Bureau including:

- Improve the quality and timeliness of receiving and responding to reports of child abuse and neglect
- Broaden family involvement from report to the best outcome for children and families
- Improve community connections and collaboration
- Develop and realign resources as needed to create better outcomes for children and their families
- Improve the experience of children in care while achieving better and faster permanency outcomes
-

The table below details alignment of MACWIS with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Maine Adult Protective Services Information System (MAPSIS)

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ➤ No alignment identified at this time 	<ul style="list-style-type: none"> ✓ Eligibility and Claims Exchange ✓ Record Locator

Maine Adult Protective Services Information System (MAPSIS)

Maine Adult Protective Services Information System (MAPSIS) is the case management system used by the Office of Elder Services for Adult Protective Services. There are five primary subsystems and five secondary subsystems in MAPSIS. They are:

- Intake – Used to record new referrals to Adult Protective Services
- Supervisor Review – For processing referrals and subsequent case actions
- Investigation – For recording findings of referral review
- Case Management – For recording detail on on-going cases
- Client Accounting – For managing client’s day-to-day financial needs
- Estate Management – Client account court reporting and final estate closings
- Reporting – Pre-defined reports primarily used by APS management
- Client Accounting (Supervisory) – Minor extension to client accounting functionality
- Administrative – User account management
- Mental Health / Mental Retardation Read-Only – Read-only access to client transaction information for MH/MR users

The table below details alignment of MAPSIS with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	<ul style="list-style-type: none"> ✓ Eligibility and Claims Exchange ✓ Record Locator

MECARE

MECARE is the electronic format of the Medical Eligibility Determination (MED) assessment form used to determine medical eligibility. This assessment is used to verify eligibility for many of the State and MaineCare funded long-term care programs that require medical and/or financial eligibility. Assessments are completed to determine initial eligibility and to review for ongoing eligibility to determine how to best serve the medical needs of MaineCare members requiring long-term care. The MED assessment is used to see if a person meets the requirements for nursing facility level of care, several MaineCare home care programs including adult day health, the state funded Home Based Care program, and the Homemaker program. The MED assessment is required for anyone entering a nursing home. Statistical analysis of the MED assessment data is completed by the Muskie Institute as part of their cooperative agreement with the state.

The table below details alignment of MECARE with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	<ul style="list-style-type: none"> ✓ Eligibility and Claims Exchange ✓ Record Locator

Provider Management System (PMS)

The Provider Management System (PMS) application, also known as the Provider Directory, is a database of all of Office of Substance Abuse’s Treatment, Prevention, Co-Occurring and Driver Education and Evaluation Program (DEEP) approved

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providers. It is linked to a public interface where those in need of services can search by service, town, county, and populations served. It stores contact and location information, provider websites if available, Executive Directors, contact staff, and other information. Internally, it is used to store data on services and treatment and send mailings to specific groups of providers. PMS interfaces with MIHMS to adjudicate the claims for the Office of Substance Abuse.

The table below details alignment of Provider Management System with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	✓ Provider

Case Mix Quality Assurance Application

The Case Mix Quality Assurance nurses use this application to review the Minimum Data Set (MDS) assessments to determine accuracy for payment purposes. The application is loaded onto laptop computers, where data is then collected, and synchronized with the system.

The Case Mix/Classification Review Unit is responsible for the ongoing monitoring of the combined Medicaid/Medicare Reimbursement and Quality Assurance System throughout the state of Maine. The Health Care Financing Administration (HCFA) mandates the use of a standardized, universal assessment tool (Minimum Data Set 2.0) for all long-term care Nursing Facility residents. The MDS is the basis for Case Mix payment and Quality Indicators in Nursing Facilities. The Case Mix Unit is also responsible for the ongoing development, implementation and education of a case mix system for Level II Cost Reimbursed Assisted Living Facilities. Case Mix payment was implemented in the summer of 2001. The facilities continue to assess residents using the MDS/Resident Care Assessment (RCA) form. This form will be the basis for the case mix payment and Quality Indicators in Assisted Living Facilities. Registered Nurses visit all Nursing Facilities and Level II Assisted Living Facilities to review the accuracy of the assessment data. The Classification Unit serves as the technical “help

desk” for all the Nursing Facilities and Home Health Agencies. They are the direct line of communication for problem solving and assistance for all facets of the data submission process.

The table below details alignment of the Case Mix Quality Assurance Application with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	<ul style="list-style-type: none"> ✓ Eligibility and Claims Exchange ✓ Quality Reporting

Minimum Data Set v 2.0 (MDS 2.0)

The Minimum Data Set v 2.0 is a Long Term Care (LTC) Resident Assessment Instrument that was developed by the Muskie Institute. The MDS 2.0 is part of CMS Nursing Home Quality Initiative. The purpose of this project is to provide computerized storage, access, and analysis of the MDS 2.0 long-term care data on residents in nursing homes across the United States. The MDS System is intended to create a standard, nationwide system for connecting LTC facilities to their respective State agencies for the purpose of electronic interchange of data, reports, and other information.

The MDS System provides the following functions:

- Receipt of MDS records from LTC facilities by State agencies
- Authentication and validation of MDS records received from LTC facilities
- Feedback to LTC facilities indicating acknowledgment of the transmission of the data and specifying the status of record validation
- Storage of MDS records in the database repository within the State agency

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The system was designed to also serve as a means of communicating information (e.g., reports, documents, and notices) between the State agencies and LTC facilities without requiring additional hardware or software at each LTC facility, the user will use the MDS System to electronically send MDS data records to the State agency. The information is transmitted via a modem or broadband and received at the State communications server where the file is validated to ensure some basic elements conform to the requirements (such as proper format and facility information). Once these minimal checks of the file are completed, a message is sent back to the LTC facility and appears on-screen indicating whether the file has been received successfully or rejected.

The MDS is collected on regular intervals for every resident in a Medicare or Medicaid certified nursing home. Information is collected on each resident's health, physical functioning, mental status, and general well-being. These data are used by the nursing home to assess the needs and develop a plan of care unique to each resident. Regulations require that a MDS assessment be performed at admission, quarterly, annually, and whenever the resident experiences a significant change in status. For residents in a Medicare Part A stay, the MDS is also used to determine the Medicare reimbursement rate. These assessments are performed on the 5th, 14th, 30th, 60th and 90th day of admission.

MDS 2.0 will be migrated to MDS 3.0 on November 1, 2010.

The table below details alignment of the Minimum Data Set with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	✓ Diagnostic Results Reporting ✓ Quality Reporting ✓ Patient Identifier ✓ Record Locator ✓ PHI De-Identification ✓ Clinical Decision Support

Outcome Assessment Information Set (OASIS)

The Outcome Assessment Information Set (OASIS) System is one part of the overall OASIS National Automation Project. The purpose of this project is to provide computerized storage, access, and analysis of the OASIS data on patients in Home Health Agencies across the United States, Puerto Rico, Virgin Islands, and Guam. The OASIS System is intended to create a standard nationwide system for connecting Home Health Agencies to their perspective State Agencies for the purpose of electronic interchange of data, reports, and other information. The patient information collected includes patient identification number, social security number, Medicare and/or Medicaid identification number, zip code, current condition information, and health assessments.

The OASIS System provides the following functions:

- Receipt of OASIS records from Home Health Agencies by State Agencies
- Authentication and validation of OASIS records received from Home Health Agencies
- Feedback to Home Health Agencies indicating acknowledgment of the transmission of the data and specifying the status of record validation Storage of OASIS records in the database repository within the State Agency

The system was designed to also serve as a means of communicating information (e.g., reports, documents, and bulletins) between the State Agencies and Home Health Agencies without requiring additional hardware or software also serves to illustrate the flow of OASIS data submissions. At each Home Health Agency, the OASIS System is utilized to electronically send OASIS data records to the State Agency. The information is transmitted via a modem or broadband and received at the State's Communications Server where the file is validated to ensure some basic elements conform to the requirements (such as proper format and Home Health Agency information). If the submission passes the initial validation check, each record is then checked for errors or exceptions to the data specifications and an OASIS Final Validation Report is generated.

The table below details alignment of OASIS with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ➤ No alignment identified at this time 	<ul style="list-style-type: none"> ✓ Diagnostic Results Reporting ✓ Quality Reporting ✓ Patient Identifier ✓ Record Locator ✓ PHI De-Identification ✓ Clinical Decision Support

Universal Hospital Discharge Data Set (UHDDS)

The Universal Hospital Discharge Data Set (UHDDS) is a database that collects and stores information on every inpatient and outpatient hospitalization encounter. Upon hospitalization, a record is created to register a patient. The registered entry is coded with demographic information, diagnosis, and payment information. Since 1990, Maine requires by law that all inpatient and outpatient hospital encounters be reported to the Maine Health Data Organization (MHDO) using the UHDDS. Data is available through 2009. This asset is owned, operated and maintained by MHDO. A variety of interest groups, including organizations, educational institutions, and providers, can purchase data from MHDO provided that purchasers agree to comply with MHDO’s data use agreement. The State does not currently use the database for regular reporting. OnPoint Health Data, a non-profit organization, is a large purchaser of the UHDDS data and they use the data to provide reports to organizations, providers, and others who have contractual agreements with OnPoint.

The table below details alignment of UHDDS with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ➤ No alignment identified at this time 	<ul style="list-style-type: none"> ✓ Claims Exchange ✓ Care Coordination ✓ Quality Reporting ✓ Provider ✓ Record Locator ✓ Audit Trail ✓ PHI De-Identification

Adult Blood Lead Epidemiology and Surveillance (ABLES)

The Adult Blood Lead Epidemiology and Surveillance (ABLES) program is a state-based surveillance program of laboratory-reported adult blood lead levels. The program objective is to build state capacity to initiate, expand, or improve adult blood lead surveillance programs which can accurately measure trends in adult blood lead levels and which can effectively intervene to prevent lead over-exposure.

The table below details alignment of ABLES with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ➤ No alignment identified at this time 	<ul style="list-style-type: none"> ✓ Diagnostic Results Reporting ✓ Laboratory Results ✓ Public Health ✓ Research ✓ PHI De-Identification

Annotated Lead Information Case Explorer (ALICE)

Annotated Lead Information Case Explorer (ALICE) tracks and manages all incidences of Childhood Blood Lead Poisoning. Interfacing with several other Microsoft Access databases (including doctors, public health nursing) and Oracle tables (LITS, Lead Master Files) this system provides data, forms, letters and alerts to environmental and health nurses for management of children (under 6 years old) with blood lead levels above 10 ugl.

The table below details alignment of ALICE with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ➤ No alignment identified at this time 	<ul style="list-style-type: none"> ✓ Diagnostic Results Reporting ✓ Laboratory Results ✓ Public Health ✓ Research ✓ PHI De-Identification

BioNumerics

BioNumerics is a uniquely comprehensive biological data analysis software of particular interest to laboratories performing typing, identification, screening and taxonomic studies. Typical applications are PFGE DNA fingerprinting E.coli O157:H7 and MRSA. BioNumerics is used by the PulseNet project in the USA and worldwide. BioNumerics integrates the analysis of gel, sequence and phenotypic data. BioNumerics is a modular software. Users may choose from 5 data type modules; 3 analysis modules; and a database sharing tools module. The minimum configuration is one data type module + one analysis module. You may add any module at a later date if desired.

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The table below details alignment of BioNumerics with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services. For detailed definitions of the EHR Incentive Program administration and oversight areas and HIE-related services, please refer to section 5.2.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	✓ Laboratory Results ✓ Public Health ✓ Research

Blood Lead Master Database

This system manages all recipients of blood lead tests (almost always human beings, the majority are children though adults are also on record). Database tables hold distinct people, distinct addresses, and all test results. Data is validated against address validation software and quality assurance checks to assure data integrity. Nationally required data for CDC is sent out quarterly and annually. Data is sent to the ALICE and ABLES systems, Lead survey and Bio-Monitoring systems.

The table below details alignment of Blood Lead Master Database with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	✓ Diagnostic Results Reporting ✓ Laboratory Results ✓ Public Health ✓ Research ✓ PHI De-Identification

AIDS Treatment Database (CAREWARE)

In order to meet funding requirements, service providers funded by the Ryan White HIV/AIDS Program must complete the Ryan White Program Data Report (RDR) detailing information on all the clients they served during the course of a calendar year. CAREWare is free, scalable software for managing and monitoring HIV clinical and supportive care and will quickly produce a completed RDR and the new RSR. The CAREWare application contains information on AIDS treatment.

The CAREWare business and data tiers are on an Enterprise server at OIT. The State has users throughout the state, most of whom are case managers employed at provider agencies who are subcontractors. Demographic data is entered into the system from paper forms, but service data and case notes are entered directly into CAREWare. The Ryan White Services Report (RSR) includes demographic data, service data, and some limited clinical and financial data. CAREWare has an RSR export built into it that will produce an XML file stripped of identifiers using the Safe Harbor method of de-identification that has been uploaded to HRSA’s secure electronic handbook online. Internally, there are four CAREWare users at Maine CDC and several users at MaineCare as well.

The table below details alignment of CAREWARE with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	<ul style="list-style-type: none"> ✓ Diagnostic Results Reporting ✓ Laboratory Results ✓ Quality Reporting ✓ Public Health ✓ Patient Identifier ✓ PHI De-Identification

Childlink

The Childlink Application and Database hosted by the University of Maine at Orono (UMO) to capture data, report, and research information on newborns including hearing

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screenings, birth defect data, metabolic data. UMO hosts this application, and pulls down data for research. Hospitals and private Audiologists use a Citrix link to submit Hearing Screening data. A Web link is available for Physicians to submit data on Birth Defects. Maine CDC provides reports and statistics.

The table below details alignment of Childlink with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	✓ Diagnostic Results Reporting ✓ Laboratory Results ✓ Quality Reporting ✓ Research ✓ PHI De-Identification

Children with Special Health Needs (CSHN)

Children with Special Health Needs (CSHN) is a program that helps pay for medical care provided by specialists to eligible families, and offers assistance with coordination of care for infants, children and adolescents with special health needs.

The table below details alignment of CSHN with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	✓ Consultations / Transfers of Care ✓ Care Coordination

Comprehensive Clinic Assessment Software Application (COCASA)

The Comprehensive Clinic Assessment Software Application (COCASA) is a program supplied by the Centers for Disease Control and Prevention (CDC) that is used to access patient up-to-date status for childhood vaccines. IMMPACT 2 has an extract

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function that creates a flat file with patient and immunization records. This file is used to assess Practices that receive CDC vaccines. This assessment includes the percentage of children up-to-date and recommendations for improving immunization coverage.

The table below details alignment of COCASA with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ✓ No alignment identified at this time 	<ul style="list-style-type: none"> ✓ Diagnostic Results Reporting ✓ Laboratory Results ✓ Public Health ✓ PHI De-Identification

Daycare Database

This is an Access database used to collect the results of annual daycare and Head Start surveys mailed and returned to the MIP. The results are keyed into the system by MIP staff. The survey collects information of those children that attend the daycare, names and birth dates and the immunizations that they have received. The system calculates the immunization status both for the child and in summary for the daycare as well as Statewide. Summaries are submitted to the Federal Centers for Disease Control and Prevention on a yearly basis. State Statute/Rules require that children in daycare have specific immunizations to be enrolled in daycare. The daycare is responsible to make sure that the children have these vaccinations before or shortly after being enrolled.

The table below details alignment of Daycare Database with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ➤ No alignment identified at this time 	<ul style="list-style-type: none"> ✓ Diagnostic Results Reporting ✓ Laboratory Results ✓ Public Health ✓ Research ✓ PHI De-Identification

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Early Aberration Reporting System (EARS)

The Early Aberration Reporting System (EARS) was pioneered as a method for monitoring bioterrorism during large-scale events. Its evolution to a standard surveillance tool began in New York City and the nation’s capitol region following the terrorist attacks of September 11, 2001. Various city, county, and state public health officials in the United States and abroad currently use EARS on syndromic data from emergency departments, 911 calls, physician office data, school and business absenteeism, and over-the-counter drug sales. EARS is a convenient, easy to use, and no cost application. The EARS program presents its analysis in a complete HTML Website containing tables and graphs linked through a home page. Viewing EARS output requires only a Web browser.

The table below details alignment of EARS with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	<ul style="list-style-type: none"> ✓ Care Coordination ✓ Public Health

Electronic Birth Certificate (EBC)

The Electronic Birth Certificate (EBC) and Birth Statistical File is an application that is undergoing a maintenance upgrade and a move off of an unsupported environment. The new EBC is scheduled to be implemented during calendar year 2011.

The table below details alignment of EBC with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	<ul style="list-style-type: none"> ✓ Public Health ✓ Research

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Electronic Death Registration System (EDRS)

Electronic Death Registration System (EDRS) is a Commercial Off the Shelf (COTS) product Database for Application of Vital Events, supplied by VitalChek Network Inc. The initial implementation will be the death module and in the future other vital events modules may be added. The application enables the capture of complete and accurate death vital event information that is statutorily required and of critical

importance for public health surveillance. It ensures the timeliness of vital events information for certification, surveillance, reporting, analysis and verification.

The table below details alignment of EDRS with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ➤ No alignment identified at this time 	<ul style="list-style-type: none"> ✓ Diagnostic Results Reporting ✓ Laboratory Results ✓ Public Health ✓ PHI De-Identification

Environmental Public Health Tracking Network (EPHTN)

The U.S. Congress appropriated funding to the Federal Centers for Disease Control and Prevention (CDC) in 2002 to begin the development and implementation of a National Environmental Public Health Tracking (EPHT) Program and Network. The National EPHT Network (EPHTN) is to provide a coordinated way for agencies responsible for protecting human health to systematically and comprehensively track information about the health of people and the environment from local to national levels. The National network was launched in February 2009. The Tracking Network will enable direct electronic data reporting and linkage of health effects, exposure, and environmental health data. The EPHTN is a portal within the IPHIS application. The functionality of this application has been built based on the existing IPHIS platform and technology.

The table below details alignment of EPHTN with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

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Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ➤ No alignment identified at this time 	<ul style="list-style-type: none"> ✓ Public Health ✓ Research ✓ PHI De-Identification

HIV/AIDS Medication Database (HIV DBMS)

This application contains AIDS Medication information. The information resides on a local drive at Key Bank building.

The table below details alignment of HIV/AIDS Medication Database (HIV DBMS) with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	✓ Medication Management ✓ Public Health ✓ Research

Induced Abortion (IA)

The data from paper records is entered into an Access database, processed using SAS, and shared de-identified only. This information is shared only in tabulated form; raw data is tightly restricted and controlled.

The table below details alignment of Induced Abortion (IA) with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

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Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	✓ Public Health ✓ PHI De-Identification

Maine Breast and Cervical Health Program (MBCHP) Data Management and Reporting System (DRMS)

Maine is one of 68 state and tribal organizations to implement a comprehensive breast and cervical cancer early detection program. The Maine Breast and Cervical Health Program (MBCHP) is funded through a

cooperative agreement with the Federal Centers for Disease Control and Prevention (CDC). The MBCHP utilizes MIHMS to reimburse providers for MBCHP covered services: MBCHP is considered a Special Benefit program under the claims system. MBCHP is responsible for the collection and management of enrollment and clinical data reported by these providers; and weekly integrates a MIHMS claims feed with claims-related data into the database. The Federal CDC mandates the reporting of both the types of services delivered and the cost of delivered services, making the MBCHP Data Management and Reporting System (DMRS) an integral component to the success of this program.

The table below details alignment of MBCHP with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ➤ No alignment identified at this time 	<ul style="list-style-type: none"> ✓ Eligibility & Claims Exchange ✓ Quality Reporting ✓ Provider

Maine Cancer Registry (MCR)

The Maine Cancer Registry (MCR) is a statewide population-based cancer surveillance system. The MCR collects information about all newly diagnosed and treated cancers in Maine residents (except in situ cervical cancer and basal and squamous cell carcinoma of the skin). This information is used to monitor and evaluate cancer incidence patterns in Maine. This information is also used to better understand cancer, identify areas in

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need of public health interventions, and improve cancer prevention, treatment, and control.

The table below details alignment of MCR with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ➤ No alignment identified at this time 	<ul style="list-style-type: none"> ✓ Quality Reporting ✓ Public Health ✓ Research

No. 17 Meditech – Office of Adult Mental Health Services - State Hospital EHR Systems

Meditech supports the mission, strategic plan, and initiatives of the two State hospitals-- Riverview Psychiatric Center and Dorothea Dix Psychiatric Center--by providing a data system of client billing management functions. Meditech enables the State to capture data and bill electronically. The back end office modules of the Meditech system were implemented 2006. Clinical modules were implemented in 2009 allowing for the use of clinical notes. These hospitals are not eligible for the Medicaid HIT Program, but would have some aligning factors with HIT/HIE.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ✓ No alignment currently planned 	<ul style="list-style-type: none"> ✓ Care Coordination ✓ Quality Reporting

Oral Health Program Sealant Application (OHP Sealant)

Used by the Oral Health Program to compile data taken on-site by Dental Hygienists conducting child dental screenings in public schools and installing dental sealants. The primary purpose is to capture MaineCare’s billing information for reimbursements to the Oral Health Program (OHP). The secondary purpose is to capture statistical information for reporting.

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The table below details alignment of OHP Sealant with the plan to administer oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
<ul style="list-style-type: none"> ➤ No alignment identified at this time 	<ul style="list-style-type: none"> ✓ Eligibility & Claims Exchange ✓ Quality Reporting

Public Health Nursing Referent Survey (PHN Referent Survey)

Public Health Nurses (PHN) conduct surveys with their patients following the patient’s discharge. Paper documents are mailed and returned without any personal identifiers. The data is then entered into an excel spreadsheet and managed by the Public Health Nursing Informatics staff. Various reports and analysis are conducted all for the sake of quality improvement.

The table below details alignment of PHN Referent Survey with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
---	------------------------------------

- | | |
|--|--|
| ➤ No alignment identified at this time | <ul style="list-style-type: none"> ✓ Quality Reporting ✓ Public Health ✓ Research |
|--|--|

Public Health Nursing Records System – CareFacts

Since 2002, the PHN program has used an electronic information management system (CareFacts™), in order to document nursing services provided. This application utilizes the Omaha System, a standardized classification system recognized by the American Nurses Association. The PHN program utilizes such information technology in order to link nursing practice, service data, health information and knowledge, pertinent to citizens’ current and emerging health needs. Program commitment to the utilization of information technology tools has supported: standardized clinical documentation; improved clinical management; public health outcomes measurement; and preparation for program pursuit of CHAPS accreditation. The program’s information technology experiences have been highlighted in state and national forums, including the recent 2006 American Public Health Association annual meeting.

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The table below details alignment of CareFacts with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
---	------------------------------------

- | | |
|--|---|
| ➤ No alignment identified at this time | <ul style="list-style-type: none"> ✓ Quality Reporting ✓ Public Health ✓ Research ✓ Clinical Decision Support |
|--|---|

STARLIMS Laboratory Information Management System v 9.0 and v 10.0

The goals of the Health and Environmental Testing Laboratory (HETL) are to isolate, identify, analyze and monitor any biological, chemical, or radiological hazards that are capable of causing harm. The HETL’s mission is to provide surveillance data necessary for prevention, treatment, and control of such hazards that threaten the community or environment. Laboratory Information Management Systems (LIMS) are a critical component of the HETL’s management of analytical data. A LIMS not only tracks analytical test requests, but manages analytical results, quality control, work lists, data review and release, reporting both electronically and by paper, and billing. LIMS are also a critical component of a National Laboratory Response Network that serves interoperable electronic data exchange for surveillance across all public health laboratories. Maine’s HETL currently needs two LIMS: one STARLIMS for the environmental and forensic sections and a second STARLIMS for the microbiology sections.

The table below details alignment of STARLIMS with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	<ul style="list-style-type: none"> ✓ Public Health ✓ Research

STD Management Information System (STD MIS)

The system is used for disease surveillance, morbidity tracking, and case management. The STD Program uses the data for grant activities, for planning purposes, and for

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disease intervention/follow up work. The community uses the information for various reasons and data is uploaded to the Federal CDC weekly.

The table below details alignment of STD MIS with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	<ul style="list-style-type: none"> ✓ Quality Reporting ✓ Public Health

Vaccine Management System (VACMAN)

VACMAN is the CDC's National Immunization Program Vaccine Management System. It is a Database Management System (DBMS) used by 59 state, city, and territorial government Immunization Programs (called Projects). Only these Projects, designated by CDC, are eligible to use VACMAN - the application is not designed or accessible for any agency other than these 59 Projects. The Projects use VACMAN to order, and to track and record information relating to publicly funded (Vaccines for Children (VFC), 317 Grant (G317), and state/other) vaccines data is entered and tracked through a direct user interface.

The table below details alignment of VACMAN with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
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Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	<ul style="list-style-type: none"> ✓ Quality Reporting ✓ Public Health

Public Health Nursing Database (PHN DB)

There is a MS-access PHN (Public Health Nursing) Database that is used to access names, phone numbers, and offices for public health nurses and supervisors. Typically the data is joined by geographic location to identify the office and staff responsible for an area.

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The table below details alignment of PHN Database with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	<ul style="list-style-type: none"> ✓ Provider

Differential Substance Abuse Treatment (DSAT) – Office of Substance Abuse

The Differential Substance Abuse Treatment (DSAT) is a web-based evaluation tool that contains clinical data on clients. Probation officers and Correctional Facility personnel can view the status of their clients.

The table below details alignment of DSAT with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	<ul style="list-style-type: none"> ✓ Care Coordination ✓ Quality Reporting

Drug Court Treatment System (DTxC) – Office of Substance Abuse

Drug Court Treatment (DTxC) is used by judges in court to make decisions about offenders. The system is also used by providers to log clinical information.

The table below details alignment of DTxC with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	✓ Care Coordination

Levels of Care Database (LOC DB) – Office of Children and Family Services

The Levels of Care Database (LOC DB) tracks requests and receipt of case information from child placing agencies for levels of care assessments. These assessments are used to determine pay rates for providers.

The table below details alignment of LOC Database with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	<ul style="list-style-type: none"> ✓ Eligibility & Claims Exchange ✓ Care Coordination

Maine Youth Drug and Alcohol Use Survey (MYDAUS)

Between 1993 and 1997, Maine was one of six states participating in the Diffusion Consortium Project, a study undertaken by the University of Washington for the purpose of developing research-based substance abuse strategies. Out of the collaboration came the Maine Youth Drug and Alcohol Use Survey (MYDAUS). The purpose of the survey is to quantify the use of alcohol, tobacco and other substances among middle and high school students in Maine, and to identify the risk and protective factors that influence a student’s choice of whether or not to engage in these and related harmful behaviors. These influences are found in the different domains of the student’s social environment: peer group, family, school and community. Identification of specific populations in which the risk factors are high and the protective factors are low, permits the targeting of interventions where they are most needed.

The table below details alignment of MYDAUS with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	<ul style="list-style-type: none"> ✓ Public Health ✓ Research

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Certified Nursing Assistants Registry (CNA Registry)

The CNA Registry is used for checking current licensing statuses for Certified Nursing Assistants.

The table below details alignment of CNA Registry with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	✓ Provider

National Electronic Disease Surveillance System (NEDSS)

The National Electronic Disease Surveillance System is the communicable disease reporting system within IPHIS.

The table below details alignment of NEDSS with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	✓ Public Health

Prescription Monitoring Program (PMP) – Office of Substance Abuse

The Prescription Monitoring Program (PMP) provides a database of controlled substances schedules II, III, and IV received by patients in the State of Maine. Data collection for the program began in July 2004 and the PMP collects records on approximately 2.4 million pharmacy transactions from 300 pharmacies both in and outside of Maine per year. The program allows health care providers to access comprehensive information through a web portal to improve patient care. The primary

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goal of the program is to provide information to both prescribers and pharmacists to identify suspicious activity related to prescribing and dispensing controlled substances.

The PMP database collects the name and date of birth of the patient who was prescribed the controlled substance as well as the name of the prescriber and pharmacist. All pharmacies and dispensaries in Maine are required to submit data via the web portal on controlled substances at least twice a month.

The table below details alignment of PMP with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	<ul style="list-style-type: none"> ✓ Medication Management ✓ Public Health

Substantiation – Office of Children and Family Services

The Substantiation database documents complaints of abuse or neglect. The database contains clinical information documenting incidences of abuse or neglect.

The table below details alignment of Substantiation with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	<ul style="list-style-type: none"> ✓ Care Coordination

Treatment Data System (TDS) – Office of Substance Abuse

The Treatment Data System (TDS) was legislatively mandated by the State Legislature in P.L. 1983 c. 464. It is also required by the Federal Government that the Office of Substance Abuse submit substance abuse treatment data on a monthly basis. TDS is the vehicle used to comply with that reporting. TDS aggregate data are used to monitor and track trends in substance use for new or changing patterns. The system allows OSA to monitor contracted agencies for utilization and effectiveness. In addition, TDS is

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used for needs assessment planning and workforce development. TDS collects de-identified admission and discharge data on clients in substance abuse treatment. Data is only disseminated from TDS in aggregate form. TDS is a secure system requiring a user ID and password to log on.

TDS has several different levels of reporting by agencies. Those levels have been consolidated over time so that eventually TDS will contain all or nearly all the substance abuse treatment information for the state as possible. Currently, reporting falls into 4 categories: OSA contracted substance abuse treatment agencies must report all their clients. All Licensed Substance Abuse providers must report all of their clients. Methadone agencies must report all their clients. Private providers, who serve clients involved in the Driver Education and Evaluation Program (DEEP), must report only their DEEP clients. MaineCare requires that any agency seeking reimbursement for substance abuse treatment must have a contract with the Office of Substance Abuse. These new contracts require that all of the agency's clients be reported to TDS.

The table below details alignment of TDS with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services

Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	<ul style="list-style-type: none"> ✓ Care Coordination ✓ Quality Reporting ✓ Provider ✓ PHI De-Identification ✓ Research

Organ Donation – Bureau of Motor Vehicles

When applicants for a Maine driver’s license or state identification card come into a Bureau of Motor Vehicles (BMV) Service Center, they are asked if they wish to be recorded as a potential organ and tissue donor. Using this information, the BMV hosts and maintains the Organ Donor registry. This database is an Access database.

The table below details alignment of Organ Donation with the plan to administer and conduct oversight for the EHR Incentive Program and alignment with State-HIE services.

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Alignment with Plan to Administer and Conduct Oversight	Potential Alignment with State HIE
➤ No alignment identified at this time	✓ Care Coordination

Division of Purchased Services

The Division of Purchased Services exists to provide support to DHHS through the effective management of purchase of service agreements. The Division reviews, approves, and processes over 2000 agreements per year. The Division also provides management tools for recording agreement information and performance as well as technical assistance regarding agreement development and management.

Division staff endeavors to manage agreements with the greatest degree of consistency, accountability and cost effectiveness to ensure that the delivery of services meets the needs of the consumers as well as Department and various Federal, State, and other funds. The Division is committed to an agreement management system that promotes the best business practices, supports the Department's public mission, and is in compliance with Federal and State statutes, rules, and regulations.

Alignment with Plan to Administer and Conduct Oversight

- No alignment identified at this time

Potential Alignment with State HIE

- No alignment identified at this time
-

Footnote 16:

Survey Approach

The survey creation, distribution, and analysis was facilitated by researchers from the Muskie School of Public Service. The survey was created by using the Muskie School's expertise in survey development and administration and various EHR adoption surveys that have been created and used by other states. There were three key steps in administering the survey to MaineCare providers:

- Sample development
- Survey development and administration
- Data collection and analysis

The following describes each step of the survey administration process:

Sample Development

Several sources of provider information were examined to identify appropriate contact information so that the survey could be web-based and more quickly administered than otherwise possible. Muskie School staff examined provider files from the current MMIS (MECMS), the new MMIS (MIHMS), the Maine Medical Association provider list, the list of hospital Chief Information Officers (CIO), and the MaineCare Primary Care Case Management and Patient Centered Medical Home program lists. Recently providers were required to re-enroll in MIHMS to support the new MMIS. Since this system had the most complete list of provider email contacts, to the extent possible, this list was reconciled with the other lists to determine omissions and/or additional contacts. However, because the data elements within each file were inconsistent, manual reconciliation was necessary to develop a single, complete and accurate data source. Provider type and specialty were used to identify hospitals, and all of types listed as "eligible professionals" including, but not limited to, physicians, FQHCs, RHCs, nurse practitioners, and dentists.

Survey Development and Administration

Muskie School researchers developed three surveys for health professionals: practices (which included the professionals who were listed in the CMS regulations as meeting

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the definition of an “eligible professional,” acute care hospitals, and dental practices. An online survey tool was used to develop the survey which was administered by the Survey Research Center at the Muskie School of Public Service. Hospital and provider associations were informed about the survey prior to distribution. The MaineCare Director met with the associations to explain the purpose of the survey and encourage association leaders to encourage their members to participate in the survey.

Links to the web-based surveys were e-mailed to the available e-mail address for each practice, which would include the professionals listed in the CMS regulations as meeting the definition of an “eligible professional,” hospital, and dental practice identified. Reminders were emailed a week after the survey and follow-up phone calls were made a week after that. Provider associations (Maine Medical Association, Maine Hospital Association, and Maine Dental Association), Maine Primary Care Organization, and MaineCare staff and the Muskie School Survey Research Center participated in follow up efforts.

Data Collection and Analysis

Muskie School researchers collected the final survey data on June 10, 2010. Prior to completing any data analysis, Muskie School researchers cleaned the data by including respondents answering the survey question about EMR adoption in the final analyses and excluding practices where physicians provide 90 percent or more of their services in a hospital setting. For the “As-Is” Assessment, frequencies were calculated using Statistical Analysis Software (SAS).

The State has all of the raw survey data that was collected from providers, hospitals, and dentists, and conducted further analysis to help feed the “gap analysis.”

Of the 1,384 sites, servicing providers were identified as providing services. The Muskie School analyzed data to determine which providers would be eligible for the EHR Incentive Payment Program. MaineCare administrative data for Non-FQHC providers enrolled in the PCCM program and MaineCare Enrollment and Capitation System (MECAPS) were examined to determine eligible member panel enrollment as of June 30, 2009. Additionally, non-Primary Care Case Management (PCCM) Medicaid Members were attributed to the sites based on who they saw the most during the 2009 fiscal year. Providers were prorated to each site. If a provider is at multiple sites during a month, the number of months attributed to each sites is 1 divided by the number of sites a provider is at during month (i.e., if a provider is at two sites in the same month, the provider counts as .5 months for each site). While the literature

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suggests 2,500 as an average panel size, based on feedback from the provider community a lower panel size estimate of 1,800 was used.

Using the 1,800 panel size estimate (150 providers met the 30 percent (20 percent for pediatricians) Medicaid patient volume threshold. CMS used a 47.3 percent estimate of providers that will meet the Meaningful Use criteria in their estimates. (2 CFR Parts 412, 413, 422, and 495 Medicare and Medicaid Electronic Health Records Incentive Program, CMS Final rule, July 13, 2010, pp 742). Applying the 47.3 percent estimate, 71 providers would be eligible for incentive payments. According to the Medical Practices (Including Eligible Professionals) Survey results, 42 percent of primary care respondents indicated they would be applying for the EHR Incentive Program. Applying the 42 percent estimate, 63 providers would apply for the incentive.

De-identified data for Federally Qualified Health Centers (FQHCs) was provided from the Maine Primary Care Association on the number of patients served by source of payment as well as number of providers. All 18 corporate FQHC entities were included. These data are provided directly from the FQHCs to Maine Primary Care Association and are part of the required cost reports and include the MaineCare and uninsured covered patients (“needy individuals”) and counts of all patients and practitioners. FQHCs also provide dental services that are included in the cost report data. From the MaineCare claims information, 1,325 members were provided dental services at 62 FQHC sites based on the diagnosis code submitted on the claims. (The FQHCs bill using a global procedure code for services. This makes it difficult to identify dental services. To identify dental services from FQHCs, diagnosis codes (V7222 and 520 thru 5259) on the claim were used).

Using the 2009 data, every FQHC but one qualifies for the Medicaid EHR Incentive Program. Since the time the survey was conducted in early 2010, FQHCs have reported that with more current 2010 data, all FQHCs qualify. According to the Medical Practices (Including Eligible Professionals), 70% percent of the centers indicate they are planning to apply for the Medicaid EHR Incentive Payment Program. This would result in a final estimate of 150+ eligible professionals from FQHCs.

For non-PCCM providers, Medicaid claims data were examined to determine the number of Members, visits, charges and payments associated with each servicing provider and site. Claims for services provided in calendar year 2009 and processed by June 2010 were analyzed. Claims were aggregated to the servicing provider noted on the claim. Services were aggregated by place of service as those occurring in and outside of the hospital. High and low patient volumes are based on work relative value units (wRVUs). CMS 2009 work RVUs were applied to the claim lines and totaled for each servicing provider. (Provided by the CMS website:

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<https://www.cms.gov/PhysicianFeeSched/PFSRVF/list.asp>). A commonly available source of physician productivity data was used as a benchmark. Because common experience in Maine is that providers generally do not meet average national benchmarks, the national 25th percentile wRVU figures were selected as the benchmark.

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Medical Practices EHR Adoption—Meeting Meaningful Use

In year two, Eligible Professionals must attest to and electronically submit quality data on a variety of Meaningful Use capabilities to receive incentive payments

Medical Practices (Including Eligible Professionals) – Practice status in meeting selected Meaningful Use Criteria		
Meaningful Use Requirement	Criteria for Eligible Professionals	Status among respondents with HER
CPOE	80 percent of all orders	69% meet criteria
Drug-drug, drug allergy, drug formulary checking	All capabilities enabled	35% drug-drug 34% Drug-allergy Formulary 18% (at point of prescribing)
Maintain up-to-date problem list	80 percent of patients have at least one entry or indication of no problems	84% meet criteria
Generate and transmit e-Rx	At least 75 percent permissible Rx transmitted electronically	60% meet criteria
Maintain active medication and allergy list	80 percent of patients seen have at least one entry or indication of none.	89 % meet criteria for medications 92% meet criteria for allergies
Record demographics	80 percent of patients seen have gender, race, DOB, ethnicity, preferred language, insurance recorded.	Age DOB 97% meet Gender 97% meet Race 57% meet Ethnicity 47% meet Language 45% meet Insurance 95% meet
Record vital signs	80 percent of patients 2+ years have BP and BMI; growth chart for ages 2-20	BP-83% meet BMI-63% meet Chart-58%
Record smoking status	80 percent of patients over 13 seen	62% meet criteria (tobacco use)

Medical Practices (Including Eligible Professionals) – Practice status in meeting selected Meaningful Use Criteria		
Meaningful Use Requirement	Criteria for Eligible Professionals	Status among respondents with HER
Incorporate test results into HER	50 percent of results expressed as a number or positive/negative. Generate at least one report	76% meet criteria
Generate list of patients with specific conditions	Generate at least one report	88% meet criteria
Report quality measures to CMS and the States	For 2011, capture required data electronically and provide aggregate numerator and denominator by attestation, for 2012 and later, submit electronically	56% using EHR 17% using EHR and paper chart
Send reminders for preventive/follow-up care	Send reminders for preventive/follow-up care to 50 percent of patients age 50+	52% meet criteria 14% send reminders, but for fewer than 50% over 50 years of age
Implement clinical decision support rules related to clinical priority, track compliance	Implement five rules and track compliance	
Check insurance eligibility	Check eligibility electronically for 80 percent patients seen	38% meet criteria (30% check eligibility for fewer than 80% of patients)
Submit claims electronically	File 80 percent of claims electronically	84% meet criteria
Provide patients with their health information on request	80 percent of patients who make the request receive it within 48 hours; test results, problem list, med list, allergies	29% usually provide within 48 hours of request (electronic copy) 59% do not have or do not know if they have this capability.
Provide access to clinical summaries	Clinical summaries provided for 80 percent of office visits	28% meet 20% provide for fewer than 80% of visits

Medical Practices (Including Eligible Professionals) – Practice status in meeting selected Meaningful Use Criteria		
Meaningful Use Requirement	Criteria for Eligible Professionals	Status among respondents with HER
Provide timely access to new results	10 percent of all patients seen receive access to lab results, problem list, medication and allergy lists within 96 hours of provider receipt	9% meet (electronic access)
Exchange meaningful clinical information with care team	One test of capability to exchange key clinical information	A small percentage of practices routinely exchange electronic data with other providers, hospitals and other care settings
Perform medication reconciliation	Provide at least 80 percent of encounters and care transitions	45% meet criteria (18% for fewer than 80% of encounters and transitions; 37% do not or are not sure)
Provide summary record at transitions in care and referrals	Provide at least 80 percent of encounters and care transitions in care and referral	43% meet criteria (7% for fewer than 80% of transitions or referrals; 51% do not or are not sure)
Information to immunization registries submitted electronically	Capability to submit data to immunization registries and submission where required and accepted (Stage 1-at least one test of electronic submission capability)	4% report sending electronic data to immunization registries electronically

Footnote: 19

Acute Care Hospitals and Meeting Meaningful Use

In year two of their participation in the Medicaid EHR Incentive Payment Program, hospitals must attest to and electronically submit quality data on a variety of Meaningful Use measures to receive an EHR incentive payment from MaineCare. .

Acute Care Hospitals – Hospital status in meeting selected Meaningful Use Criteria		
Meaningful Use Requirement	Criteria for Eligible Professionals	Status among respondents with HER
CPOE	10 percent of all orders	Lab orders – 70% meet criteria Radiology – 70% meet criteria Medications– 66% meet criteria Consultation–39% meet criteria Nursing – 65% meet criteria
Drug-drug, drug allergy, drug formulary checking	All capabilities enabled	47% drug-drug 47% Drug-allergy Formulary 20% (at point of prescribing)
Maintain up-to-date problem list	80 percent of patients have at least one entry or indication of no problems	54% meet criteria
Maintain active medication and allergy list	80 percent of patients seen have at least one entry or indication of none	81 % meet criteria for medications 86% meet criteria for allergies
Record demographics	80 percent of patients admitted have gender, race, DOB, ethnicity, preferred language, insurance recorded, and cause of death recorded	Name address contact info. 100% meet Gender and DOB 100% meet Race and ethnicity 86% meet Preferred language 81%meet Insurance 100% meet Cause of death 56% meet

Acute Care Hospitals – Hospital status in meeting selected Meaningful Use Criteria

Meaningful Use Requirement	Criteria for Eligible Professionals	Status among respondents with HER
Record vital signs	80 percent of patients 2+ years have BP and BMI; growth chart for ages 2-20	Height, weight, BP - 82% meet criteria Calculate display BMI - 68% meet criteria Growth chart - 43% meet criteria
Incorporate test results into HER	50 percent of results expressed as a number or positive/negative	Of respondents with EHR providing data: Lab. Reports – 100% meet criteria Radiology reports– 100% meet Radiology images – 76% meet Diagnostic test results – 77% Diagnostic test images – 28%
Report quality measures to CMS and the States	For 2011, capture required data electronically and provide aggregate numerator and denominator by attestation, for 2012 and later, submit electronically	To outside Organization 15% using EHR only 74% using EHR and paper chart To Public health agencies 63% (electronically submit)
Implement clinical decision support rules related to clinical priority, track compliance	Implement five rules and track compliance	** (not outlined for Stage 1 of Meaningful Use)
Check insurance eligibility	Check eligibility electronically for 80 percent patients admitted	79% meet criteria 7% check, but for <80%
Submit claims electronically	File 80 percent of claims electronically	96% meet criteria
Provide patients with their health information on request	80 percent of patients who make the request receive it within 48 hours; test results, problem list, med list, allergies, discharge summary, procedures	18% meet criteria 25% provide information but to <80% 57% Do not provide patients

Acute Care Hospitals – Hospital status in meeting selected Meaningful Use Criteria

Meaningful Use Requirement	Criteria for Eligible Professionals	Status among respondents with HER
Provide patients with discharge information	80 percent of patients who request it, receive electronic copy of discharge instructions	Medication list – 82% meet Discharge summary – 93% meet
Exchange meaningful clinical information with care team	One test of capability to exchange key clinical information (cannot share EHR)	96% (EHR not specified)
Perform medication reconciliation	Provide at least 80 percent of encounters and care transitions	Nine of the 15 hospitals reporting data on this item meet criteria
Provide summary record at transitions in care and referrals	Provide summary care record at 80 percent of transitions in care and referral	7% meet criteria 18% provide, but for less than 80% percent of transitions/referrals

When asked to select the two most challenging Meaningful Use criteria to achieve, hospitals most frequently selected the following:

- Generate the numerator and denominator data for quality reporting directly from EHR (12 hospitals)
- Perform medication reconciliation across settings of care (10 hospitals)
- Exchange clinical information with other providers (9 hospitals)
- Implement CPOE at the specified level of sophistication (7 hospitals)
- Implement clinical decision support rules, give patients access to their data in electronic form, and generate problem lists using codified data sets (6 hospitals)
- Meet requirements for all quality reporting measures (1 hospital)
- Submit data to public health agency (1 hospital)

Footnote: 21**Dental Practices Meeting Meaningful Use**

The level of dental provider readiness to meet Meaningful Use criteria is difficult to assess, in part, because the terminology used in the draft regulations is not generally used in dental practices. For example, Meaningful Use criteria include several items related to using information to improve quality, safety, efficiency, and reducing health disparities. One of these criteria is that a Computerized Provider Order Entry (CPOE) be used for at least 80 percent of orders. CPOE software is widely available for physician practices and hospitals, but CPOE capabilities are rarely built into PMS/EDRs.

The dental survey data indicate that dental practices with PMS/EDR systems use the systems to record some data that is relevant to the Meaningful Use criteria objectives related to improving quality, safety, and efficiency. Of the dental practices with PMS/EDR, two-thirds of the respondent practices indicated using their systems with more than 80 percent of their patients, to record several data elements included in Meaningful Use criteria.

Dental Practices – Recorded Elements in PMS/EDR System	
Gender and date of birth	100%
Insurance type	100%
Problem lists	53%
Medication lists	54%
Allergy lists	68%
Blood pressure	30%
Smoking status	37%

Seventy-one percent of the practices indicated that they routinely file insurance claims electronically for patients, while only 16 percent met the criteria for routinely checking insurance eligibility electronically. Two-thirds use their systems to send reminders to patients for preventive/follow-up care.

These data show that a minority of dental practices meet the Meaningful Use criteria related to engaging patients in their health care. For example, 30 percent of the respondents with PMS/EDR systems reported providing patients with an electronic copy of their dental information upon request within 48 hours of the request. Nineteen percent of practices with systems reported providing clinical summaries for most of their patients, while 68 percent do not have this functionality in their PMS/EDR system or it is turned off.

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Footnote: 30

MaineCare used guidance provided by CMS in the State Medicaid Directors Letter distributed on September 1, 2009 to create the SMHP “To-Be” Environment Landscape Deliverable. Below is a crosswalk of the CMS guidance and the corresponding SMHP Section:

question Number	CMS Guidance	“To-Be” Landscape Report Section
1.	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.	Section B, Parts 1 and 2
2.	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?	Section B, Parts 1 and 2
3.	How will Medicaid providers interface with the SMA IT system as it relates to the EHR Incentive Program (registration, reporting of MU data, etc.)?	Section B, Parts 1 and 2
4.	Given what is known about HIE governance structures currently in place, what should be in place by 5 years from now in order to achieve the SMA’s HIT/E goals and objectives? While CMS does not expect the SMA to know the specific organizations will be involved, etc., CMS 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.	Section B, Parts 1 and 2
5.	What specific steps is the SMA planning to take in the next 12 months to encourage provider adoption of certified EHR technology?	Section B, Parts 1 and 2
6.	** 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?	Section B, Parts 1 and 2
7.	How will the SMA assess and/or provide technical assistance to Medicaid providers around adoption and meaningful use of certified EHR technology?	Section B, Parts 1 and 2

CMS Guidelines Cross Walk

Question Number	CMS Guidance	• “To-Be” Landscape Report Section
8.	** How will the SMA assure that populations with unique needs, such as children, are appropriately addressed by the EHR Incentive Program?	Section B, Parts 1 and 2
9.	If the State included in a description of a HIT-related grant award (or awards) in Section A, 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.?	Section B, Parts 1 and 2
10.	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.	Section B, Parts 1 and 2

Footnote: 31

MaineCare HIT Visioning Session Participants

Below is a complete list of the participants that were invited and/or attended the DHHS Program Director, MaineCare Members, and MaineCare Provider Stakeholder visioning sessions.

DHHS Program Directors Stakeholder Group

DHHS Program Directors Stakeholder Group	Organization
Stephen Meister, M.D.	Maine CDC
Jane Gallivan	Office of Adults with Cognitive and Physical Disabilities Services
Diana Scully	Office of Elder Services
Ron Welch	Office of Adult Mental Health Services
Jay Yoe	Office of Quality Improvement
Joan Smyrski	Office of Children's Services
Denise Brigham	Office of Information Technology
Muriel Littlefield	Commissioners' Office
Sue MacKenzie	DHHS Audit
Jim Lopatosky	Office of Information Technology
Tim Lawrence	DHHS Audit
Cindy Hopkins	Office of Information Technology
Tony Marple	MaineCare
Phil Saucier	Governor's Office of Health Policy and Finance
Rod Prior	MaineCare
Dawn Gallagher	MaineCare
James Beougher	Office of Children and Family Services
Guy Cousins	Office of Substance Abuse
Herb Downs	Commissioners' Office
Barbara VanBurgel	Office of Integrated Access and Support
Marya Faust	Office of Adult Mental Health Services
Catherine Cobb	Commissioners' Office
Sally Fingar	Deloitte Consulting LLP
Laura Lisien	Deloitte Consulting LLP

MaineCare Member Stakeholder Group

MaineCare Member Stakeholder Group	Organization
Kait Bragdon-Roe	MaineCare Member
Rose Strout	MaineCare Member
Jess Vear	MaineCare Member
David McCluskey	Community Care
Marcia Cooper	Brain Injury Information Network
Leo Delicata	Legal Services for the Elderly
Misty Marston	Legal Services for the Elderly
Andrea Irwin	Consumers for Affordable Health Care
Lisa Webber	Consumers for Affordable Health Care
Helen Bailey	Disability Rights Center
Kim Moody	Disability Rights Center
Julia Bell	Maine Developmental Disabilities Council
Barbara Rankin	Maine Association of Interdependent Neighborhoods
Jim Leonard	Office of the State Coordinator
Phil Saucier	Governor's Office of Health Policy and Finance
Matt Twomey	HIV Advisory Committee
Tony Marple	MaineCare
Rod Prior	MaineCare
Sarah Stewart	MaineCare
Jim Lopatosky	Office of Information Technology
Cindy Hopkins	Office of Information Technology
Denise Brigham	Office of Information Technology
Jaye Martin	Legal Services for the Elderly
Anne Smith	Legal Services for the Elderly
Jamie D'Errico	Consumers for Affordable Health Care
Ana Hicks	Maine Equal Justice Partners
Jack Comart	Maine Equal Justice Partners
Chris Hastedt	Maine Equal Justice Partners
Carol Coruthers	National Alliance for Mentally Ill (NAMI)
Nikki McLean	MaineCare Member
Marina Thibeau	Office of Legal Affairs
Stefanie Nadeau	MaineCare
Dawn Gallagher	MaineCare
Sally Fingar	Deloitte Consulting LLP
Laura Lisien	Deloitte Consulting LLP

OIT Stakeholder Group

OIT Stakeholder Group	Organization
Jim Lopatosky	Office of Information Technology
Cindy Hopkins	Office of Information Technology
Denise Brigham	Office of Information Technology
Jim Leonard	Office of the State Coordinator
Phil Lindley	ConnectME Authority
Lisa Tuttle	Commissioner's Office - Finance
Stefanie Nadeau	MaineCare
Dawn Gallagher	MaineCare
Rod Prior, MD	MaineCare
Ben Laflin	MaineCare
Aimee Campbell-O'Conner	MaineCare
Sally Fingar	Deloitte Consulting LLP
Mary Sheridan	Deloitte Consulting LLP
Susan Cobb	Deloitte Consulting LLP

MaineCare Provider Stakeholder Group

MaineCare Provider Stakeholder Group	Organization
Daniel Burgess	Maine General Health
Josh Cutler, MD	Dirigo Health
Lori Geiger	CBHS
Ralph Johnson	Franklin Memorial Hospital
Laurie Kane-Lewis	DFD Russell Medical Centers
Robert Kohl	Maine Primary Care Association
Kevin Lewis	Maine Primary Care Association
John Yindra, MD	DFD Russell Medical Centers
David Silsbee	Cary Medical Center
Steven Thebarge	Dorthea Dix & Riverview State Hospitals
Donald Krause, MD	St. Joseph Hospital
Lawrence, Legutko	
Sandra Yarmal	Pleasant Point Health Center

MaineCare Provider Stakeholder Group (contd)

MaineCare Provider Stakeholder Group	Organization
Patricia Knox-Nicola	Penobscot Nation Health Department
Martha Elbaum-Williamson	Muskie Institute
Charles Dwyer	DHHS
Robin Chacon	MaineCare
Benjamin Laflin	MaineCare
Tim Lawrence	Commissioner's Office- Audit
Sue MacKenzie	Commissioner's Office- Audit
Jim Leonard	Office of the State Coordinator
Rod Prior	MaineCare
Dawn Gallagher	MaineCare
Stefanie Nadeau	MaineCare
Denise Brigham	Office of Information Technology
Shelly Drew, BSN	Millinocket Regional Hospital
Catherine Bruno	Eastern Maine Health care Systems
Tanya Freeman	Central Maine Health care
Barry Blumenfeld	MaineHealth
Jeff Aalberg, MD	MMC Family Medicine
Jane Pringle, MD	Internal Medicine Clinic
Patrice Thibodeau, MD	MMC Internal Medicine/Pediatric Clinic
Debra Pyle	MMC Outpatient Department
Paul Klainer	
Patrick Douglas	
Andy Cook	
Ralph Swain	
Andrea Hanson	Indian Township Health Center
Ann Stevens	Houlton Band of Maliseet Indians Health Department
John Ouellette	Micmac Service Unit , Indian Health Service
Perry Ciszewski	IHS/ NAS
Stephen Meister, MD	Maine CDC
Terry Sandusky	OACPDS

MaineCare Provider Stakeholder Group (contd)

MaineCare Provider Stakeholder Group	Organization
Diana Scully	Office of Elder Services
Ron Welch	OAMHS
Jay Yoe	Office of Quality Improvement
Joan Smyrski	Office of Children's Services
James Beougher	OCFS
Jim Lopatosky	Associate CIO
Cindy Hopkins	DHHS Director of Applications
Barbara VanBurgel	OIAS
Marya Faust	OAMHS
Catherine Cobb	Commissioner's Office/Department of Licensing and Regulatory Services
Guy Cousins	OSA
Herb Downs	Commissioner's Office- Audit
Phil Saucier	Governor's Office of Health Policy and Finance
Russel Begin	Finance
Geoffrey Green	Commissioner's Office- Operations
Muriel Littlefield	Commissioner's Office
Dora Anne Mills	Maine CDC
David Hellmuth	Commissioner's Office- Audit
Marc Fecteau	Commissioner's Office- Audit
Dev Culver	HealthInfoNet
Shaun Alfreds	HealthInfoNet
Tony Marple	MaineCare
Andy Coburn	Muskie Institute
Sally Fingar	Deloitte Consulting LLP
Laura Lisien	Deloitte Consulting LLP

MaineCare HIT Visioning Session Outcomes

Below is a complete list of the visioning statements that were discussed by the DHHS Program Director, MaineCare members, and MaineCare provider stakeholder groups during the visioning sessions MaineCare conducted throughout Spring 2010.

Stakeholder Group	Vision Category	Vision Session Outcomes
MaineCare Providers	Governance	The HIE and HIT governance structure and steering committees should be used to develop collaborative governance at the State, private sectors and public levels.
	Data Standardization	To achieve Meaningful Use, providers will need to capture and enter compliant data into their EHR. Some providers may find it challenging to capture the type of data necessary under Meaningful Use.
	Participation in the HIE Data Exchange	One of the State’s shortcomings is the lack of participation of FQHCs in the State’s HIE. The State’s goal is to have all of the FQHCs participate with the HIE.
	Systems Interoperability	<p>Q: What can MaineCare be doing that they are not already doing to help the provider community?</p> <p>A: MaineCare can do the following to help the provider community:</p> <ul style="list-style-type: none"> • Provide the ability for providers to access information for the purposes of research, determining patterns of care, and evaluating cost. Participants also discussed having access to claims data available to do population analysis by disease classification, region, utilization of services, etc. • Assist providers with a better way to access IMMEDIATE to avoid double entry of patient information • Improve the utilization of IMMEDIATE. It is estimated that only 40% of the providers participate in the registry today. One of the reasons for low participation is IMMEDIATE’s algorithm which presents challenges for EHR systems to accept its data logic • Improve electronic access to immunization records. The Maine CDC may not have accurate patient immunization information. A recommendation was made for the State to utilize the HIE to store all vaccination information • Provide a central location for infection control and prevention information through the HIE. • Integrate Indian Health Services (IHS) data into the • State systems to allow for sharing of information. IHS

Stakeholder Group	Vision Category	Vision Session Outcomes
		<p>is developing a HL7 interface to facilitate the exchange of information</p> <ul style="list-style-type: none"> • Improve access to insurance verification. Insurance verification is an administrative burden especially when additional staff is hired to specifically focus on insurance verification via the phone. MaineCare is working to map insurance information to the HIE with the goal to eliminate the need to contract with external vendors and clearinghouses to conduct insurance verification • Reassess physician Medicaid reimbursement. Attendees commented that the current Medicaid reimbursement does not take into consideration the amount of time needed to capture data for Meaningful Use and the impact it has on patient volume
	Comprehensive Data Exchange	<p>An area that presents a particular challenge for providers is managing care between behavioral health services and acute care facilities. HITECH requires acute care hospitals to implement certified EHRs that have the ability to exchange patient information between entities. However, mental health, substance abuse, long-term care and nursing facilities are excluded from HITECH and are excluded from the interoperability requirement. The exchange of patient information can be an issue when there are multiple entities providing care. The health data exchanged should include all health information, including mental health, substance abuse, long-term care, and HIV data.</p>
	Legislation	<p>Providers would like legislation in place to lessen their liability for a consumer's release (or non-release) of personal health information needed to provide health care services.</p>
	Communication, Education and Outreach	<p>Providers would like the State to help in outlining and reviewing the final rule once available. Assisting providers in understanding the ARRA/HITECH Meaningful Use incentive payments and eligibility requirements should be a joint responsibility between MaineCare and the REC.</p>
	Communication, Education and Outreach	<p>The SMHP should include a robust plan to help providers in adopting EHR technologies, as a major issue for MaineCare providers is widespread adoption of the technology.</p>
	Communication, Education and Outreach	<p>The State should encourage hospitals and/or physicians to share patient information. To do so, the State will need to develop communication strategies to</p>

Stakeholder Group	Vision Category	Vision Session Outcomes
		<p>gain the trust of the hospitals and providers. A strong communication effort will be needed to illustrate the benefits in engaging in the sharing of secure patient information.</p>
<p>MaineCare Members</p>	<p>Comprehensive Data Exchange</p>	<p>Members would like all health information to be included in EHRs, including mental health, substance abuse and HIV-related drugs.</p> <ul style="list-style-type: none"> • The Attorney General (AG) has recommended that all classes of psychoactive medications be removed from the filled prescription information which Goold Health System, Maine’s current PBM, is releasing each week to the HIE. Furthermore, mental health, substance abuse, and long-term care providers are not included in the eligibility requirements for the EHR Incentive Program • Members believe that all drugs should be reported to allow for the most comprehensive and informed care possible by providers. However, there needs to be stringent security and privacy controls around the data to protect the consumer • The exclusion of mental health drugs in order to prevent discrimination is understandable, but it may adversely impact the consumer and still result in discrimination • The member community generally feels disappointment that mental health and HIV data is not included in reporting requirements. They feel disappointment because if mental health, substance abuse and long-term care providers are not included in the EHR Incentive Program then the benefits of HIT may not be fully realized
	<p>Access to Personal Health Information</p>	<p>Members believe that HIT should be accessible and affordable to all consumers.</p> <ul style="list-style-type: none"> • Some members may not have access to computers or cannot afford access to their records (in the case where there is a fee to access medical records). In the development of policies and HIT plans, this should be considered and alternative means to obtaining and sharing data, especially at the individual level, need to be developed • The medical costs that are being saved as a result of HIT should, at least in part, go towards providing technology or alternative paper-based means of obtaining health records for those who do not have access to technology

Stakeholder Group	Vision Category	Vision Session Outcomes
	Access to HIT	<p>Access to HIT should be timely, easy and complete, especially in emergency situations.</p> <ul style="list-style-type: none"> • A method to handle emergency care situations needs to be included in the SMHP (i.e., “Break the Glass”) • A card that members swipe at the point of care (like their MaineCare member card) would work in addition to the traditional HIE/internet access • Another option is to provide consumers with USB storage drives containing their EHRs • Language, cultural and disability barriers need to be examined and considered when developing a plan for HIT
	Other Potential Uses for HIT	<p>HIT can be used to send text messaging by providers to certain populations. (e.g., expectant mothers or those with high cholesterol) reminding the member of the proper care or a reminder to go see their doctor. MaineCare should coordinate with the provider community to make this happen.</p>
	Privacy and Security	<p>Members should have the ultimate choice, via an opt-in/opt-out policy, in sharing their health information. Reasons for having opt-in options for MaineCare members include:</p> <ul style="list-style-type: none"> • The ability for providers and consumers to coordinate medications • The ability for consumers to access metrics around their care (e.g., for mental health care that is regulated, consumers may be able to login and see how many visits they have left) • Not all members would opt-in, but they should at least be given the choice • Access to clinical quality measures, x-rays and tests should be included in EHRs and consumers should also be allowed to decide whether or not to share this information via a opt-in/opt-out mechanism • Opt-in/Opt-out choices should be made available for the HIE as a whole and at a more granular level allowing consumers to opt-in or opt-out portions of their health information • Additional assurances/policies also need to be in place to ensure that discrimination will not occur as a result of one’s opt-in/opt-out choice

Stakeholder Group	Vision Category	Vision Session Outcomes
	Privacy and Security	<p>Members would like the ultimate choice for deciding access rights and control over their health information, including mental health, HIV and substance abuse information.</p> <ul style="list-style-type: none"> • Members should have ultimate control, ownership and access to all of their health information in EHRs. However, technology should still be developed to allow robust data sharing as the benefits for care coordination and reduced medical costs are significant • It should not be only an opt-in/opt-out choice that is granted to consumers, but also an ability to deny or grant access rights • The opt-in/opt-out policies that are developed to protect the consumer/member should not be a mechanism to deny care if incomplete information is provided or if the consumer decides to opt-out • Members should also have access to their medical records to help identify and correct errors that medical records sometimes contain
	Privacy and Security	<p>Adequate security and privacy controls need to be in place at all levels of HIT and HIEs.</p> <ul style="list-style-type: none"> • There are 3 levels of health information that all need to be coordinated and have the right level of security and privacy in place: <ol style="list-style-type: none"> 1. Personal health information that is currently collected electronically and via paper based methods represents an individual's medical history. This should be the most restrictive in terms of access and security and privacy controls. The consumer/individual should have ultimate control over the use and access of this information. 2. General health information that is found in medical records and is shared among providers. Security and privacy controls must be in place for general medical record information that is controlled by providers. Use of this data should be used for decision-making purposes and so that providers may better coordinate care. Since personally identifiable information is still linked to

Stakeholder Group	Vision Category	Vision Session Outcomes
		<p>this data, however, the consumer should have the choice as to what information is shared and who has access to it.</p> <p>3. Population health information that is collected and exchanged via an HIE. Other agencies may have access to this information and will be used for trending and analysis of general population health. Access to this information may be less restrictive as the personally identifiable information is not tied to this data.</p>
	Legislation	<p>Legislation around mental health and HIV data need to be updated. The laws are general and allow for many interpretations, but they are still outdated and do not necessarily reflect the needs and wants from those that the law is supposed to protect- especially in the case of allowing Mental Health and HIV data to be shared.</p>
	Communication, Education and Outreach	<p>HIT education, especially around EHRs and personal health information, should come from the State so that consumers may make the choice on whether or not to opt-in or opt-out their health information in an informed manner.</p>
	Communication, Education and Outreach	<p>Members would like to be an active voice in the planning and implementation of HIT and the HIE. Member voices should be heard directly, not by third parties acting on the behalf of members.</p> <ul style="list-style-type: none"> • MaineCare wants active participation from members and will plan future sessions that will involve their attendance • OSC Steering Committee team meetings are held on a monthly basis and welcomes member participation
DHHS Program Directors	Interoperability	<p>While the incentive payments are attached to eligible health care providers, the HIT vision should not be limited to only those outlined as eligible professionals and hospitals. Program directors believe that they have a collective job to better connect our systems, applications and data to benefit all health care workers, including case workers, behavioral health, long-term care and other professionals not included in the</p>

Stakeholder Group	Vision Category	Vision Session Outcomes
		proposed/final rule.
	Interoperability	<p>Implementing a secure email system among all providers to aid in the exchange of clinical information and in the decision making process is a high priority for DHHS programs.</p> <ul style="list-style-type: none"> The systems that are servicing adult services are often built in a single system. Providers can share clinical and patient information using email. However, the email system is often not available. Program directors would like to see a secure email system among all providers. There is a risk of having incomplete information if this is implemented across only a subset of providers, such as only those eligible for incentive payments
	Interoperability	<p>Having a single portal for providers to obtain HIT information is a high-priority goal.</p> <ul style="list-style-type: none"> In provider practices, there are many third party payers & providers who may have different systems. In order to consolidate and streamline HIT and the EHR Incentive Program, state systems can be leveraged, such as the HIE, MIHMS, and others, to provide a single repository and point of contact for HIT data, information, and the EHR incentive payment program
	Interoperability	<p>Maine's MMIS system, MIHMS, may be leveraged by providers to obtain clinical information.</p> <ul style="list-style-type: none"> Currently, MIHMS may only be accessed by MaineCare. However, the system is capable, with some modification, of producing reports containing some clinical information which may be accessed by providers. Robust system access and security will need to be put into place to make this happen
	Interoperability	<p>DHHS Adult Services Program Directors want their members to be on a comprehensive wellness path.</p> <ul style="list-style-type: none"> Making sure patients receive comprehensive services is of critical importance to us. Currently, this is a challenge given the multiple systems and reports that case managers have to navigate in order to obtain the clinical information they need to manage member health care

Stakeholder Group	Vision Category	Vision Session Outcomes
		<ul style="list-style-type: none"> • Pharmacy is another example of manual process that is less than adequate. Case managers often do not know the health-related outcomes due to lack of coordinated technology
	Interoperability	<p>Coordination and data exchange between disparate systems is a critical element to the State's HIT vision.</p> <ul style="list-style-type: none"> • Access to data and information is the primary need, the technology and infrastructure of data is a secondary need • Currently, program directors do not have access to certain information needed to effectively manage programs. Program directors would like to have access to certain patient data for coordination of care. Presently the lack of coordination between disparate systems causes a lot of work inefficiencies, which ultimately places a burden on the staff. Program directors feel that having access to integrated technology systems will ultimately improve their ability to address member needs
	Access to Data	<p>Having the ability to process data rapidly is a top priority.</p> <ul style="list-style-type: none"> • There are certain routine data queries that one can be given access to within a technology system. In order to receive data in a timely manner, these systems can be leveraged to obtain aggregated data • Having the ability to process and access data rapidly is critical for program directors. This becomes apparent in the instances when members need emergency care. When members visit the emergency room, it is imperative that case managers, and even the patients themselves, have the ability to access their data within various HIT systems, so that care and medications can be coordinated rapidly, especially in life or death situations
	Other Potential Uses for HIT	<p>A potential future use of HIT is to use it as a vehicle for early health screening and intervention.</p> <ul style="list-style-type: none"> • Some members, with both physical and mental health issues, have a higher mortality rate. This

Stakeholder Group	Vision Category	Vision Session Outcomes
		<p>raises a question of how HIT can be used as a vehicle to establish criteria for an early intervention system. When health care intervention occurs, health care costs go down as well as mental health issues. So using HIT as an early screening and intervention vehicle needs to be an important part in the future uses of health care technology</p>
	<p>Other Potential Uses for HIT</p>	<p>HIT may be leveraged to facilitate longitudinal health care relationships in order to better meet the comprehensive care needs of our members.</p> <ul style="list-style-type: none"> • If a patient has heart disease in addition to mental health problems, it is critical for providers to coordinate care so that each ailment is treated and addressed. Patients need a medical home which will coordinate this care. For some people, a Primary Care Physician (PCP) may not be needed. A mental health organization may be better able to provide coordination of care in a longitudinal manner. HIT will be a critical tool used by those providers coordinating comprehensive care for MaineCare providers
	<p>Systems Integration</p>	<p>Clinical care summaries are a critical aspect of HIT that DHHS would like to implement.</p> <ul style="list-style-type: none"> • Program Directors would like access to critical care summaries that includes information regarding medications and interactions between PCP and specialist. Duplication of medications and drug interactions is a large concern and clinical care summaries would help in managing programs • Clinical care summaries will also help to prevent “doctor shopping”
	<p>Security and Privacy</p>	<p>The EHR incentive payment program and all other HIT initiatives need robust security and privacy policies and controls.</p> <ul style="list-style-type: none"> • With mental health, HIV, substance abuse and other protected groups, there are legal considerations that need to be reviewed. Data privacy statutes need to be reviewed and even modified. For instance, mental health does not share information in state systems as there is

Stakeholder Group	Vision Category	Vision Session Outcomes
		<p>strict control of the member data. There are Federal laws and certain groups which are protected. Members and providers would like these restrictions lifted, with robust security and privacy policies in place, so that they may benefit from care coordination that is offered through HIT</p>
	<p>Communication, Education and Outreach</p>	<p>MaineCare should work collaboratively with providers to answer their pertinent questions. The state will leverage its website and existing email systems to communicate and educate providers on the EHR incentive payment program and other HIT initiatives.</p>
	<p>HIT Initiative Coordination</p>	<p>Planning and coordination among all HIT initiatives and grant funding is of critical importance.</p> <ul style="list-style-type: none"> In the case where current grants are dependent upon technology, there may be an opportunity for thorough planning to ensure coordination between HIT planning and the ongoing grant-related technology projects in order to aid in transparency
	<p>HIT Initiative Coordination</p>	<p>Coordination of program initiatives and funding is imperative as DHHS begins planning for HIT and the EHR Incentive Program.</p> <ul style="list-style-type: none"> There are many initiatives, including ICD-10, MIHMS and PBM that are happening concurrently. MaineCare is making a conscious effort to coordinate these endeavors. However, there is no global strategy to connect all of these initiatives. Part of the SMHP will be to coordinate all health care technology initiatives in each of the DHHS offices so work efforts are not duplicated
	<p>HIT Initiative Coordination</p>	<p>Coordination with the REC and HIN is critical to DHHS' success in administering the EHR Incentive Program and encouraging the adoption of HIT.</p> <ul style="list-style-type: none"> The REC is responsible for assisting providers with Meaningful Use and technical assistance. They are also playing a large role in communication, education and outreach efforts. Coordination between the REC and MaineCare is crucial to administering the EHR Incentive

Stakeholder Group	Vision Category	Vision Session Outcomes
		Program and to the success of HIE
OIT	HIT Initiative Coordination	<ul style="list-style-type: none"> • OIT plans to allocate 80% of their HIT resources to DHHS and 20% to other statewide needs • Jim Lopatosky explained he believes OITs responsibilities for the HIT projects falls within the ‘technology behind the scenes,’ identifying systems associated with HIT, statewide system capability assessment and implementation, revision of duplicative systems and consolidations of those systems, and development of solutions for security and privacy issues within health information exchange • OIT has expressed the need to know exactly what the State of Maine wants to accomplish within the planned roll-out phases for both Medicaid and statewide initiatives • OIT is working on ways to integrate additional systems into MIHMS; this is a culture change-trying to combine data across systems and possibly have fewer systems eventually, but at least have them dump info into a central place-there are 300+ systems with data about an individual across the state <p>Broadband Capacity in the State of Maine:</p> <ul style="list-style-type: none"> • The Broadband program is a 5 year, Federally funded grant program designed to help enhance and develop the State of Maine’s broadband capacity • The State of Maine has received grant funding for ‘As-Is’ Landscape Assessment by mapping and planning for implementation of broadband in the most needed areas of the state • Phil Lindley, representative of ConnectME Authority’s Broadband program, has drafted a map of Maine indicating areas of capacity weakness in the State. He also has access to a list of all grant applicants, and grant recipients which includes their locations • Jim Leonard stressed the importance of contacting and evaluating priority providers ability to implement EHR, since the time frame for HIT incentive payments is limited; noting tribes have

Stakeholder Group	Vision Category	Vision Session Outcomes
		<p>a separate process to get funds</p> <ul style="list-style-type: none"> Phil Lindley informed the group that the Broadband program has included HIT within their RFP document <p>Concerns/Next Steps:</p> <ul style="list-style-type: none"> Cindy Hopkins (OIT) stated groups making decisions without consulting other state organizations who are impacted has been a problem in the past (“silos”) Lisa Tuttle (Commissioner’s Office – Finance) stated we need to consider the interactions of future Health care Reform initiatives as the groups HIT planning process continues to move forward Jim Lopatosky (OIT) suggested less focus on the MaineCare (Medicaid) HIT Incentive Programs; and considering other State needs for coordinated information such as public health functions
	<p>Infrastructure and Systems</p>	<p>OIT’s Infrastructure and Systems Vision:</p> <ul style="list-style-type: none"> DHHS services are client-centered and enable common information to be shared Operating costs are reduced by eliminating the duplication of business functions and data and their associated maintenance efforts Management of confidential and privileged data is enhanced by instituting standardized controls that limit access to authorized individuals and maintain audit trails of access and changes One of the highest priority areas for potential sharing within DHHS is the need for ‘Common Individual Identifiers’ <p>OIT’s Infrastructure and Systems Principles:</p> <ul style="list-style-type: none"> Significant classes of data that are used across multiple applications are collected and managed as a common asset rather than duplicated in each application Each class of shared data has a designated “authoritative source” application or service that is the reference point for current data, change histories and audit trails

Stakeholder Group	Vision Category	Vision Session Outcomes
		<ul style="list-style-type: none"> • Rather than making copies or directly accessing shared data, the preferred way to access shared data is through service modules that enforce the use of standardized business logic and access controls • Shared business functions and data have documented standards for names, syntax, content and meaning. DHHS standards are based on national standards wherever they exist • Shared data and services are managed to provide quality (correctness), timeliness and on-going improvements in behalf of other applications and business functions that use them • The group agreed that developing a Master Provider Index (MPI) will be needed as the HIT project moves forward --- a) need for analytics to show performance b) need to credential “staff” as Providers c) how to handle ‘a-typical’ providers <p>NOTE: Cindy Hopkins discussed the need for group collaboration on establishing a core set of ‘operating principles’</p>



MaineCare HIT Initiative Weekly Status Report

Week of: 1/24/2011 – 1/28/2011

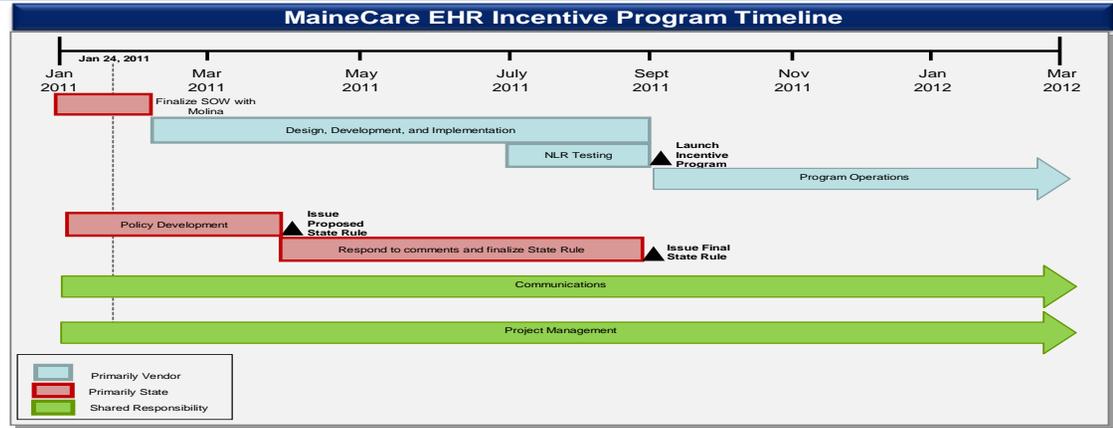
Overall Status:

Status Summary

- Awaiting SOW/change order response from Molina
- Awaiting approval of SMHP from CMS
- Finalizing recent communications about the MaineCare EHR Incentive Program including:
 - “Core” EHR Incentive Program Presentation
 - Internal talking points slide
 - 2nd email packet to provider associations
 - Presentation for 2/4 MeHAF Policy Leaders’ Academy
 - HIT website

Risks / Issues

- Need completed SOW/change order response from Molina to complete the IAPD, secure implementation funds, and proceed with implementation. Molina’s timeline must align to and support key CMS testing dates.
- Need to finalize key messages to ensure consistent communication to all stakeholders about the MaineCare EHR Incentive Program



Upcoming Activities

Description	Date
Submit CMS Monthly Report	1/31/2011
Revise and finalize key communications materials	2/4/2011
Receive and finalize SOW with Molina	2/9/2011
Submit IAPD to CMS	2/11/2011

Upcoming Key Meetings

Name	Purpose	Date
MeHAF Policy Leaders’ Academy	An overview of the MaineCare EHR Incentive Program to legislators	2/4/2011
Quality Counts “Ask the Experts” HIT Roundtable Webinar	Answer provider’s questions about the MaineCare EHR Incentive Program	2/10/2011
Maine Osteopathic Association Winter Conference	Present information about the MaineCare EHR Incentive Program to providers	2/11/2011 – 2/13/2011
MPCA Monthly Board Meeting	Present information about the MaineCare EHR Incentive Program to providers	2/15/2011



Overall Status	
Key Escalation Issues	
Accomplishments / Activities	
Key Accomplishments (Over Last Week)	Key Upcoming Activities (This Week)
<ul style="list-style-type: none"> Scheduled meeting with DHHS Policy Team on 2/2 to discuss new policy development timeframe Scheduled meeting with David Guiney (CMS) on 2/2 to discuss feedback on the SMHP 	<ul style="list-style-type: none"> Receive and review SOW/change order response from Molina Follow up with David Guiney on the status of the SMHP and the patient volume methodology Meet with policy group to discuss progress on drafting a state rule
Key Meetings	
Recent Interactions (Over Last Week)	Scheduled Interactions (This Week)
<ul style="list-style-type: none"> Spoke with CMS and the State of Kentucky to discuss the hospital incentive payment calculation 	<ul style="list-style-type: none"> Call with David Guiney (CMS) – 2/2 Meeting with OMS policy group – 2/2
Risks / Issues	
Risk / Issue	Resolution Strategy
Need completed SOW/change order response from Molina to complete the IAPD, secure implementation funds, and meet the program launch timeline	Continue to follow up with Molina on delivery of the SOW.

 On Track	 Off Track: Impact to Milestone		
 Off Track: Potential Impact to Milestone	 Complete		
Milestones			
Key Milestones	Start	Finish	Status
Revise SMHP and resubmit to CMS	12/14/2010	1/18/2011	
Submit CMS Monthly Report	1/26/2011	1/31/2011	
Receive, respond, and finalize SOW from Molina	1/25/2011 2/2/2011	2/9/2011	
Revise and submit IAPD to CMS for approval and funding	2/2/2011	2/4/2011 2/11/2011	
Design, Development, and Implementation	3/1/11	9/1/11	
NLR Testing	7/1/11	8/26/11	
Program Operations	9/1/11		



Overall Status
Key Escalation Issues

	On Track		Off Track: Impact to Milestone
	Off Track: Potential Impact to Milestone		Complete

Accomplishments / Activities	
Key Accomplishments (Over Last Week)	Key Upcoming Activities (This Week)
<ul style="list-style-type: none"> Revised the "core" presentation and internal talking points document Revised materials for Provider Association 2nd follow up email Finalizing revisions to the HIT website Coordinated communications with the HIN/MEREC 	<ul style="list-style-type: none"> Finalize the "core" presentation and internal talking points document Draft and finalize presentation for 2/4 MeHAF Policy Leaders Academy meeting Finalize and send materials for the Provider Association 2nd follow up email Post revisions to the HIT website
Key Meetings	
Recent Interactions (Over Last Week)	Scheduled Interactions (This Week)
<ul style="list-style-type: none"> Biweekly communications meeting with Sarah Stewart and Dawn Gallagher HIT website meeting with Shannon Martin and Linda Riddell 	<ul style="list-style-type: none"> Communications Coordination call with MaineCare and the MEREC – 1/31 Presentation at MeHAF Policy Leaders Academy- 2/4

Milestones			
Key Milestones	Start	Finish	Status
Complete communications plan and schedule	1/10/11	1/18/2011	
Finalize "core" presentation and internal talking points document	1/12/11	1/28/2011 2/2/2011	
Prepare materials for MeHAF Policy Leaders Academy	1/18/2011	2/2/2011	
Finalize and send materials for Provider Association 2 nd follow up email	1/12/11	1/28/2011 2/4/2011	
Finalize and publish HIT website updates	1/15/11	2/4/2011	
Prepare materials for MQC webinar	1/31/2011	2/9/2011	

Risks / Issues	
Risk / Issue	Resolution Strategy

PROJECT CALENDAR

Monday	Tuesday	Wednesday	Thursday	Friday
4/11	4/12	4/13	4/14	4/15
(E) CMS Communities of Practice Webinar (Topic: SMHP and IAPD), 3 - 4pm		(E) ONC HIT Policy Committee Meeting, 10am - 3pm	(E) MQC- Health IT Roundtable "Ask the Experts" Webinar, 12 - 1 pm	
4/18	4/19	4/20	4/21	4/22
State Holiday - Patriot's Day	State Shutdown Day			
(E) CMS HITECH All State Call (Topic: TBD), 1 - 2pm (E) CMS Communities of Practice Webinar (Topic: Regional Collaborative), 3 - 4pm		(E) ONC HIT Standards Committee Meeting, 9am - 3pm		
4/25	4/26	4/27	4/28	4/29
(E) CMS Communities of Practice Webinar (Topic: Auditing), 3 - 4pm				

APPENDIX B-3

PROJECT CALENDAR

5/2	5/3	5/4	5/5	5/6
(E) CMS HITECH All State Call (Topic: TBD), 1 - 2pm (E) CMS Communities of Practice Webinar (Topic: Meaningful Use), 3 - 4pm				
5/9	5/10	5/11	5/12	5/13
(E) CMS Communities of Practice Webinar (Topic: SMHP and IAPD), 3 - 4pm	NEW REC Franklin Memorial 1:30 - 5:30	(E) ONC HIT Policy Committee Meeting, 10am - 3pm	(E) MQC- Health IT Roundtable "Ask the Experts" Webinar, 12 - 1 pm	
		NEW REC Mt. Desert Hospital 2-6		
5/16	5/17	5/18	5/19	5/20
(E) CMS HITECH All State Call (Topic: TBD), 1 - 2pm (E) CMS Communities of Practice Webinar (Topic: Regional Collaborative), 3 - 4pm		(E) ONC HIT Standards Committee Meeting, 9am - 3pm		

PROJECT CALENDAR

5/23	5/24	5/25	5/26	5/27
				State Shutdown Day
	(E) Third Annual CMS Multi-State Medicaid HITECH Conference, Baltimore, MD	(E) Third Annual CMS Multi-State Medicaid HITECH Conference, Baltimore, MD	(E) Third Annual CMS Multi-State Medicaid HITECH Conference, Baltimore, MD	
		NEW REC Mayo Hospital 2-6		
5/30	5/31	6/1	6/2	6/3
State Holiday - Memorial Day				
(E) CMS HITECH All State Call (Topic: TBD), 1 - 2pm (E) CMS Communities of Practice Webinar (Topic: Auditing), 3 - 4pm		NEW REC Goodall Hos. 2-6		
6/6	6/7	6/8	6/9	6/10
(E) MaineCare MEREC EHR Incentive Program Communications Coordination Meeting, 4 - 5pm				

APPENDIX B-3

PROJECT CALENDAR

(E) CMS Communities of Practice Webinar (Topic: Meaningful Use), 3 - 4pm		(E) ONC HIT Policy Committee Meeting, 10am - 3pm	(E) MQC- Health IT Roundtable "Ask the Experts" Webinar, 12 - 1 pm	
6/13	6/14	6/15	6/16	6/17
(E) CMS HITECH All State Call (Topic: TBD), 1 - 2pm(E) CMS Communities of Practice Webinar (Topic: SMHP and IAPD), 3 - 4pm				
6/20	6/21	6/22	6/23	6/24
(E) CMS Communities of Practice Webinar (Topic: Regional Collaborative), 3 - 4pm		(E) ONC HIT Standards Committee Meeting, 9am - 3pm		
6/27	6/28	6/29	6/30	7/1

MaineCare's EHR Incentive Program: External Communications Schedule									
JANUARY, 2011									
Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
01	Conference Call: Center for Medicare and Medicaid Services (CMS) HITECH Call	First Medicaid EHR Incentive Payments and Other Topics	1/10/2011	1/10/2011	Participant	State Medicaid Agencies	(a) The first week of registration for Medicaid EHR Incentive Programs and the first incentive payments (b) Federal funds for health IT planning activities vs. federal funds for health IT implementation activities (c) The CMS contractor providing technical assistance to the States around their incentive programs	CMS	CMS
02	Email: Email to Provider Associations, Part 1	Provider Association Meeting Follow-up, Part 1	1/11/2011	1/13/2011	Written	Provider Associations	"Thank you" for feedback on communications planning; Patient Volume Calculation information and letter of support; Feedback on spreadsheet to identify potentially eligible providers	Deloitte HIT Team	Tony Marple
03	Webinar: Maine Quality Counts (MQC) Webinar: "Health IT Roundtable 'Ask the Experts' Webinar, Part 1"	Program Requirements	1/13/2011	1/13/2011	Participant	Provider Associations MaineCare Providers Other interested parties	Share information about EHRs, Meaningful Use, and the EHR Incentive Program	MQC and Maine Regional Extension Center (MRECEC)	MQC and MERECEC
04	Forum: TBD: CMS 50-50-50 Event	CMS' Project Status and Success Stories	1/13/2011	TBD	Participant	State Medicaid Agencies Providers Other interested parties	Share information on the status of CMS' EHR Incentive Program and success stories thus far	CMS	CMS

Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
05	Forum: TBD: Registration & Program Highlights preview for States, ROs and internal CMS	CMS' Project Status and Success Stories	1/18/2011 - 1/19/2011	TBD	Participant	State Medicaid Agencies CMS Regional Offices (RO) Providers Other interested parties	Share information on the status of CMS' EHR Incentive Program and success stories thus far	CMS	CMS
06	Meeting: MaineCare EHR Incentive Program Communications Workgroup Meeting	MaineCare EHR Incentive Program Communications Workgroup Session	1/19/2011	N/A	Representative	INTERNAL: DHHS, MaineCare Services; HIT Team	Review key EHR Incentive Program Topics: (a) Communications schedule (b) Internal documents (c) Packet for providers (d) HIT website	N/A	N/A
07	Email: Email to Provider Associations, Part 2	Provider Association Meeting Follow-up, Part 2	1/21/2011 1/28/2011 2/4/2011 2/11/2011 2/25/2011	2/25/2011	Written	Provider Associations	Notification about CMS change to NAAC; EHR Incentive Program fact sheet for distribution; MaineCare Provider 'Quick Reference Guide'	Deloitte HIT Team	Sarah Stewart
08	Meeting: MaineCare EHR Incentive Program Communications Workgroup Meeting	MaineCare EHR Incentive Program Communications Workgroup Session	1/24/2011	1/24/2011	Representative	INTERNAL: DHHS, MaineCare Services; HIT Team	Provide updates on EHR Incentive Program communication activities and discuss upcoming communications and events	N/A	N/A
09	Conference Call: CMS HITECH Call	Lessons learned	1/24/2011	1/24/2011	Participant	State Medicaid Agencies	Lessons learned from the first Medicaid EHR Incentive Programs to go live	CMS	CMS
10	Press Release: Registration & Program Highlights walk through for Press	CMS' Project Status and Success Stories	1/25/2011	TBD	Participant	Press Other interested parties	Share information on the status of CMS' EHR Incentive Program and success stories thus far	CMS	CMS

Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
11	Teleconference: NESCSO Multi-State HIE Collaborative	Update from the six New England states to discuss key initiatives for Medicaid Agencies	1/25/2011	1/25/2011	Participant	TBD	Provide basic information about the ways in which provider directories support simple interoperability and basic capabilities for health information exchange, and the roles that state leaders might play to assure that all providers have access to openly-available directories before the end of 2011	NESCSO	NESCSO
12	Meeting: MaineCare and MEREC/HIN HIT Communications Coordination Discussion	Coordination of communications amongst HIT initiatives and the upcoming MQC webinar	1/31/2011	1/31/2011	Representative	INTERNAL: DHHS, MaineCare Services (HIT Team) MEREC/HIN	To coordinate communications amongst HIT initiatives, including roles and responsibilities moving forward, and discuss the topics for the 2/10/11 MQC webinar	N/A	N/A
13	Newsletter: "MaineCare Matters" Newsletter Update	Project Status	1/31/2011	Message was drafted on 1/24/2011;	Written	Provider Associations MaineCare Providers DHHS, MaineCare Services	Update on project status Legislative changes to Net Average Allowable Costs (NAAC) Direct questions to MaineCare HIT website	Deloitte HIT Team	Sarah Stewart
14	Newsletter: "MaineCare News" Newsletter Update	Project Status	1/31/2011	Message was drafted on 1/24/2011;	Written	DHHS, MaineCare Services	Update on project status Direct questions to MaineCare HIT website	Deloitte HIT Team	Sarah Stewart

FEBRUARY 2011									
Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
15	Website: MaineCare HIT Website Updates	Project Status	2/4/2011 2/11/2011 2/18/2011 2/25/2011 3/3/2011 3/10/2011	3/9/2011	Written	Provider Associations MaineCare Providers Other interested parties	Update FAQ document Update Webpage with implementation activities	Deloitte HIT Team	Linda Riddell
16	Conference: Maine Policy Leadership Symposium	(a) Project Status (b) Program Requirements	2/4/2011	2/4/2011	Presenter	Maine State Legislature Public Advocates	Provide updates and high-level information for Maine's legislature regarding Maine's HIT initiatives and MaineCare's EHR Incentive Program	Deloitte HIT Team	Dr. Rod Prior
17	Listserv Message: MaineCare HIT Listserv Updates	Project Status	2/7/2011 2/14/2011 2/22/2011 2/25/2011 2/28/2011 3/4/2011 3/11/2011	3/11/2011	Written	All subscribers to MaineCare's HIT listserv	Direct subscribers to the updated content on MaineCare's HIT website	Deloitte HIT Team	Sarah Stewart
18	Conference Call: CMS HITECH Call	CMS EHR Certification Number	2/7/2011	2/7/2011	Participant	State Medicaid Agencies	To help State's communicate to the provider community the difference between ONC's Certification Number and CMS EHR Certification Number	CMS	CMS
19	Meeting: MaineCare EHR Incentive Program Communications Workgroup Meeting	MaineCare EHR Incentive Program Communications Workgroup Session	2/7/2011	2/7/2011	Representative	INTERNAL: DHHS, MaineCare Services; HIT Team	Provide updates on EHR Incentive Program communication activities and discuss upcoming communications and events	N/A	N/A
Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor

20	Webinar: Maine Quality Counts (MQC) Webinar: "Health IT Roundtable 'Ask the Experts' Webinar, Part 2"	Program Requirements	2/10/2011	2/10/2011	Presenter	Provider Associations MaineCare Providers Other interested parties	Provide an overview of MaineCare's EHR Incentive Program, including timeline, eligibility, benefits, and where to find additional support for the program	Deloitte HIT Team, MQC and Maine Regional Extension Center (MERIC)	Dawn Gallagher, MQC and MERIC
21	Conference: Maine Osteopathic Association (MOA) Winter Conference	(a) Project Status (b) Program Requirements	2/11/2011 - 2/13/2011	2/13/2011	Presenter	MaineCare Providers	Provide information about MaineCare's EHR Incentive Program, including project status and timeline	Deloitte HIT Team	Dawn Gallagher
22	Conference Call: CMS HITECH Call	Provider Readiness for the EHR Incentive Programs	2/14/2011	2/14/2011	Participant	State Medicaid Agencies	Outcomes of CMS' research and analysis regarding provider readiness for the Medicare and Medicaid EHR Incentive Programs	CMS	CMS
23	Meeting: MaineCare EHR Incentive Program Communications Workgroup Meeting	MaineCare EHR Incentive Program Communications Workgroup Session	2/14/2011 2/15/2011	2/15/2011	Representative	INTERNAL: DHHS, MaineCare Services; HIT Team	Reviewed materials and content for the Provider Association Email Part 2, MaineCare's HIT Website, and MaineCare's Intranet message. Discussed upcoming CMS National Provider Call regarding eligibility and registration for the Medicare and Medicaid EHR Incentive Programs.	N/A	N/A
24	Conference Call: CMS National Provider Education Call	Registration for the Medicaid EHR Incentive Program for Eligible Professionals	2/18/2011	2/18/2011	Representative	Providers	Discuss eligibility for the Medicaid EHR Incentive Program, registration, steps to receive an incentive payment, switching between the Medicare and Medicaid programs, reassigning incentive payments, and where to find additional support for the programs	N/A	N/A
Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
25	Meeting: MaineCare EHR Incentive Program Communications Workgroup Meeting	MaineCare EHR Incentive Program Communications Workgroup Session	2/24/2011	N/A	Representative	INTERNAL: DHHS, MaineCare Services; HIT Team	Provide updates on EHR Incentive Program communication activities and discuss upcoming communications and events	N/A	N/A
26	Meeting: MaineCare EHR Incentive Program Communications Workgroup Meeting	MaineCare EHR Incentive Program Communications Workgroup Session	2/28/2011 3/1/2011	N/A	Representative	INTERNAL: DHHS, MaineCare Services; HIT Team	Provide updates on EHR Incentive Program communication activities and discuss upcoming communications and events	N/A	N/A

MARCH, 2011									
Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
27	Conference Call: CMS HITECH Call	Physician Assistant Eligibility/NLR Issues/State MMIS & HITECH Systems/National Broadband Map	3/7/2011	3/7/2011	Participant	State Medicaid Agencies	CMS will address the following topics: 1) Clarification of physician assistant eligibility; 2) National Level Repository issues; 3) Spreadsheet showing the HITECH vendor, HITECH connectivity vendor, and MMIS vendor for each State; and 4) The National Broadband Map (http://www.broadbandmap.gov/), which went live on February 17	CMS	CMS
28	Meeting: MaineCare EHR Incentive Program Communications Workgroup Meeting	MaineCare EHR Incentive Program Communications Workgroup Session	3/7/2011	N/A	Representative	INTERNAL: DHHS, MaineCare Services; HIT Team	Provide updates on EHR Incentive Program communication activities and discuss upcoming communications and events	N/A	N/A

Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
29	Call: MaineCare and MEREC EHR Incentive Program Communications Coordination	Coordination of communications amongst HIT initiatives and upcoming events	3/7/2011	3/7/2011	Representative	MaineCare HIT Communications Team MEREC Communications Team	To discuss past communication efforts and upcoming communication events to coordinate communicate efforts amongst organizations and initiatives	N/A	N/A
30	Webinar: Maine Quality Counts (MQC) Webinar: "Health IT Roundtable 'Ask the Experts' Webinar, Part 3"	Program Requirements	3/10/2011	3/10/2011	Representative	Provider Associations MaineCare Providers Other interested parties	1. Registration and Attestation 2. Certified EHRs 3. Provider experiences with navigating the early stages of MU 4. Tools and resources to support practices	MQC and Maine Regional Extension Center (MEREC)	MQC and MEREC
31	Meeting: MaineCare EHR Incentive Program Communications Workgroup Meeting	MaineCare EHR Incentive Program Communications Workgroup Session	3/14/2011 3/16/2011	N/A	Representative	INTERNAL: DHHS, MaineCare Services; HIT Team	Provide updates on EHR Incentive Program communication activities and discuss upcoming communications and events	N/A	N/A
32	Meeting: Maine Primary Care Association (MPCA) Monthly Board Meeting	(a) Project Status (b) Program Requirements	3/15/2011 3/22/2011	3/22/2011	Presenter	MaineCare Providers	Provide information about MaineCare's EHR Incentive Program, including project status and timeline, with a focus on FQHC providers	Deloitte HIT Team Dawn Gallagher	Dawn Gallagher
33	Newsletter: "MaineCare Matters" Newsletter Update	Project Status	3/18/2011	Sent to Com. Team: 3/17/2011 Published: TBD	Written	Provider Associations MaineCare Providers DHHS, MaineCare Services	Provide information on new project timeline and content provided on the MaineCare HIT website.	Deloitte HIT Team	Sarah Stewart
34	Newsletter: "MaineCare News" Newsletter Update	Project Status	3/18/2011	Sent to Com. Team: 3/17/2011 Published: TBD	Written	DHHS, MaineCare Services	Update staff on MaineCare's HIT initiative; including new project timeline, benefits of EHRs and benefits of the program.	Deloitte HIT Team	Sarah Stewart

Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
35	Conference Call: CMS HITECH Call	TBD	3/21/2011	3/21/2011	Participant	State Medicaid Agencies	a. Draft Medicare MU attestation screen shots (discussion of States' MU attestations) b. COP Webinars starting on March 21st c. Housekeeping Issues d. Next round of State testing e. Checklist for States launching their programs in 2011	CMS	CMS
36	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	3/21/2011	3/21/2011	Participant	State Medicaid Agencies	Discuss State Medicaid HIT Plans (SMHP) and Implementation Advanced Planning Documents (IAPD)	N/A	N/A
37	Webinar: Maine Quality Counts (MQC) Webinar	HealthInfoNet (HIN) Update	3/22/2011	3/22/2011	Participant	Providers Advocates	HealthInfoNet Update: Using Maine's Regional Health Information Exchange to Help Providers & Patients Better Communicate	MQC and HIN	MQC and HIN
38	Website: MaineCare HIT Website Updates	Project Status	3/28/2011 4/1/2011		Written	Provider Associations MaineCare Providers Other interested parties	Update FAQ document Update website with implementation activities and project milestones	Deloitte HIT Team	Linda Riddell
39	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	3/28/2011	3/28/2011	Participant	State Medicaid Agencies	Discuss auditing aspects of the EHR Incentive Program	N/A	N/A
40	Listserv Message: MaineCare HIT Listserv Updates	Project Status	3/29/2011 4/4/2011		Written	All subscribers to MaineCare's HIT listserv	Direct subscribers to the updated content on MaineCare's HIT website	Deloitte HIT Team	Sarah Stewart
41	Teleconference: NESCSO Multi-State HIE Collaborative	TBD	3/29/2011	3/29/2011	Participant	TBD	TBD	N/A	N/A

Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
42	Conference: Maine Broadband Summit 1.0	Broadband efforts and other Recovery Act initiatives in Maine	3/30/2011		Participant	TBD	To provide Recovery Act stakeholders awareness of broadband efforts underway, discuss opportunities and forge relationships to leverage our strengths and challenges to benefit Maine	TBD	Dawn Gallagher
APRIL, 2011									
Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
43	Conference Call: CMS National Provider Education Call	Registration for the Medicare EHR Incentive Program for Eligible Professionals	4/1/2011		Participant	Providers	1. Eligibility for Incentives 2. Switching between Medicare and Medicaid Incentive Programs 3. Reassigning Payments 4. Before you Register 5. Registration 6. Helpful Resources and Q&A Session	CMS	CMS
44	Conference Call: CMS HITECH Call	TBD	4/4/2011		Participant	State Medicaid Agencies	TBD	CMS	CMS
45	Call: MaineCare and MEREC EHR Incentive Program Communications Coordination	Coordination of communications amongst HIT initiatives and upcoming events	4/4/2011		Representative	MaineCare HIT Communications Team MEREC Communications Team	To discuss past communication efforts and upcoming communication events to coordinate communicate efforts amongst organizations and initiatives	N/A	N/A
46	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	4/4/2011		Participant	State Medicaid Agencies	Discuss Meaningful Use (attestation and auditing) components of the EHR Incentive Program	N/A	N/A

Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
47	Quality Counts 2011 Annual Meeting	(a) Project Status (b) Program Requirements	4/6/2011		Representative	Provider Associations Providers	Provide information about MaineCare's EHR Incentive Program, including project status, requirements, and timeline	Deloitte HIT Team	Dawn Gallagher
48	Conference Call: CMS National Provider Education Call	Registration for the Medicare and Medicaid EHR Incentive Programs for Eligible Hospitals	4/6/2011		Participant	Providers	1. Eligibility for Incentives 2. Dually Eligible Hospitals 3. Before you Register 4. Registration 5. Helpful Resources and Q&A Session	CMS	CMS
49	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	4/11/2011		Participant	State Medicaid Agencies	Discuss State Medicaid HIT Plans (SMHP) and Implementation Advanced Planning Documents (IAPD)	N/A	N/A
50	Webinar: Maine Quality Counts (MQC) Webinar: "Health IT Roundtable 'Ask the Experts' Webinar, Part 4"	Program Requirements	4/14/2011		TBD	Provider Associations MaineCare Providers Other interested parties	TBD	MQC and Maine Regional Extension Center (MERIC)	MQC and MERIC
51	Newsletter: "MaineCare Matters" Newsletter Update	Project Status	4/15/2011		Written	Provider Associations MaineCare Providers DHHS, MaineCare Services	TBD	Deloitte HIT Team	Sarah Stewart
52	Newsletter: "MaineCare News" Newsletter Update	Project Status	4/15/2011		Written	DHHS, MaineCare Services	TBD	Deloitte HIT Team	Sarah Stewart
53	Newsletter: HealthCare Management PCP Newsletter Update	Project Status	4/15/2011		Written	Provider Associations MaineCare Providers (Primary Care Physicians)	TBD	Deloitte HIT Team	HealthCare Management

Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
54	Conference Call: CMS HITECH Call	TBD	4/18/2011		Participant	State Medicaid Agencies	TBD	CMS	CMS
55	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	4/18/2011		Participant	State Medicaid Agencies	Regional Collaborative discussion	N/A	N/A
56	Website: MaineCare HIT Website Updates	Project Status	4/25/2011		Written	Provider Associations MaineCare Providers Other interested parties	Update FAQ document Update website with implementation activities and project milestones	Deloitte HIT Team	Linda Riddell
57	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	4/25/2011		Participant	State Medicaid Agencies	Discuss auditing aspects of the EHR Incentive Program	N/A	N/A
58	Listserv Message: MaineCare HIT Listserv Updates	Project Status	4/26/2011		Written	All subscribers to MaineCare's HIT listserv	Direct subscribers to the updated content on MaineCare's HIT website	Deloitte HIT Team	Sarah Stewart
MAY, 2011									
Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
59	Conference Call: CMS HITECH Call	TBD	5/2/2011		Participant	State Medicaid Agencies	TBD	CMS	CMS

Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
60	Call: MaineCare and MEREC EHR Incentive Program Communications Coordination	Coordination of communications amongst HIT initiatives and upcoming events	5/2/2011		Representative	MaineCare HIT Communications Team MEREC Communications Team	To discuss past communication efforts and upcoming communication events to coordinate communicate efforts amongst organizations and initiatives	N/A	N/A
61	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	5/2/2011		Participant	State Medicaid Agencies	Discuss Meaningful Use (attestation and auditing) components of the EHR Incentive Program	N/A	N/A
62	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	5/9/2011		Participant	State Medicaid Agencies	Discuss State Medicaid HIT Plans (SMHP) and Implementation Advanced Planning Documents (IAPD)	N/A	N/A
63	Webinar: Maine Quality Counts (MQC) Webinar: "Health IT Roundtable 'Ask the Experts' Webinar, Part 5"	Program Requirements	5/12/2011		TBD	Provider Associations MaineCare Providers Other interested parties	TBD	MQC and Maine Regional Extension Center (MEREC)	MQC and MEREC
64	Conference Call: CMS HITECH Call	TBD	5/16/2011		Participant	State Medicaid Agencies	TBD	CMS	CMS
65	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	5/16/2011		Participant	State Medicaid Agencies	Discuss State Medicaid HIT Plans (SMHP) and Implementation Advanced Planning Documents (IAPD)	N/A	N/A
66	Newsletter: "MaineCare Matters" Newsletter Update	Project Status	5/20/2011		Written	Provider Associations MaineCare Providers DHHS, MaineCare Services	TBD	Deloitte HIT Team	Sarah Stewart

Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
67	Newsletter: "MaineCare News" Newsletter Update	Project Status	5/20/2011		Written	DHHS, MaineCare Services	TBD	Deloitte HIT Team	Sarah Stewart
68	Newsletter: HealthCare Management PCP Newsletter Update	Project Status	5/20/2011		Written	Provider Associations MaineCare Providers (Primary Care Physicians)	TBD	Deloitte HIT Team	HealthCare Management
69	Website: MaineCare HIT Website Updates	Project Status	5/23/2011		Written	Provider Associations MaineCare Providers Other interested parties	Update FAQ document Update website with implementation activities and project milestones	Deloitte HIT Team	Linda Riddell
70	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	5/23/2011		Participant	State Medicaid Agencies	Regional Collaborative discussion	N/A	N/A
71	Listserv Message: MaineCare HIT Listserv Updates	Project Status	5/24/2011		Written	All subscribers to MaineCare's HIT listserv	Direct subscribers to the updated content on MaineCare's HIT website	Deloitte HIT Team	Sarah Stewart
72	Conference: Third Annual CMS Multi-State Medicaid HITECH Conference	Medicaid EHR Incentive Programs Federal HIT Initiatives	5/24/2011 - 5/26/2011		TBD	State Medicaid Agencies	Collaboration opportunities for state Medicaid agencies to discuss with CMS and other industry leaders the Medicaid EHR Incentive Program and health information technology. Topics of discussion include: 1) implementation, 2) financing, and 3) demonstrating operational value of health IT	N/A	N/A
73	Conference Call: CMS HITECH Call	TBD	5/30/2011		Participant	State Medicaid Agencies	TBD	CMS	CMS
Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor

74	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	5/30/2011		Participant	State Medicaid Agencies	TBD	N/A	N/A
JUNE, 2011									
Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
75	Call: MaineCare and MEREC EHR Incentive Program Communications Coordination	Coordination of communications amongst HIT initiatives and upcoming events	6/6/2011		Representative	MaineCare HIT Communications Team MEREC Communications Team	To discuss past communication efforts and upcoming communication events to coordinate communicate efforts amongst organizations and initiatives	N/A	N/A
76	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	6/6/2011		Participant	State Medicaid Agencies	Discuss Meaningful Use (attestation and auditing) components of the EHR Incentive Program	N/A	N/A
77	Webinar: Maine Quality Counts (MQC) Webinar: "Health IT Roundtable 'Ask the Experts' Webinar, Part 6"	Program Requirements	6/9/2011		TBD	Provider Associations MaineCare Providers Other interested parties	TBD	MQC and Maine Regional Extension Center (MEREC)	MQC and MEREC
78	Conference Call: CMS HITECH Call	TBD	6/13/2011		Participant	State Medicaid Agencies	TBD	CMS	CMS

Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
79	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	6/13/2011		Participant	State Medicaid Agencies	Discuss State Medicaid HIT Plans (SMHP) and Implementation Advanced Planning Documents (IAPD)	N/A	N/A
80	Newsletter: "MaineCare Matters" Newsletter Update	Project Status	6/17/2011		Written	Provider Associations MaineCare Providers DHHS, MaineCare Services	TBD	Deloitte HIT Team	Sarah Stewart
81	Newsletter: "MaineCare News" Newsletter Update	Project Status	6/17/2011		Written	DHHS, MaineCare Services	TBD	Deloitte HIT Team	Sarah Stewart
82	Newsletter: HealthCare Management PCP Newsletter Update	Project Status	6/17/2011		Written	Provider Associations MaineCare Providers (Primary Care Physicians)	TBD	Deloitte HIT Team	HealthCare Management
83	Newsletter: PCPIP Newsletter Updates	Project Status	6/17/2011		Written	Provider Associations MaineCare Providers (Primary Care Physicians)	TBD	Deloitte HIT Team	Sarah Stewart
84	Website: MaineCare HIT Website Updates	Project Status	6/20/2011		Written	Provider Associations MaineCare Providers Other interested parties	Update FAQ document Update website with implementation activities and project milestones	Deloitte HIT Team	Linda Riddell
85	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	6/20/2011		Participant	State Medicaid Agencies	Regional Collaborative discussion	N/A	N/A
86	Listserv Message: MaineCare HIT Listserv Updates	Project Status	6/21/2011		Written	All subscribers to MaineCare's HIT listserv	Direct subscribers to the updated content on MaineCare's HIT website	Deloitte HIT Team	Sarah Stewart

Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
87	Conference Call: CMS HITECH Call	TBD	6/27/2011		Participant	State Medicaid Agencies	TBD	CMS	CMS
88	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	6/27/2011		Participant	State Medicaid Agencies	Discuss auditing aspects of the EHR Incentive Program	N/A	N/A
JULY, 2011									
Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
89	Call: MaineCare and MEREC EHR Incentive Program Communications Coordination	Coordination of communications amongst HIT initiatives and upcoming events	7/5/2011		Representative	MaineCare HIT Communications Team MEREC Communications Team	To discuss past communication efforts and upcoming communication events to coordinate communicate efforts amongst organizations and initiatives	N/A	N/A
90	Conference Call: CMS HITECH Call	TBD	7/11/2011		Participant	State Medicaid Agencies	TBD	CMS	CMS
91	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	7/11/2011		Participant	State Medicaid Agencies	Discuss State Medicaid HIT Plans (SMHP) and Implementation Advanced Planning Documents (IAPD)	N/A	N/A
92	Webinar: Maine Quality Counts (MQC) Webinar: "Health IT Roundtable 'Ask the Experts' Webinar, Part 7"	Program Requirements	7/14/2011		TBD	Provider Associations MaineCare Providers Other interested parties	TBD	MQC and Maine Regional Extension Center (MEREC)	MQC and MEREC

Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
93	Newsletter: "MaineCare Matters" Newsletter Update	Project Status	7/15/2011		Written	Provider Associations MaineCare Providers DHHS, MaineCare Services	TBD	Deloitte HIT Team	Sarah Stewart
94	Newsletter: "MaineCare News" Newsletter Update	Project Status	7/15/2011		Written	DHHS, MaineCare Services	TBD	Deloitte HIT Team	Sarah Stewart
95	Newsletter: HealthCare Management PCP Newsletter Update	Project Status	7/15/2011		Written	Provider Associations MaineCare Providers (Primary Care Physicians)	TBD	Deloitte HIT Team	HealthCare Management
96	Website: MaineCare HIT Website Updates	Project Status	7/18/2011		Written	Provider Associations MaineCare Providers Other interested parties	Update FAQ document Update website with implementation activities and project milestones	Deloitte HIT Team	Linda Riddell
97	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	7/18/2011		Participant	State Medicaid Agencies	Regional Collaborative discussion	N/A	N/A
98	Listserv Message: MaineCare HIT Listserv Updates	Project Status	7/19/2011		Written	All subscribers to MaineCare's HIT listserv	Direct subscribers to the updated content on MaineCare's HIT website	Deloitte HIT Team	Sarah Stewart
99	Conference Call: CMS HITECH Call	TBD	7/25/2011		Participant	State Medicaid Agencies	TBD	CMS	CMS
100	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	7/25/2011		Participant	State Medicaid Agencies	Discuss auditing aspects of the EHR Incentive Program	N/A	N/A

Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
AUGUST 2011									
101	Call: MaineCare and MEREC EHR Incentive Program Communications Coordination	Coordination of communications amongst HIT initiatives and upcoming events	8/1/2011		Representative	MaineCare HIT Communications Team MEREC Communications Team	To discuss past communication efforts and upcoming communication events to coordinate communicate efforts amongst organizations and initiatives	N/A	N/A
102	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	8/1/2011		Participant	State Medicaid Agencies	Discuss Meaningful Use (attestation and auditing) components of the EHR Incentive Program	N/A	N/A
103	Conference Call: CMS HITECH Call	TBD	8/8/2011		Participant	State Medicaid Agencies	TBD	CMS	CMS
104	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	8/8/2011		Participant	State Medicaid Agencies	Discuss State Medicaid HIT Plans (SMHP) and Implementation Advanced Planning Documents (IAPD)	N/A	N/A
105	Webinar: Maine Quality Counts (MQC) Webinar: "Health IT Roundtable 'Ask the Experts' Webinar, Part 8"	Program Requirements	8/11/2011		TBD	Provider Associations MaineCare Providers Other interested parties	TBD	MQC and Maine Regional Extension Center (MEREC)	MQC and MEREC
106	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	8/15/2011		Participant	State Medicaid Agencies	Regional Collaborative discussion	N/A	N/A
107	Newsletter: "MaineCare Matters" Newsletter Update	Project Status	8/19/2011		Written	Provider Associations MaineCare Providers DHHS, MaineCare Services	TBD	Deloitte HIT Team	Sarah Stewart

Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
108	Newsletter: "MaineCare News" Newsletter Update	Project Status	8/19/2011		Written	DHHS, MaineCare Services	TBD	Deloitte HIT Team	Sarah Stewart
109	Newsletter: HealthCare Management PCP Newsletter Update	Project Status	8/19/2011		Written	Provider Associations MaineCare Providers (Primary Care Physicians)	TBD	Deloitte HIT Team	HealthCare Management
110	Conference Call: CMS HITECH Call	TBD	8/22/2011		Participant	State Medicaid Agencies	TBD	CMS	CMS
111	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	8/22/2011		Participant	State Medicaid Agencies	Discuss auditing aspects of the EHR Incentive Program	N/A	N/A
112	Website: MaineCare HIT Website Updates	Project Status	8/29/2011		Written	Provider Associations MaineCare Providers Other interested parties	Update FAQ document Update website with implementation activities and project milestones	Deloitte HIT Team	Linda Riddell
113	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	8/29/2011		Participant	State Medicaid Agencies	TBD	N/A	N/A
114	Listserv Message: MaineCare HIT Listserv Updates	Project Status	8/30/2011		Written	All subscribers to MaineCare's HIT listserv	Direct subscribers to the updated content on MaineCare's HIT website	Deloitte HIT Team	Sarah Stewart

Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
SEPTEMBER 2011									
115	Conference Call: CMS HITECH Call	TBD	9/5/2011		Participant	State Medicaid Agencies	TBD	CMS	CMS
116	Call: MaineCare and MEREC EHR Incentive Program Communications Coordination	Coordination of communications amongst HIT initiatives and upcoming events	9/5/2011		Representative	MaineCare HIT Communications Team MEREC Communications Team	To discuss past communication efforts and upcoming communication events to coordinate communicate efforts amongst organizations and initiatives	N/A	N/A
117	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	9/5/2011		Participant	State Medicaid Agencies	Discuss Meaningful Use (attestation and auditing) components of the EHR Incentive Program	N/A	N/A
118	Webinar: Maine Quality Counts (MQC) Webinar: "Health IT Roundtable 'Ask the Experts' Webinar, Part 9"	Program Requirements	9/8/2011		TBD	Provider Associations MaineCare Providers Other interested parties	TBD	MQC and Maine Regional Extension Center (MEREC)	MQC and MEREC
119	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	9/12/2011		Participant	State Medicaid Agencies	Discuss State Medicaid HIT Plans (SMHP) and Implementation Advanced Planning Documents (IAPD)	N/A	N/A
120	Newsletter: "MaineCare Matters" Newsletter Update	Project Status	9/16/2011		Written	Provider Associations MaineCare Providers DHHS, MaineCare Services	TBD	Deloitte HIT Team	Sarah Stewart

Task ID	Communication Activity	Communication Topic	Target Distribution Date / Event Date	Completed Distribution Date / Event Date	MaineCare Involvement	Audience	Purpose/Message	Content Developer	Content Distributor
121	Newsletter: "MaineCare News" Newsletter Update	Project Status	9/16/2011		Written	DHHS, MaineCare Services	TBD	Deloitte HIT Team	Sarah Stewart
122	Newsletter: HealthCare Management PCP Newsletter Update	Project Status	9/16/2011		Written	Provider Associations MaineCare Providers (Primary Care Physicians)	TBD	Deloitte HIT Team	HealthCare Management
123	Conference Call: CMS HITECH Call	TBD	9/19/2011		Participant	State Medicaid Agencies	TBD	CMS	CMS
124	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	9/19/2011		Participant	State Medicaid Agencies	Regional Collaborative discussion	N/A	N/A
125	Website: MaineCare HIT Website Updates	Project Status	9/26/2011		Written	Provider Associations MaineCare Providers Other interested parties	Update FAQ document Update website with implementation activities and project milestones	Deloitte HIT Team	Linda Riddell
126	Webinar: CMS' Communities of Practice (COP)	Medicaid EHR Incentive Programs Topics	9/26/2011		Participant	State Medicaid Agencies	Regional Collaborative discussion	N/A	N/A
127	Listserv Message: MaineCare HIT Listserv Updates	Project Status	9/27/2011		Written	All subscribers to MaineCare's HIT listserv	Direct subscribers to the updated content on MaineCare's HIT website	Deloitte HIT Team	Sarah Stewart

Footnote: 45

1.1 CMS SMHP Template Crosswalk

The following is a crosswalk between the questions posed by CMS to the States providing direction on what content should be included in the Activities Necessary to Administer and Oversee the EHR Incentive Payment Program section of the SMHP to the sections in this document:

Question Number	CMS Guidance	EHR Incentive Program Process Report Section
1.	How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?	Section C, Parts 1 and 2
2.	How will the SMA verify whether EPs are hospital-based or not?	Section C, Parts 1 and 2
3.	How will the SMA verify the overall content of the provider attestations?	Section C, Parts 1 and 2
4.	How will the SMA communicate to its providers regarding their eligibility, payments, etc. ?	Section C, Parts 1 and 2
5.	What methodology will the SMA use to calculate patient volume?	Section C, Parts 1 and 2
6.	What data sources will the SMA use to verify patient volume for EPs and acute care hospitals?	Section C, Parts 1 and 2
7.	How will the SMA verify that EPs at FQHC/RHC meet the practices predominantly requirement?	Section C, Parts 1 and 2
8.	How will the SMA verify adopt, implement or upgrade of certified electronic health record technology by providers?	Section C, Parts 1 and 2
9.	How will the SMA verify meaningful use of certified electronic health record technology for providers' second participation year?	Section C, Parts 1 and 2
10.	Will the SMA be proposing any changes to the Meaningful Use definition as permissible per the final rule? 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.	Maine is not proposing changes to the MU definition.
11.	How will the SMA verify providers' use of certified electronic health record technology?	Section C, Parts 1 and 2
12.	How will the SMA verify providers' meaningful use data, including the reporting of clinical quality measures? Does the State envision different approaches for short-term and a different approach for the longer-term?	Section C, Parts 1 and 2
13.	*How will data collection and analysis process align with the collection of other clinical quality measures data, such as CHIPRA?	Section A, Part 6; Section C, Parts 1 and 2
14.	What IT, fiscal and communication systems will be used to implement the EHR Incentive Program?	All Sections
15.	What IT systems changes are needed by the SMA to implement the EHR Incentive Program?	See Section E- Implementation Roadmap
16.	What is the SMA's IT timeframe for systems modifications?	See Section E- Implementation Roadmap
17.	When does the SMA anticipate being ready to test and interface with the CMS National Level Repository (NLR)?	See Section E- Implementation Roadmap (July 2011)
18.	What is the SMA's plan for accepting the registration data for its Medicaid providers from the CMS NLR (e.g. mainframe to mainframe interface or other means)?	Section C, Parts 1 and 2

Question Number	CMS Guidance	EHR Incentive Program Process Report Section
19.	What kind of website will the SMA host for Medicaid providers for enrollment, program information, etc.?	Section C, Parts 1, 2 and 5
20.	Does the SMA anticipate modifications to the MMIS and if so, when does the SMA anticipate submitting an MMIS IAPD?	See Section E- Implementation Roadmap
21.	What kinds of call centers/help desks and other means will be established to address EP and hospital questions regarding the incentive program?	Section C, Parts 1 and 2
22.	What will the SMA establish as a provider appeal process relative to: 1) the incentive payments, 2) provider eligibility determinations, 3) demonstration of efforts to adopt, implement or upgrade and meaningful use of certified EHR technology?	Section C, Part 3
23.	What will be the process to assure that all Federal funding, both for the 100 percent incentive payments, as well as the 90 percent HIT administrative match, are accounted for separately for the HITECH provisions and not reported in a commingled manner with the enhanced MMIS FFP?	Sections C, Part 6
24.	What is the SMA's anticipated frequency for making the EHR Incentive Payments (e.g. monthly, semi-monthly, etc.)?	Section C, Part 2
25.	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?	Section C, Part 2
26.	What will be the process to assure that Medicaid payments go to an entity promoting the adoption of certified EHR technology, as designated by the state and approved by the US DHHS Secretary, are made only if participation in such payment arrangement is voluntary by the EP and that no more than 5 percent of such payments is retained for costs unrelated to EHR technology adoption?	Section C, Part 2
27.	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 percent of the capitation rate per 42 CFR Part 438.6, as well as a methodology for verifying such information?	Section C, Part 2
28.	What will be the process to assure that all EH calculations and EP incentive payments (including tracking EPs' 15% of the net average allowable costs of certified EHR technology) are made consistent with the Statute and regulation?	This question is no longer relevant per the Extender Act
29.	What will be the role of existing SMA contractors in implementing the EHR Incentive Program- such as MMIS, PBM, fiscal agent, managed care contractors, etc.?	See Section E- Implementation Roadmap
30.	States should explicitly describe what their assumptions are, and where the path and timing of their plans have dependencies based upon: <ul style="list-style-type: none"> • The role of CMS (e.g., the development and support of the National Level Repository; provider outreach/help desk support) • The status/availability of certified EHR technology • The role, approved plans and status of the Regional Extension Center • The role, approved plans and status of the HIE cooperative agreements • State-specific readiness factors 	Throughout the SMHP

Footnote: 46

Description of Process Flows

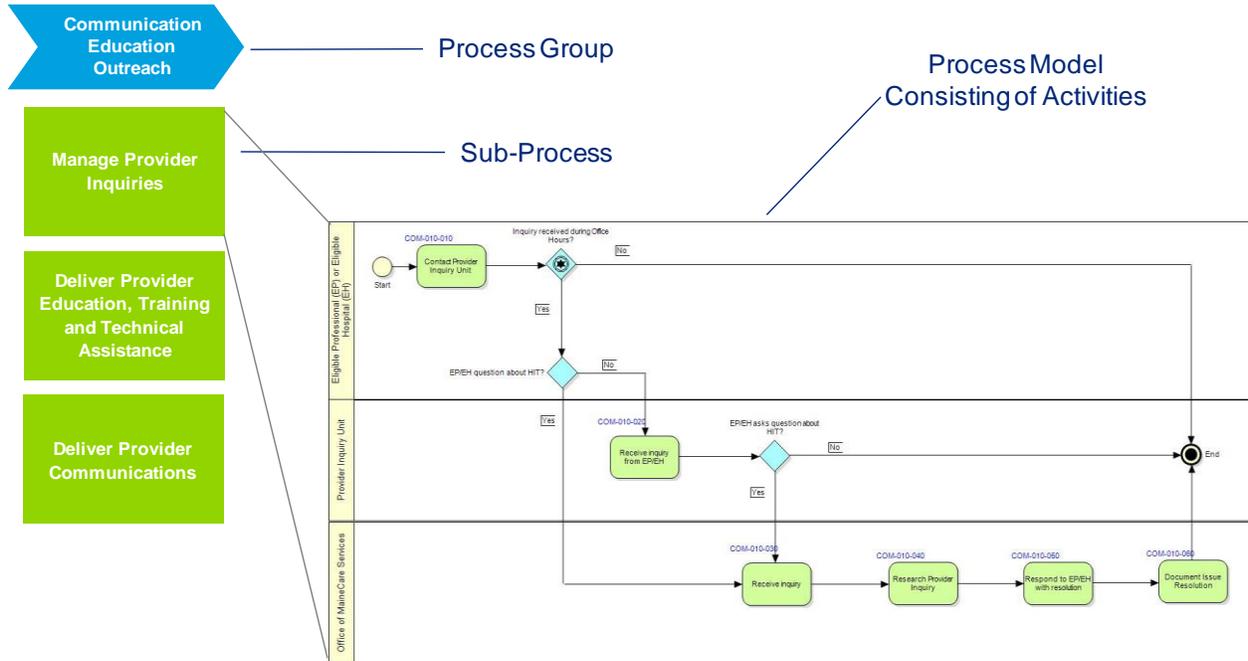


Figure 3: Example of process group, sub-process, and process model consisting of activities

There are three levels of the process flows:

Process groups are the major high-level components of the initiative. Each process group consists of one or more **sub-processes**. A sub-process uses a graph to show **activities** as the basic building blocks.

The left column on the sub-process graph identifies the “who” (CMS, OMS, Provider) that is taking or receiving the activity (action):

Entity Who is Taking or Receiving the Action	Description
Eligible Professionals (EP) and Eligible Hospitals (EH)	An Eligible Professional (EP) in the Medicaid EHR Incentive Program is defined as a physician, a dentist, a certified nurse-midwife, a nurse practitioner, or a physician assistant who is practicing in a Federally Qualified Health Center (FQHC) led by a physician assistant, or a Rural Health Clinic (RHC) led by a physician assistant. EPs must meet the 30% (at least 20% if pediatrician) Medicaid patient volume requirements and cannot be hospital-based professionals as defined in the Final Rule as providing substantially all (more than 90%) of their clinical activity in an inpatient or emergency room setting.

	<p>For FQHC EPs to be eligible, they must meet the 30% “needy individual” requirements.</p> <p>Eligible hospitals (EH) for the Medicaid EHR Incentive Program include Acute Care and Children’s Hospitals. To be eligible for a Medicaid EHR incentive payment, Acute Care Hospitals must have at least a 10% patient volume attributable to Medicaid (Title XIX). Children’s Hospitals do not have patient volume requirements under Medicaid. Hospitals are eligible to receive both Medicare and Medicaid EHR Incentive payments in the same year.</p>
CMS	<p>Centers for Medicare & Medicaid Services (CMS) is the US Federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program. CMS directly oversees and conducts the Medicare Incentive Payment Programs. CMS oversees state Medicaid Agency HIT and EHR Incentive Payment Programs. CMS will also maintain the National Level Repository (NLR), the system that will facilitate and capture EP and Hospital registration for the Medicare and Medicaid EHR Incentive Programs.</p>
Office of MaineCare Services	<p>The Office of MaineCare Services (OMS) is the entity responsible for administering and overseeing the Maine Medicaid HIT Program, including the EHR Incentive Payment Program.</p>

APPENDIX C-3

Footnote 47: Register EP or EH Sub-Process

Tasks in this process:

RE-010-010: Register for EHR Incentive Program

Description:	<p>Description: EPs and EHs will login to the NLR to register for the EHR Incentive Program. They will navigate to the Home tab and login by entering their User ID and Password. From there, they will complete the registration form. The registration form will capture information such as demographics, TIN, CCN and other identifying information.</p> <p>Once the form is completed, the EP or EH will complete a legal notice attesting that the information they provided is complete and accurate to the best of their knowledge. The form will then be submitted to the NLR for processing.</p> <p>Resources: EP/EH, CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-010-020: Confirm Medicare/Medicaid Enrollment Status and Check for Exclusions

Description:	<p>Description: Upon receiving the registration request from the EP or EH, the NLR will complete an initial check of the EP/EH Medicare/Medicaid enrollment status and a check for exclusions.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-010-030: Populate NLR

RE-010-040: Search for Duplicate Registration

Description:	<p>Description: The NLR will run a check for any duplicate registrations the EP or EH may have made for Medicare or Medicaid in a different state.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-010-050: Add Registration Record

Description:	<p>Description: If duplicate registration check is cleared, a registration record is created for the EP or EH.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-010-060: Send Status to EP/EH

Description:	Description: Once a registration record is created for the EP or EH, the registration status is posted to the Inquiry tab of the NLR. Resources: CMS Proposed Technology to leverage: NLR
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RE-010-070: Receive CMS Registration Status

Description:	Description: To receive notice of registration status, the EP or EH will log into the NLR and navigate to the Inquiry tab. The registration information and status for the EP or EH will be updated and posted to the Inquiry tab. Resources: EPs or EHs Proposed Technology to leverage: NLR
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APPENDIX C-3

RE-010-080: Send Registration Information to State

Description:	<p>Description: Parallel with posting the EPs or EHs registration status to the Inquiry tab of the NLR, the NLR will send MaineCare the EP's or EH's registration information, which will include the provider's TIN, CCN, demographic information, and program selection.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-010-090: Receive Registration Information from CMS

Description:	<p>Description: MaineCare receives the EP's or EH's registration information.</p> <p>Resources: CMS, MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system</p>
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RE-010-100: Queue Registration Request

Description:	<p>Description: The registration request is then queued and routed to the OMS HIT Team.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system</p>
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RE-010-110: Review and Verify Provider Registration Information

Description:	<p>Description: An OMS HIT Team Specialist (HIT Specialist) will contact the provider at the email address provided during the NLR registration (or telephone contact if no email address). The HIT Specialist will assist the provider with the application process. MaineCare will review and verify the registration information by cross-checking against provider enrollment information within appropriate data sources for active/pending sanctions, licensing, and the eligibility requirements for the EHR Incentive Program as documented in the Final Rule.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system MIHMS Online Provider Enrollment Portal</p>
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Footnote 48: Determine Eligibility

Tasks in this process:

RE-020-010: Apply Eligibility Methodology

Description:	<p>Description: MaineCare will apply the encounter method to calculate patient volume thresholds and ensure that all eligibility criteria as defined in the Final Rule (including "practices predominantly", "hospital based", and that hospitals have demonstrated an average length of stay of 25 days or less) are met. MaineCare will check that providers are not sanctioned and are licensed.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system</p>
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RE-020-020: Determine/Set Eligibility Status

Description:	<p>Description: Once the registration request is reviewed and the eligibility methodology is applied, the EP's or EH's registration record is updated to reflect the determined eligibility status. If determined ineligible, a reason code will be added to the file.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system</p>
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RE-020-030: Send Eligibility Status

Description:	<p>Description: MaineCare will send the status of the EP or EH to CMS via the NLR interface. If the EP or EH was determined ineligible, the reason code will be included. MaineCare will send the eligibility status to the EP or EH.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: NLR, Maine OIT developed system</p>
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RE-020-040: Receive Eligibility Status

Description:	<p>Description: CMS receives the eligibility status from the State via the NLR interface.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR, Maine OIT developed system</p>
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RE-020-050: Send Eligibility Status to EP/EH

Description:	<p>Description: The eligibility status will be posted to the Inquiry tab of the NLR to</p>
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	<p>reflect the State's eligibility determination.</p> <p>Resources: CMS</p> <p>Potential Technology to Leverage: NLR</p>
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RE-020-060: Receive Eligibility Status

Description:	<p>Description: The EP or EH will receive their status from MaineCare via email (or other method if no email) Alternatively, the EP or EH may log into the NLR to check their eligibility status.</p> <p>Resources: EP or EH</p> <p>Proposed Technology to leverage: NLR, Maine OIT developed system</p>
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EP/EH determined to be eligible?

Description:	<p>If the EP/EH is determined by the State to be eligible for the EHR Incentive Program, the EP/EH will submit their payment request and attestations.</p> <p>If the EP/EH is determined by the State to be ineligible for the EHR Incentive Program, the EP/EH can appeal the eligibility determination.</p>
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Events in this process:

P-010: Submit Payment Request and Attestations

RE-010: Register EP or EH

APP-010: Appeal Eligibility, AIU, MU, and Payment Determinations

APPENDIX C-5

Footnote 49 - Switch EP between Program and/or State Sub-Process

Tasks in this process:

RE-030-010: Request change in EHR Incentive Program registration

Description:	<p>Description: The EP will log into the NLR to submit a request to change the EHR Incentive Program they previously registered for. The EP will request the change by selecting the program in the appropriate fields.</p> <p>Resources: EP</p> <p>Proposed Technology to leverage: NLR</p>
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RE-030-020: Receive request to switch EHR Incentive Program registration

Description:	<p>Description: The NLR receives the request to switch EHR Incentive Program registration. If the EP is switching to the Medicare EHR Incentive Program, the NLR will do a check against death records and sanctions/licensing status and to ensure that the EP is enrolled as a Medicare provider.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-030-030: Reject Request to Switch

Description:	<p>Description: If a switch between Medicare and Medicaid programs has already occurred, the change request will be rejected.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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RE-030-040: Notify EP of Rejection

Description:	<p>Description: CMS updates the EPs record in the NLR to show that their request to switch programs has been rejected. This information can be viewed by the EP in the Inquiry tab.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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APPENDIX C-5

RE-030-050: Receive Rejection Notification

Description:	Description: The EP will receive notification of the rejection of their request to switch programs by logging into the NLR and viewing the Inquiry tab. Resources: EP Proposed Technology to leverage: NLR
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RE-030-060: Record switch between EHR Incentive Programs

Description:	Description: If no previous switch occurred, the NLR will record the switch between EHR Incentive Programs. Resources: CMS Proposed Technology to leverage: NLR
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RE-030-070: Notify State of EP's switch between EHR Incentive Programs

Description:	Description: The NLR will notify the State of the EP's switch to registration in the State's Medicaid program or request to end participation in the State's Medicaid program. Resources: CMS Potential Technology to Leverage: NLR
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RE-030-080: Receive Change Notification

Description:	Description: MaineCare will receive a notification from the NLR of the EP's change in registration for the EHR Incentive Program. Resources: MaineCare Services Proposed Technology to leverage: Maine OIT developed system
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APPENDIX C-5

RE-030-090: Inactivate EP

Description:	Description: MaineCare will update the system to show that the EP has been inactivated from participating in the EHR Incentive Program. Resources: MaineCare Services Proposed Technology to leverage: Maine OIT developed system
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RE-030-100: Send Notification of Inactivation to the NLR

Description:	Description: MaineCare will notify the NLR once the EP has been inactivated. Resources: MaineCare Services Proposed Technology to leverage: Maine OIT developed system
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RE-030-110: Receive Inactivation Notice

Description:	Description: The NLR will receive a notification of the inactivation of the EP from the State system. Resources: CMS Proposed Technology to Leverage: NLR
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RE-030-120: Notify EP of inactivation

Description:	Description: CMS updates the EPs record in the NLR to show that their registration with the State's Medicaid EHR Incentive Program has been inactivated. This information can be viewed by the EP in the Inquiry tab. Resources: CMS Proposed Technology to leverage: NLR
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APPENDIX C-5

RE-030-130: Receive Inactivation Notification

Description:	<p>Description: The EP is notified that they have been inactivated from the State's Medicaid EHR Incentive Program by logging into the NLR and viewing the Inquiry tab.</p> <p>Resources: EP</p> <p>Proposed Technology to leverage: NLR</p>
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Gateways in this process:

First request to switch EHR Incentive Programs?

Description:	<p>Once the NLR receives the request to switch programs, the NLR will do a check to ensure that this is the first request to switch EHR Incentive Program registration.</p> <p>If this is the first request to switch programs, the EP is able to switch their registration for the EHR Incentive Program.</p> <p>If this is not the first request to switch programs and a previous request has been submitted and processed, the EP is unable to switch their registration for the EHR Incentive Program.</p>
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Did EP switch registration to State's Medicaid EHR Incentive Program?

Description:	<p>Once the State receives the information from the NLR of the EP's requested switch in the EHR Incentive Program, the State must assess if the EP's eligibility needs to be determined for participation in the program or if the EP should be inactivated in the system.</p> <p>If the EP has switched their registration to the State's Medicaid program, the state must determine the eligibility of the EP.</p> <p>If the EP has switched their registration to another State's Medicaid program or the Medicare program, the EP should be inactivated from the system.</p>
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Events in this process:

RE-020: Determine Eligibility

RE-010: Register EP or EH

Footnote 50 - Submit Payment Request and Attestations Sub-Process

Tasks in this process:

P-010-020-010: Submit attestation of AIU (Application Process)

Description:	<p>Description: The EP or EH logs into the OIT developed system to provide the State with their attestation of adoption, implementation, or upgrade of certified EHR technology. EPs/EHs would be required to provide the following information:</p> <ul style="list-style-type: none"> Attestation date EHR incentive payment year – Year 1 EHR participant participating year EHR reporting period dates NPI CCN <p>The Certified EHR Technology that the Provider uses and attestation that it is a CMS certified technology.</p> <p>Resources: EP/EH</p> <p>Proposed Technology to leverage: NLR, Maine OIT developed system</p>
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P-010-020-020: Receive attestation of AIU

Description:	<p>Description: MaineCare Services receives the attestation from the EP or Medicaid EH stating that they have adopted, implemented, or upgraded certified EHR technology.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system</p>
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P-010-020-030: Receive attestation of AIU

Description:	<p>Description: CMS receives the attestation from the dually eligible hospital stating that they have adopted, implemented, or upgraded certified EHR technology. CMS sends the attestation information to MaineCare.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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APPENDIX C-6

P-010-020-040: Verify attestation

Description:	<p>Description: MaineCare Services verifies the attestation from the EP or EH stating that they have adopted, implemented, or upgraded certified EHR technology. The State reviews the attestation for validity and completeness, including checking the ONC list of certified EHR technology to validate that the technology that the provider attested to using is CMS certified technology.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system</p>
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P-010-020-050: Log attestation record

Description:	<p>Description: MaineCare logs the attestation record to the EP/EHs file for attestation history for the EHR Incentive Program. MaineCare documents all the information provided by the EP/EH in the attestation. This information is sent to the NLR.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT developed system</p>
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P-010-020-060: Receive attestation record and send status to EP/EH

Description:	<p>Description: CMS receives the attestation record from MaineCare Services and logs the attestation status to the EP/EH record.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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P-010-020-070: Receive attestation status

Description:	<p>Description: The EP or EH will receive their status from MaineCare via email (or other method if no email) Alternatively, the EP or EH may log into the NLR to check their eligibility status. Once the State determines the eligibility for the EP or EH, the Inquiry tab of the NLR will reflect the change.</p> <p>Resources: EP/EH</p> <p>Proposed Technology to leverage: NLR, Maine OIT Developed System</p>
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APPENDIX C-6

P-010-020-080: Notify EP/EH of rejected attestation

Description:	<p>Description: MaineCare notifies the EP/EH that the attestation has been rejected. Reasons for attestation rejection include:</p>
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	Invalid Format Invalid attestation reporting period More than one initial attestation for the same reporting period Resources: MaineCare Services Proposed Technology to leverage: Maine OIT Developed System
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P-010-020-090: Receive notification of rejected attestation

Description:	Description: The EP/EH receives electronic notification that their attestation has been rejected. Resources: EP/EH Proposed Technology to leverage: Maine OIT Developed System
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Gateways in this process:

Type of Applicant

Description:	The type of applicant determines what system in which the attestation is logged. If the applicant is a dually eligible hospital, they will log their attestation in the National Level Repository managed by CMS. If the applicant is an EP or Medicaid hospital, they will log their attestation in a State system.
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Attestation received and valid?

APPENDIX C-6

Description:	Based on the attestation status, the EP/EH has a few options. If the attestation is rejected, the EP/EH will have to resubmit their attestations to the State or to the NLR. If the attestations are deemed invalid by the State, the EP/EH can appeal the attestation determination. If the attestation is received and valid, MaineCare services will initiate the verify eligibility process to determine if the EP/EH is eligible to receive an incentive payment.
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Events in this process:

APP-010: Appeal Eligibility, AIU, MU, and Payment Determinations

P-010-040: Receive Payment Request and Attestations

P-010-010: Submit Payment Request and Attestations

Footnote 51 - Submit Adoption, Implementation or Upgrade of Certified EHR Technology Attestations Sub-Activity

Tasks in this process:

P-010-010: Submit Payment Request and Attestations

Description:	<p>Description: An EP or EH will log into the State system and complete a payment request form and their attestations.</p> <p>Resources: EP or EH</p> <p>Potential Technology to Leverage: Maine OIT Developed System</p>
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P-010-040: Receive Payment Request and Attestations

Description:	<p>Description: MaineCare will receive the payment request and attestation data provided by the EP/EH.</p> <p>Resources: MaineCare Services</p> <p>Potential Technology to Leverage: Maine OIT Developed System</p>
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P-010-050: Log Payment Request

Description:	<p>Description: MaineCare will log the payment request in the State system.</p> <p>Resources: MaineCare Services</p> <p>Potential Technology to Leverage: Maine OIT Developed System</p>
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Gateways in this process:

Participation Year?

Description:	<p>The EP or EH must provide different attestations depending on the year of participation in the EHR Incentive Program.</p> <p>If the EP or EH is providing an attestation for Year 1 of participation in the EHR Incentive Program, they must attest to adopting, upgrading, or implementing certified EHR technology.</p> <p>For Years 2 and thereafter EPs and Medicaid only hospitals must also attest to Meaningful Use of certified EHR technology as proscribed by CMS rules (expected in 2011 and updates thereafter.) Dually-eligible hospitals will submit MU to CMS.</p>
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Events in this process: P-020: Verify Eligibility, RE-020: Determine Eligibility

APPENDIX C-8

Footnote 52 - MU Attestation (NOTE: This process is included as a place holder for CMS rules on MU that are forthcoming in 2011 and thereafter.

Tasks in this process:

P-010-030-010: Submit attestation of Meaningful Use

Description:	<p>Description: The EP or EH logs into a system to provide the State with their attestation of Meaningful Use as defined by CMS.</p> <p>Resources: EP/EH</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-010-030-020: Receive attestation of Meaningful Use

Description:	<p>Description: MaineCare Services receives the attestation from the EP or Medicaid EH of Meaningful Use and the clinical quality measures.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-010-030-030: Receive attestation of Meaningful Use

Description:	<p>Description: CMS receives the attestation from the dually eligible hospital of Meaningful Use and the clinical quality measures. CMS sends the attestation information to MaineCare Services for their records.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR, Maine OIT Developed System</p>
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APPENDIX C-8

8P-010-030-040: Verify attestation

Description:	<p>Description: MaineCare Services verifies the attestation from the EP or EH stating Meaningful Use and the clinical quality measures. The State reviews the attestation for validity and completeness.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-010-030-050: Log attestation record

Description:	<p>Description: MaineCare Services logs the attestation record to the EP/EHs file for attestation history for the EHR Incentive Program. MaineCare would document all the information provided by the EP/EH in the attestation. This information is sent to the NLR.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-010-030-060: Receive attestation record and send status to EP/EH

Description:	<p>Description: CMS receives the attestation record from MaineCare Services and logs the attestation status to the EP/EH record.</p> <p>Resources: MaineCare Services, CMS</p> <p>Proposed Technology to leverage: NLR, Maine OIT Developed System</p>
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P-010-030-070: Receive attestation status

Description:	<p>Description: The EP or EH will receive their status from MaineCare via email (or other method if no email) Alternatively, the EP or EH may log into the NLR to check their status.</p> <p>Resources: EP/EH</p> <p>Proposed Technology to leverage: NLR</p>
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APPENDIX C-8

P-010-030-080: Notify EP/EH of rejected attestation

Description:	<p>Description: MaineCare notifies the EP/EH that the attestation has been rejected. Reasons for attestation rejection include: Invalid Format Invalid attestation reporting period More than one initial attestation for the same reporting period Non-compliant Meaningful Use measures (This is a place holder for CMS rules on MU expected in 2011 and later.)</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-010-030-090: Receive notification of rejected attestation

Description:	<p>Description: The EP/EH receives electronic notification that their attestation has been rejected.</p> <p>Resources: EP/EH</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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Gateways in this process:

Type of Applicant

Description:	<p>The type of applicant determines what system in which the attestation is logged.</p> <p>If the applicant is a dually eligible hospital, they will log their attestation in the National Level Repository managed by CMS.</p> <p>If the applicant is an EP or Medicaid hospital, they will log their attestation in a State system.</p>
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Attestation received and valid?

APPENDIX C-8

Attestation received and valid?

Description:	<p>Based on the attestation status, the EP/EH has a few options.</p> <p>If the attestation is rejected, the EP/EH will have to resubmit their attestations to the State or to the NLR.</p> <p>If the attestations are deemed invalid by the State, the EP/EH can appeal the decision. (Dually-eligible hospitals can not appeal MU, which must be done through CMS.)</p> <p>If the attestation is received and valid, MaineCare services will initiate the verify eligibility process to determine if the EP/EH is eligible to receive an incentive payment.</p>
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Events in this process:

P-010-010: Submit Payment Request and Attestations

P-010-040: Receive Payment Request and Attestations

APP-010: Appeal Eligibility, AIU, MU, and Payment Determination

Footnote 52: Verify Eligibility

Tasks in this process:

P-020-010: Request hospital registration status

Description:	Description: MaineCare will request the hospital's registration status for the EHR Incentive Programs from CMS via the NLR. Resources: MaineCare Services Proposed Technology to leverage: Maine OIT Developed System
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P-020-020: Receive request for hospital registration status

Description:	Description: CMS will receive the request from MaineCare for the hospital's registration status for the EHR Incentive Programs via the NLR. Resources: CMS Proposed Technology to leverage: NLR
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P-020-030: Send hospital registration status

Description:	Description: CMS will send the hospital's registration status for the EHR Incentive Programs to MaineCare Services via the NLR. Resources: CMS Proposed Technology to leverage: NLR
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P-020-040: Receive hospital registration status

Description:	Description: MaineCare Services will receive the hospital's registration status for the EHR Incentive Programs to MaineCare Services from CMS via the NLR. Resources: MaineCare Services Proposed Technology to leverage: Maine OIT Developed System
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P-020-050: Verify Eligibility and Attestation Requirements

Description:	<p>Description: MaineCare will check the eligibility status of EPs and EHS to ensure that their attestations have been received and are valid before processing payment. MaineCare will verify the following information:</p> <ul style="list-style-type: none"> - State eligibility status, including patient volume requirements, "practices predominantly" requirements, death records, licenses, sanctions - Adoption, Implementation or Upgrade to EHR technology attestation or Meaningful Use and clinical quality measures attestations - Hospital registration in PECOS (EHS only) <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System, MIHMS Provider portal, Licensing, All Claims Database, MIHMS claims system</p>
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P-020-060: Send data request to check payment history

Description:	<p>Description: MaineCare sends a data request to the National Level Repository to check for payments from other states or other exclusions from the EHR Incentive Program.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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APPENDIX C-9

P-020-070: Search payment history

Description:	<p>Description: The NLR will search for the EP/EH payment history to ensure that the EP/EH has not received a payment from the Medicare program, a payment from another state's Medicaid program, or is excluded from receiving an incentive payment from the EHR Incentive Program. The NLR will also check for any sanctions against the provider as well as death files to ensure that the provider may receive a payment. This activity prevents an EP/EH from receiving a duplicate payment.</p> <p>Note: EHS can receive a Medicare and Medicaid payment.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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P-020-080: Send Payment History

Description:	<p>Description: The NLR will send the EP/EH payment history to MaineCare.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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P-020-090: Receive Payment History

Description:	<p>Description: MaineCare will receive the provider or hospital payment record from the NLR. MaineCare will review the payment history to ensure that the EP has not received a Medicare payment; or for EP and EHS, payment from another state's Medicaid program; or is excluded from receiving an incentive payment from the EHR Incentive Program. This activity prevents an EP/EH from receiving a duplicate payment.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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APPENDIX C-9

P-020-100: Generate Payment Denial Notice

Description:	Description: A payment denial notice is generated indicating that the EP's or EH's eligibility for payment has been denied or attestation requirements have not been met and an incentive payment will not be issued. Resources: MaineCare Services Proposed Technology to leverage: Maine OIT Developed System
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P-020-110: Notify NLR of Payment Denial

Description:	Description: MaineCare sends a notification to the NLR that the EP/EH eligibility has been denied or attestation requirements have not been met and an incentive payment will not be issued. Resources: MaineCare Services Proposed Technology to leverage: Maine OIT Developed System
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P-020-120: Update Payment History

Description:	Description: CMS will update the EP's or EH's payment history to reflect payment denial. Resources: CMS Proposed Technology to leverage: NLR
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P-020-130: Notify EP or EH

Description:	Description: CMS will post the payment denial on the Inquiry tab of the NLR. Resources: CMS Proposed Technology to leverage: NLR
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APPENDIX C-9

P-020-140: Receive Payment Denial Notification

Description:	<p>Description: The EP or EH will receive their status from MaineCare via email (or other method if no email) Alternatively, the EP or EH may log into the NLR to check their status.</p> <p>Resources: EP/EH</p> <p>Proposed Technology to leverage: NLR</p>
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Gateways in this process:

Does EP/EH Meet Eligibility and Attestation Requirements?

Description:	<p>The EP/EH must meet the eligibility and attestation requirements to receive a payment.</p> <p>If the EP/EH does meet the eligibility and attestation requirements, MaineCare will continue the payment process.</p> <p>If the EP/EH does not meet the eligibility and attestation requirements, MaineCare will issue a payment denial notice.</p>
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Has the EP/EH already received a payment?

Description:	<p>MaineCare reviews the payment history to ensure that the EP/EH has not received a Medicare payment or a payment from another state's Medicaid program, or is excluded from receiving an incentive payment from the EHR Incentive Program.</p> <p>If the EP has not received a payment from Medicare or in the case of EPs and EHs, another state for the participation year, MaineCare will move forward and adjudicate the incentive payment.</p> <p>If the EP has already received a payment from Medicare or if the EP or EH received a payment from another state for the participation year, MaineCare will issue a payment denial notice.</p> <p>Note: EHs can receive a Medicare and Medicaid payment.</p>
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APPENDIX C-9

Payment denial valid?

Description:	If the EP/EH agrees that the payment denial was valid, they can resubmit their payment request and attestations with the complete and valid information to receive an incentive payment. If the EP/EH disagrees with the payment denial, the EP can appeal the payment denial.
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Events in this process:

P-010: Submit Payment Request and Attestations

P-030: Adjudicate Payment

APP-010: Appeal Eligibility, AIU, MU, and Payment Determinations

P-010: Submit Payment Request and Attestations

Footnote 54: Adjudicate Payment

Swim Lane	Description
CMS	Centers for Medicare & Medicaid Services (CMS) is the US Federal agency which administers Medicare, Medicaid, and the Children's Health Insurance Program. CMS is responsible for overseeing the Medicare and Medicaid EHR Incentive Programs. CMS will monitor State Medicaid Agency EHR Incentive Programs through mandatory reporting. CMS will also maintain the National Level Repository (NLR), the system that will facilitate and capture EP and Hospital registration for the Medicare and Medicaid EHR Incentive Programs.
DHHS Finance	DHHS Finance is the entity that issues payment to eligible professionals and eligible hospitals for the Maine Medicaid EHR Incentive Program.
Office of MaineCare Services	The Office of MaineCare Services (OMS) is the entity responsible for administering and overseeing the Maine Medicaid EHR Incentive Program.
Eligible Professionals (EPs) or Eligible Hospitals (EHs)	<p>An Eligible Professional (EP) in the Medicaid EHR Incentive Program is defined as a physician, a dentist, a certified nurse-midwife, a nurse practitioner, or a physician assistant who is practicing predominantly in a Federally Qualified Health Center (FQHC) led by a physician assistant, or a Rural Health Clinic (RHC) led by a physician assistant. EPs must meet the 30% (at least 20% if pediatrician) Medicaid patient volume requirements and cannot be hospital-based professionals as defined in the Final Rule as providing substantially all (more than 90%) of their clinical activity in an inpatient or emergency room setting.</p> <p>Eligible hospitals (EH) for the Medicaid EHR Incentive Program include Acute Care and Children's Hospitals. To be eligible for a Medicaid EHR incentive payment, Acute Care Hospitals must have at least a 10% patient volume attributable to Medicaid (Title XIX). Children's Hospitals do not have patient volume requirements under Medicaid. Hospitals are eligible to receive both Medicare and Medicaid EHR Incentive payments in the same year.</p>

APPENDIX C-10

<p>Entity who may receive the EP/EH's incentive payment (Reassigned)</p>	<p>An entity may be the employer or biller for an EP/EH that has a voluntary contractual relationship to be designated by the EP /EH to receive the EP/EH incentive payments. The final rule also allows states to designate an entity promoting the adoption of certified EHR technology by enabling oversight of the business, operational, and legal issues involved in the adoption and implementation of certified EHR technology or by enabling the exchange and use of electronic clinical and administrative data between participating providers, in a secure manner, including maintaining the physical and organizational relationship integral to the adoption of certified EHR technology by eligible providers. Maine does not have any State-designated entities.</p>
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P-030-010: Execute Payment Trigger

<p>Description:</p>	<p>Description: The payment trigger can be executed by en mass or by individual payment requests.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-030-020: Review Payment Requests

<p>Description:</p>	<p>Description: MaineCare reviews the payment requests to validate EP or EH information and verifying the frequency of payments to ensure that the EP or EH has not already received a payment for that year. Participation year follows the calendar year for EPs and the Federal Fiscal Year for EHs.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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APPENDIX C-10

P-030-030: Perform Adjudication and Calculate Payment

Description:	Description: Adjudicate the payment by setting the payment request to "pay" or "deny" status for the EP or the EH. For EP incentive payments: According to CMS' guidance on the Medicare and Medicaid Extenders Act of 2010, payments of \$21,250 the first year, and payments of \$8,500 for years 2 through 6 will be made. For EH incentive payments: MaineCare will verify hospital incentive payment calculation against hospital cost reports supplied by CMS. Resources: MaineCare Services Proposed Technology to leverage: Maine OIT Developed System
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P-030-040: Create Payment File

Description:	Description: Create a payment file to be sent to AdvantageME to process the incentive payment. Resources: MaineCare Services Proposed Technology to leverage: Maine OIT Developed System (Flexi Financial)
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P-030-050: Process Payment File and Make Payment

Description:	Description: The payment file is processed, DHHS Finance draws down ARRA funds and the incentive payment is sent to the EP or EH. Resources: DHHS Finance Proposed Technology to leverage: AdvantageME
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APPENDIX C-10

P-030-060: Create Feedback File

Description:	<p>Description: Once the payment is processed and paid to the EP/EH, a feedback file is created and sent to MaineCare.</p> <p>Resources: DHHS Finance</p> <p>Proposed Technology to leverage: Advantage ME</p>
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P-030-070: Receive Payment

Description:	<p>Description: The EP or EH receives the incentive payment. This could be done manually via a paper based check or electronically via EFT.</p> <p>Resources: EP or EH</p> <p>Proposed Technology to Leverage: AdvantageME, EFT</p>
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P-030-080: EP/EH Retains Payment

Description:	<p>Description: EP or EH retains the incentive payment.</p> <p>Resources: EP or EH</p> <p>Proposed Technology to leverage: None identified at this time</p>
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P-030-090: Payments that have been reassigned by the EP/EH to another entity

Description:	<p>Description: EP or EHs may reassign their payment to an employer or entity which provides billing services. This reassignment is done through the NLR process by listing the TIN of the “reassigned.” The payments, when they are processed through AdvantageME will be made to the reassignee’s TIN/address. (The other option of reassigning the payment to a State-designated entity is not available at this time in Maine.)</p> <p>Resources: EP/EH</p> <p>Proposed Technology to leverage: None identified at this time</p>
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P-030-120: Update Payment File

Description:	<p>Description: Upon receipt of the payment feedback file from DHHS Finance or receipt of payment use from an EP or EH, MaineCare will update the payment file to indicate the amount paid, date, and designation of the incentive payment.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: (FlexiFinancial) Maine OIT Developed System</p>
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P-030-130: Notify CMS of Payment

Description:	<p>Description: MaineCare will notify CMS through the NLR that an incentive payment was made to an EP or EH.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-030-140: Update Payment History

Description:	<p>Description: CMS will update the EP's or EH's payment history. This data will include the amount of the incentive payment, the state that issued the incentive payment, the date, and if the incentive payment was made by the EP or EH or reassigned as allowed by CMS.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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P-030-150: Notify EP or EH

Description:	<p>Description: MaineCare will notify the EP/EH with information that reflects the date of payment and the payment amount.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR, Maine OIT Developed System</p>
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P-030-160: Receive Payment Notification

Description:	<p>Description: In addition to getting OMS notification, The EP or EH may log into the NLR and navigate to the Inquiry tab to view their payment history.</p> <p>Resources: EP or EH</p>
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	Proposed Technology to leverage: NLR
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Gateways in this process:

Payment Amount Correct?

Description:	<p>If the EP/EH agrees that the payment amount was correct, the payment process is complete.</p> <p>If the EP/EH disagrees with the payment amount received, the EP/EH can appeal the payment amount.</p>
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Events in this process:

P-020: Verify Eligibility

APP-010: Appeal Eligibility, AIU, MU, and Payment Determinations

Footnote 55: Manage Recoupment

Tasks in this process:

P-040-010: Initiate Recoupment Request

<p>Description:</p>	<p>Description: Incentive payment recouplements are initiated by the discovery of an overpayment--for example, an HIT Incentive Payment audit or receipt of notice from the NLR via the payment history file or for situations where monies are owed to the agency due to fraud/abuse, or EH/EPs owed funds from a Federal or State audit, or from a Medicaid overpayment. A DHHS staff will create a recoupment file which will include the following:</p> <ul style="list-style-type: none"> NPI TIN Program Year Record Number Payment Amount State Provider Type Exclusion Indicator Exclusion Type Exclusion Description Business Classification State- where sanctions are effective Date range of the exclusion Notes <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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APPENDIX C-11

P-040-020: Notify EP or EH of Recoupment

Description:	<p>Description: MaineCare will create and send a notification to the EP or EH to request that they pay the State the amount of the overpayment. Information listed in the notification includes:</p> <ul style="list-style-type: none"> NPI TIN Program Year Record Number Payment Amount State Provider Type Exclusion Indicator Exclusion Type Exclusion Description Business Classification State- where sanctions are effective Date range of the exclusion Notes <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: None identified at this time</p>
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P-040-030: Receive Notification

Description:	<p>Description: EP or EH receives recoupment request notification.</p> <p>Resources: EP or EH</p> <p>Proposed Technology to leverage: None identified at this time</p>
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P-040-040: Verify Overpayment/Duplicate Payment

Description:	<p>Description: EP or EH will verify with their own records and payment system to verify that an overpayment or duplicate payment was made.</p> <p>Resources: EP or EH</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APPENDIX C-11

P-040-050: Cut Check

Description:	<p>Description: The EP or EH issues a check for the amount of the overpayment or duplicate payment to MaineCare.</p> <p>Resources: EP or EH</p> <p>Proposed Technology to leverage: None identified at this time</p>
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P-040-060: Generate Receipt

Description:	<p>Description: EP or EH will generate a receipt for the issuance of funds to MaineCare for the overpayment or duplicate payment.</p> <p>Resources: EP or EH</p> <p>Proposed Technology to leverage: Maine OIT Developed System</p>
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P-040-070: Send Payment and Receipt

Description:	<p>Description: EP or EH sends the payment reimbursement and receipt to MaineCare.</p> <p>Resources: EP or EH</p> <p>Proposed Technology to leverage: None identified at this time</p>
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P-040-080: Apply Recoupment in System

Description:	<p>Description: DHHS Finance performs the accounting function in the State system to recoup payment by adjusting future incentive payment request or processing the payment made by the EP or EH.</p> <p>Resources: DHHS Finance</p> <p>Proposed Technology to leverage: AdvantageME</p>
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APPENDIX C-11

P-040-090: Notification of Recoupment

Description:	Description: MaineCare receives notification of recoupment and updates the EP's or EH's payment history. Resources: MaineCare Services Proposed Technology to leverage: Maine OIT Developed System
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P-040-100: Update Payment History

Description:	Description: MaineCare will update the payment history by indicating that the overpayment or duplicate payment has been recouped. Resources: MaineCare Services Proposed Technology to leverage: Maine OIT Developed System, MIHMS
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P-040-110: Send Payment and History

Description:	Description: MaineCare will send the payment and updated payment history to CMS via the NLR. Resources: MaineCare Services Proposed Technology to leverage: NLR
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P-040-120: Receive Payment Resolution Report

Description:	Description: CMS will receive payment and payment history. Resources: CMS Proposed Technology to leverage: NLR
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APPENDIX C-11

P-040-130: Notify EP or EH of Recoupment Status

Description:	<p>Description: CMS will notify the EP or EH that the overpayment or duplicate payment has been recouped and received by CMS. The payment history will be updated on the Inquiry tab of the NLR.</p> <p>Resources: CMS</p> <p>Proposed Technology to leverage: NLR</p>
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P-040-140: Receive Notification

Description:	<p>Description: The EP or EH will receive notice of the receipt of recoupment by viewing their payment history which can be found on the Inquiry tab on the NLR.</p> <p>Resources: EP or EH</p> <p>Proposed Technology to leverage: NLR</p>
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Gateways in this process:

Is Recoupment Request Valid?

Description:	<p>If the EP/EH believes that the recoupment request is valid, the EP/EH issues the overpayment or duplicate payment amount to MaineCare.</p> <p>If the EP/EH believes that the recoupment request is invalid, the EP/EH can appeal the payment or payment amount requested by MaineCare.</p>
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What Type of Recoupment?

Description:	<p>Once the recoupment record is created, MaineCare will determine if they will request a direct payment from the EP or EH or if they will apply the recoupment as an adjustment to future incentive or other type of payments/reimbursements.</p>
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Events in this process:

AUD-040: Audit Incentive Payments

APP-010: Appeal Eligibility, AIU, MU, and Payment Determinations

P-020-040: Send Payment History

APPENDIX C-12

Footnote 56: Appeals Sub Process

Tasks in this process:

APP-010-010: Request Informal Review

Description:	Description: An EP or EH may make an appeal based on an eligibility determination, AIU attestation determination, MU attestation determination (EPs and Medicaid Hospitals only), incentive payment, or an audit of any of those items. A request for an informal review may be done through writing a letter to MaineCare within 60 days of receipt of the original notification. Resources: EP or EH Proposed Technology to leverage: None identified at this time
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APP-010-020: Receive Informal Review Request

Description:	Description: MaineCare will receive the request from an EP or EH for an informal review. Resources: MaineCare Services Proposed Technology to leverage: None identified at this time
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APP-010-030: Track Request

Description:	Description: Once the request for an informal review is received, MaineCare will track the request. Resources: MaineCare Services Proposed Technology to leverage: None identified at this time
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APPENDIX C-12

APP-010-040: Conduct an Informal Review

Description:	Description: MaineCare performs the informal review by reviewing documentation sent in by the EP or EH, cross-checking state systems for eligibility, incentive payment determinations and amounts, attestation information gathered through an audit, and incentive program policy to make a determination on whether to uphold or reverse the MaineCare decision. Resources: MaineCare Services Proposed Technology to leverage: MIHMS, NLR, Maine OIT Developed System
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APP-010-050: Reverse MaineCare Decision

Description:	Description: The eligibility, incentive payment, or attestation decision is reversed. Based on the type of appeal, the EP/EH could be determined eligible for the incentive program, receive an incentive payment, or have their attestations accepted. Resources: MaineCare Services Proposed Technology to leverage: None identified at this time
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APP-010-060: Send Notification to EP or EH

Description:	Description: If the informal review decision is to uphold the OMS original decision, a decision letter is sent to the EP or EH notifying them of the decision and appeal rights. Resources: MaineCare Services Proposed Technology to leverage: None identified at this time
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APPENDIX C-12

APP-010-070: Receive Notification

Description:	Description: The EP or EH receives notification of the decision made based on their request for an informal review. Resources: EPs or EHs Proposed Technology to leverage: None identified at this time
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APP-010-080: Request Administrative Hearing

Description:	Description: The EP or EH decides not to accept the decision made through the informal review and requests an administrative hearing. The EP or EH may request an administrative hearing through writing a letter to the Commissioner of DHHS. Office of MaineCare Services. Resources: EP or EH Proposed Technology to leverage: None identified at this time
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APP-010-090: Receive Administrative Hearing Request

Description:	Description: The Hearings Office receives the administrative hearing request. Resources: DHHS Proposed Technology to leverage: None identified at this time
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APP-010-100: Gather Documentation

Description:	Description: MaineCare will gather all relevant documentation on the case. Documentation may include information from the system on eligibility determinations, attestations, incentive payments, information provided by the EP or EH, and any relevant documentation gathered from an audit. Resources: MaineCare Services Proposed Technology to leverage: MIHMS, NLR, Maine OIT Developed System
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APPENDIX C-12

APP-010-110: Send Administrative Hearing Request and Documentation

Description:	<p>Description: MaineCare sends all relevant documentation to the Office of Administrative Hearings within the DHHS Commissioner's Office.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-120: Receive Administrative Hearing Request

Description:	<p>Description: The Office of Administrative Hearings receives the administrative hearing request and all supporting documentation from MaineCare (or directly from the provider).</p> <p>Resources: Office of Administrative Hearings</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-130: Assign Hearing Officer

Description:	<p>Description: A DHHS Hearing Officer is assigned to the case.</p> <p>Resources: Office of Administrative Hearings, DHHS Hearing Officer</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-140: Create Hearing Case

Description:	<p>Description: The DHHS Hearing Officer creates hearing case by reviewing all relevant information and program policy.</p> <p>Resources: Office of Administrative Hearings, DHHS Hearing Officer</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APPENDIX C-12

APP-010-150: Conduct Administrative Hearing

Description:	<p>Description: An administrative hearing is conducted in which representatives from MaineCare and the EP or EH have the opportunity to present his/her case with supporting evidence. Hearings are generally held at the regional DHHS offices throughout the State.</p> <p>Resource: Office of Administrative Hearings, DHHS Hearing Officer, MaineCare Services, EP or EH</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-160: Make Recommendation to DHHS Commissioner

Description:	<p>Description: The DHHS Hearing Officer reviews the case and all supporting documentation. The DHHS Hearing Officer makes a recommendation to the DHHS Commissioner to either uphold the MaineCare decision, modify it, or reverse the MaineCare decision. The DHHS Hearing Officer will provide MaineCare and the EP or EH with a copy of his/her recommendation. Once they receive a copy of the recommendation, MaineCare and the EP or EH have 10 days to send a letter to the DHHS Commissioner to state their case.</p> <p>Resource: Office of Administrative Hearings, DHHS Hearing Officer, MaineCare Services, EP or EH</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APP-010-170: Receive and Review Administrative Hearing Case

Description:	<p>Descriptions: The DHHS Commissioner receives and reviews the administrative hearing case and recommendation.</p> <p>Resources: DHHS Commissioner</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APPENDIX C-12

APP-010-180: Make Ruling

Description:	Description: The DHHS Commissioner decides the ruling for the case. Resources: DHHS Commissioner Proposed Technology to leverage: None identified at this time
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APP-010-190: Notify MaineCare

Description:	Description: The Office of Administrative Hearings notifies MaineCare of the ruling and MaineCare analyzes it to consider any program changes that may need to be made. Resources: Office of Administrative Hearings, OMS Proposed Technology to leverage: None identified at this time
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APP-010-200: Notify EP/EH

Description:	Description: The Office of Administrative Hearings notifies the EP or EH of the ruling on the case. This may be done via a written letter and email. Resource: Office of Administrative Hearings Proposed Technology to leverage: None identified at this time
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APP-010-210: Receive Notification

Description:	Description: The EP or EH receives notification of the ruling from the administrative hearing. Resources: Office of Administrative Hearings, EPs or EHs Proposed Technology to leverage: None identified at this time
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APP-010-220: Request Superior

Court Hearing

Description:	Description: The EP or EH appeals the ruling and requests a Superior Court Hearing and uses the rules of the court. Resources: EPs or EHs Proposed Technology to leverage: None identified at this time
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APPENDIX C-12

APP-010-230: Receive Notification

Description:	Description: MaineCare receives the Superior Court hearing request and processes it in manner that is in line with current procedures.
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	Resources: MaineCare Services Proposed Technology to leverage: None identified at this time
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Gateways in this process:

Uphold MaineCare decision?

Description:	MaineCare decides whether to uphold their original determination or reverse the original decision.
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EP or EH accepts informal review decision?

Description:	The EP or EH decides whether or not to accept the decision made through the informal review by MaineCare. EPs and EHs have the option of either accepting the decision to uphold the original determination or request an administrative hearing to appeal the determination.
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EP or EH accepts administrative hearing ruling?

Description:	The EP or EH decides on whether or not to accept the administrative hearing decision. If not, they may appeal the ruling made by the DHHS Commissioner to Maine Superior Court.
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Events in this process:

- RE-020: Determine Eligibility
- P-030: Adjudicate Payment
- P-030: Adjudicate Payment
- AUD-040: Audit Incentive Payments
- AUD-020: Audit AIU of EHR Technology
- P-040: Manage Recoupment
- P-040: Manage Recoupment
- AUD-010: Audit Eligibility Determinations
- AUD-030: Audit Meaningful Use
- RE-020: Determine Eligibility

Footnote 57: Annual CMS Report

Tasks in this process:

R-010-010: Query Incentive Program data from data sources

Description:	<p>Description: MaineCare will query data from the State system(s) that house data on the EHR Incentive Program including information on EPs/EHs who have received an incentive payment for AIU or MU of certified EHR technology, provider AIU of certified EHR technology, data representing the EPs/EHs clinical quality measures data, and data on how the incentive program addressed individuals with unique needs such as children.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System and other systems and sources</p>
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R-010-020: Query data on EP/EH qualified for incentive payment for AIU

Description:	<p>Description: MaineCare will query a list of all EPs and EHs who qualified for an incentive payment on the basis of AIU certified EHR technology. This query would also capture the provider type and practice location.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System and other systems and sources</p>
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R-010-030: Query data on EP/EH qualified for incentive payment for MU

Description:	<p>Description: MaineCare will query a list of all EPs and EHs who qualified for an incentive payment on the basis of demonstrating that they are meaningful users of certified EHR technology. This query would also capture the provider type and practice location.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System and other systems and sources</p>
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APPENDIX C-13

R-010-040: Populate aggregated data tables of AIU

Description:	<p>Description: MaineCare will query the data to populate aggregated data tables representing the provider adoption, implementation, or upgrade of certified EHR technology.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System and other systems and sources</p>
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R-010-050: Populate aggregated data tables of clinical quality measures

Description:	<p>Description: MaineCare will query the data to populate aggregated data tables representing the clinical quality measures data collected by EPs and EHS.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System and other systems and sources</p>
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R-010-060: Compile report on individuals with unique needs

Description:	<p>Description: MaineCare will query quantitative data showing how the incentive program addressed individuals with unique needs and will include a description of how the incentive program activities specifically include individuals with unique needs.</p> <p>Resources: MaineCare Services</p> <p>Proposed Technology to leverage: Maine OIT Developed System and other systems and sources</p>
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R-010-070: Compile annual CMS report

Description:	<p>Description: The HIT Manager compiles the information queried and the aggregated data tables into the annual report to CMS.</p> <p>Resources: HIT Manager</p> <p>Proposed Technology to leverage: Maine OIT Developed System and other systems and sources</p>
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APPENDIX C-13

R-010-080: Review annual CMS report

Description:	<p>Description: Upon completion of the annual CMS Report, relevant MaineCare and DHHS stakeholders will review the report for accuracy and integrity. Stakeholders include HIT Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, and others as identified.</p> <p>Resources: MaineCare Leadership, OSC Director, HIT Program Manager Proposed Technology to leverage: None identified at this time</p>
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R-010-090: Approve annual CMS report

Description:	<p>Description: Stakeholders must approve the annual CMS report before it can be submitted to CMS.</p> <p>Resources: Stakeholders include HIT Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, and others as identified.</p> <p>Proposed Technology to leverage: None identified at this time</p>
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R-010-100: Submit annual report to CMS

Description:	<p>Description: Once stakeholders review and approve the annual CMS report, the HIT Manager sends the report to CMS.</p> <p>Resources: MaineCare Leadership, HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time</p>
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Events in this process:

- P-030: Adjudicate Payment
- P-010-020: Submit Attestation of AIU of EHR technology
- P-010-030: Submit Attestation of Meaningful Use

Footnote 58: Submit Quarterly HHS Report Sub-Process

Tasks in this process:

R-020-010: Compile quarterly HHS report

Description:	<p>Description: The HIT Program Manager will compile information on the EHR Incentive Program to submit a comprehensive report to HHS based on a variety of inputs. Some information used in the quarterly report may come from the monthly report submitted to CMS which reports on the administration of the program and use of FFP. Other inputs include reports of EP/EH payments, eligibility determination, audits, appeals, and other key management areas for the EHR Incentive Program. The report to HHS will provide a comprehensive overview of the State's EHR Incentive Program as well as a progress report on the implementation of the State's approved Medicaid HIT Plan.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: Maine OIT Developed System and other systems and sources</p>
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R-020-020: Review quarterly HHS report

Description:	<p>Description: Upon completion of the quarterly HHS Report, relevant MaineCare and DHHS stakeholders will review the report for accuracy and integrity. Stakeholders include HIT Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, and others as identified.</p> <p>Resources: MaineCare Leadership, HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time</p>
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R-020-030: Approve quarterly HHS report

Description:	<p>Description: Stakeholders must approve the quarterly HHS report before it can be submitted to HHS.</p> <p>Resources: Stakeholders include HIT Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, and others as identified</p> <p>Proposed Technology to leverage: None identified at this time</p>
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R-020-040: Submit quarterly report to HHS

Description:	<p>Description: Once stakeholders review and approve the quarterly HHS report, the HIT Manager sends the quarterly report on the State's EHR Incentive Program and progress report on the implementation of the State's approved</p>
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	Medicaid HIT Plan to HHS. Resources: MaineCare Leadership, HIT Program Manager Proposed Technology to leverage: None identified at this time
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Events in this process:

SOV-040: Track and report FFP for the Administration of Program

SOV-050: Manage FFP for Incentive Payments

SOV-020: Maintain SMHP

Footnote 59: Managing Provider Inquires and Deliver Provider Education

COM-010-010: Contact Help Desk

Description:	<p>Description: The EP or EH has a question about the EHR Incentive Program and contacts the Help Desk via email or phone.</p> <p>Resources: OMS HIT Specialist</p> <p>Proposed Technology to leverage: None identified at this time</p>
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COM-010-020: Receive inquiry from EP/EH

Description:	<p>Description: The Help Desk receives inquiry from an EP or EH. Topics of inquiries might include EHR technology, technical assistance, incentive payments, attestation, and eligibility for Meaningful Use.</p> <p>Resources: OMS HIT Specialist</p> <p>Proposed Technology to leverage: Interactive Voice Response (IVR)</p>
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COM-010-030: Research Provider Inquiry

Description:	<p>Description: HIT Specialist researches the most current CMS Provider Inquiry Toolkit, MaineCare website, MaineCare rules, State Plan and other relevant rules, regulations, and guidelines. All inquiries unable to be answered by the HIT Specialist will be escalated to the OMS HIT Program Manager and/or CMS' EHR Information Center.</p> <p>Resources: OMS HIT Specialist / HIT Program Manager</p> <p>Proposed Technology to leverage: Web access and documents</p>
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APPENDIX C-15

COM-010-040: Respond to EP/EH with resolution

Description:	Description: OMS HIT Specialist notifies EP/EH of resolution to their inquiry. Resources: OMS HIT Specialist / HIT Program Manager Proposed Technology to leverage: None identified at this time.
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COM-010-050: Document Issue Resolution

Description:	Description: HIT/EHR Incentive Program resource documents that the EP/EH inquiry has been resolved and closed. Resources: Help Desk Proposed Technology to leverage: None identified at this time.
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Gateways in this process:

Inquiry received during Office Hours?

Events in this process:

Start

Description:	Help desk receives a call or email from a provider with an inquiry regarding the EHR Incentive Program.
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Footnote 59 (Cont'd): Deliver Provider Education, Training, and Technical Assistance Sub-Process

Tasks in this process:

COM-020-010: Create Education and Training Plan

Description:	<p>Description: Develop a training plan in coordination with the OSC and the MeREC that includes a curriculum, content areas, targeted provider groups, schedule, and resource planning.</p> <p>Resources: HIT Program Manager, MeREC, OMS Training Unit</p> <p>Proposed Technology to leverage: Training modules, teleconference and videoconference tools and</p>
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COM-020-020: Develop Education and Training Materials

Description:	<p>Description: Develop training materials in coordination with the MeREC, including training presentations, webinar content, user guides, quick-tip sheets, and train-the-trainer content, guides and materials,</p> <p>Resources: HIT Program Manager, OMS Training Unit, MeREC</p> <p>Proposed Technology to leverage: Training modules, teleconference and videoconference tools and technology</p>
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COM-020-030: Conduct Provider Education and Training

Description:	<p>Description: This activity includes scheduling and conducting provider education and training sessions. For applicable audiences, OMS will team up with the MeREC to deliver provider training. Provider satisfaction surveys will be completed to ascertain the effectiveness of the sessions.</p> <p>Resources: HIT Program Manager, OMS Training Unit, MeREC</p> <p>Proposed Technology to leverage: Training modules, teleconference and videoconference tools and technology</p>
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Footnote 60: Deliver Provider Communications

Tasks in this process:

COM-030-010: Create Communication Plan

Description:	<p>Description: MaineCare and the MeREC have developed a communication plan which includes the topic areas, frequency and schedule of communications, and distribution channels for communication. MaineCare and MeREC will continue this collaboration.</p> <p>Resources: HIT Program Manager, MaineCare Director of Communications, MeREC.</p> <p>Proposed Technology to leverage: MaineCare website</p>
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COM-030-020: Develop Provider Communication Materials

Description:	<p>Description: In conjunction with the communication plan, MaineCare and the MeREC have collaborated and will continue to do so, to enhance provider communication's materials.</p> <p>Resources: HIT Program Manager, MaineCare Director of Communications, MeREC.</p> <p>Proposed Technology to leverage: MaineCare website</p>
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COM-030-030: Communications

Description:	<p>Description: MaineCare and the MeREC will send/deliver provider announcements and communications as outlined in the communication plan.</p> <p>Resources: HIT Program Manager, MaineCare Director of Communications, MeREC.</p> <p>Proposed Technology to leverage: MaineCare website</p>
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Footnote 61: Develop Rules

Tasks in this process:

SOV-010-010: Receive request to add, delete, or change rule or state plan (NOTE: No State Plan Amendment is needed for the HIT Incentive Payment Program. SPA processes are just being included should an SPA be required at some time.)

Description:	<p>Description: Activity to add, delete, or change policies related to the EHR Incentive Payment Program initiated.</p> <p>Resources: Policy Division</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-010-020: Analyze rule or state plan

Description:	<p>Description: Information is requested to appropriately analyze the suggested policy addition, deletion, or revision. Assess impact of policy on budget, stakeholders, and other benefits.</p> <p>Resources: Policy Division, HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-010-030: Formulate, get approval, and propose rule

Description:	<p>Description: Policy Division drafts the rule that is being added, deleted or changed.</p> <p>Resources: Approvals are required from the HIT Program Manager, OMS Director, Operations, Commissioner's Office, and Attorney General's Office.</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-010-040: Hold Public Hearing (if recommended)

Description:	<p>Description: Follow Maine's APA and hold public hearing (if recommended) to review the proposed rule.</p> <p>Resources: Policy Division</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-010-050: Finalize rule and Respond to Public Comments

Description:	<p>Description: Finalize the rule based on outcomes from the public hearings, and respond to all public comments.</p> <p>Resources: Policy Division</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-010-060: Approve rule

Description:	<p>Description: Receive approvals from the State to execute the new rule.</p> <p>Resources: Policy Division, OMS Director, Commissioner's Office, Attorney General's Office, Secretary of State</p> <p>Proposed Technology to leverage: None identified at this time.</p>
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SOV-010-070: Publish the final rule

Description:	<p>Description: Publish the final rule per the APA.</p> <p>Resources: Policy Division, Director of Communications</p> <p>Proposed Technology to leverage: MaineCare website, DHHS website</p>
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SOV-010-080: Implement final rule

Description:	<p>Description: Develop plan for implementation of the new, changed, or deleted rule.</p> <p>Resources: Implementation done by the appropriate Program Office within DHHS, including Operations</p> <p>Proposed Technology to leverage: None identified at this time</p>
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Gateways in this process:

Is a rule needed?

Description:	Use the Maine APA process to adopt the rule.
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APPENDIX C-18

Footnote 62: Maintain SMHP

Tasks in this process:

SOV-020-010: Receive prompt to review SMHP

Description:	<p>Description: SMHP needs to be reviewed and updated on an annual basis. This activity is the prompt to review the SMHP.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-060: Compile revised SMHP

Description:	<p>Description: This activity includes the compilation of the HIT Landscape Assessment, the HIT Vision, the Meaningful Use Sustainability Plan, and the Roadmap into the SMHP.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-070: Disseminate SMHP for review

Description:	<p>Description: This activity is the distribution of the SMHP to relevant stakeholders for review and approval. Stakeholders include HIT Program Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, and others as identified.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-080: Modify SMHP Revisions

Description:	<p>Description: If stakeholders do not approve the revised SMHP, it must be modified to meet stakeholders' expectations. Upon modification, it will then go through the review process again.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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APPENDIX C-18

SOV-020-090: Submit SMHP to CMS for approval

Description:	Description: CMS must approve the SMHP prior to any changes in the EHR Incentive Payment Program or request for additional funding to administer the EHR Incentive Payment Program. Resources: HIT Program Manager Proposed Technology to leverage: None identified at this time
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SOV-020-100: Communicate revised SMHP

Description:	Description: This activity is the final step in the Maintain SMHP process. The SMHP is published and distributed to all relevant stakeholders. Resources: HIT Program Manager, OMS Director of Communications Proposed Technology to leverage: HIT web page on MaineCare Services website
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Gateways in this process:

Stakeholder approval received?

Description:	Description: Stakeholders must approve the SMHP before it can be published and released as the updated SMHP. Stakeholders include HIT Program Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, and others as identified. Resources: HIT Program Manager Proposed Technology to leverage: None identified at this time.
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Events in this process:

SOV-030: Submit IAPD

Footnote 63: Revise HIT Landscape

Tasks in this process:

SOV-020-020-010: Review Current HIT Landscape Assessment

Description:	<p>Description: The HIT Landscape Assessment must be reviewed on an annual basis to understand if revisions need to be made to reflect the current HIT landscape in Maine.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-020-020: Assess need for updates to HIT Landscape Assessment

Description:	<p>Description: This activity assesses the need for any revisions of the HIT Landscape Assessment specific to changes in the governance structure, DHHS systems changes, and DHHS and HIT initiatives.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-020-030: Assess use of EHR technology

Description:	<p>Description: This activity includes surveying providers, hospitals, dentists, and other Eligible Professionals on adoption, implementation, and use of EHR technology.</p> <p>Resources: HIT Program Manager, Vendor</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed, vendor systems</p>
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SOV-020-020-040: Document revisions and additions to HIT Landscape Assessment

Description:	<p>Description: This activity includes making revisions to the HIT Landscape Assessment based on the necessary updates in the previous two steps (changes in the state HIT environment and rates of EHR technology adoption).</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-020-050: Disseminate HIT Landscape Assessment for review

Description:	<p>Description: This activity is the distribution of the HIT Landscape Assessment to relevant stakeholders for review and approval. Stakeholders include HIT Program Manager, OMS, OSC, Operations, OIT, and the Commissioner's Office.</p> <p>Resources: HIT Manager, Special Projects Unit</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-020-020-060: Modify HIT Landscape Assessment

Description:	<p>Description: If stakeholders do not approve the revised HIT Landscape Assessment, it must be modified to meet stakeholders' expectations. Upon modification, it will then go through the review process again.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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Gateways in this process:

Stakeholder approval received?

Description:	<p>Description: Stakeholders must approve the HIT Landscape Assessment before it can be compiled with the revised SMHP.</p> <p>Resources: Stakeholders include OMS, HIT Program Manager, Operations, OIT, Commissioner's Office, OSC</p> <p>Proposed Technology to leverage: None identified at this time</p>
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Updates needed?

Description:	<p>A decision should be made as to whether revisions and updates are needed to the HIT Landscape Assessment.</p>
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Events in this process:

SOV-020-060: Compile revised SMHP

SOV-020-010: Receive prompt to review SMHP

APPENDIX C-20

Footnote 64: Revise Roadmap

Tasks in this process:

SOV-020-050-010: Review current HIT Roadmap

Description:	<p>Description: The HIT Roadmap must be reviewed on an annual basis to understand if MaineCare is making progress toward its HIT goals.</p>
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	<p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-050-020: Track progress toward HIT Roadmap goals

Description:	<p>Description: This activity tracks current progress toward meeting milestones and accomplishing HIT goals set in the HIT Roadmap. The progress report will be completed quarterly.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-050-030: Assess need for updates to HIT Roadmap

Description:	<p>Description: This activity assesses the need for any revisions of the HIT Roadmap based upon tracking progress toward accomplishing HIT goals.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-050-040: Document revisions and additions to HIT Roadmap

Description:	<p>Description: This activity includes making revisions to the HIT Roadmap based on current progress toward achieving goals and milestones.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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SOV-020-050-050: Disseminate HIT Roadmap for review

Description:	<p>Description: This activity is the distribution of the HIT Roadmap to relevant stakeholders for review and approval. Stakeholders include HIT Program Manager, OMS, Operations, OIT, OSC, and the Commissioner's Office.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-020-050-060: Modify HIT Roadmap

Description:	<p>Description: If stakeholders do not approve the revised HIT Roadmap, it must be modified to meet stakeholders' expectations. Upon modification, it will then go through the review process again.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: MIHMS, OIT Developed System, other systems as needed</p>
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Gateways in this process:

Stakeholder approval received?

Description:	<p>Description: Stakeholders must approve the HIT Roadmap before it can be compiled with the revised SMHP.</p> <p>Resources: Stakeholders include HIT Manager, OMS, Operations, OIT, Commissioner's Office, OSC</p> <p>Proposed Technology to leverage: None identified at this time</p>
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Updates needed?

Description:	A decision should be made as to whether revisions and updates are needed to the HIT Roadmap.
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Events in this process:

SOV-020-060: Compile revised SMHP

SOV-020-010: Receive prompt to review SMHP

APPENDIX C-21

Footnote 65: Submit IAPD Sub-Process

Tasks in this process:

SOV-030-010: Conduct annual review of EHR Incentive Program for modifications

Description:	<p>Description: The first activity in the IAPD submission sub-process is to assess the EHR Incentive Program for needed modifications, both on the program side and system side. This could include additional resources, training/education/outreach efforts, and/or systems modifications.</p> <p>If system modifications are required, all system modifications will go through the Change Control Board and follow the change request protocols and processes that are already in place and used by DHHS.</p> <p>Resources: MaineCare Leadership, HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-030-020: Develop business case for modifications

Description:	<p>Description: Once the needed program and system modifications are identified, the MaineCare Services and HIT team will need to develop a business case to ask for FFP from CMS for the needed modifications and enhancements.</p> <p>Resources: MaineCare Leadership, HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-030-030: Develop IAPD

Description:	<p>Description: Using the business case as a guide, MaineCare Services and the HIT team will develop the IAPD requesting FFP funding from CMS to fund EHR Incentive Program modifications and enhancements.</p> <p>Resources: MaineCare Leadership, HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time</p>
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APPENDIX C-21

SOV-030-040: Review IAPD

Description:	<p>Description: Upon completion of the IAPD, relevant MaineCare and DHHS stakeholders will review the IAPD for accuracy and integrity. Stakeholders include HIT Program Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, and others as identified.</p>
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	Resources: MaineCare Leadership, HIT Program Manager, Special Projects Unit Proposed Technology to leverage: None identified at this time
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SOV-030-050: Submit IAPD to CMS

Description:	Description: Once stakeholders review and approve the IAPD, it is then submitted to CMS to request FFP funds. Resources: MaineCare Leadership, HIT Program Manager, Special Projects Unit Proposed Technology to leverage: None identified at this time
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Gateways in this process:

Stakeholder approval received?

Description:	Description: Stakeholders must approve the IAPD before it can be submitted to CMS. Resources: Stakeholders include HIT Program Manager, OMS Director, Operations, DHHS Offices, OIT, Commissioner's Office, Office of the State Coordinator, and others as identified. Proposed Technology to leverage: None identified at this time
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Events in this process:

SOV-040-010: Receive approved IAPD from CMS

SOV-020: Maintain SMHP

Footnote 66: Track and Report FFP

Tasks in this process:

SOV-040-010: Receive approved IAPD from CMS

Description:	<p>Description: CMS approves the IAPD from MaineCare for the administration of the EHR Incentive Program.</p> <p>Resources: MaineCare Leadership, HIT Program Manager, Finance and Accounting</p> <p>Proposed Technology to leverage: None identified at this time</p>
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SOV-040-020: Follow Regular State budget process

Description:	<p>Description: MaineCare follows the State budget process to secure funds if needed for the administration of the EHR Incentive Program. MaineCare will estimate the expenditures for the Medicaid EHR Incentive Program on the quarterly budget estimate report via Form CMS-37, including projections of administration related expenditures for the implementation costs.</p> <p>Resources: MaineCare Leadership, HIT Program Manager, Finance and Accounting, Commissioner's Office, OIT, Governor's Office, Bureau of the Budget, Legislature</p> <p>Proposed Technology to leverage: BFMS (State Budget System) and AdvantageME</p>
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SOV-040-030: Process invoices for EHR Incentive Program Expenditures

Description:	<p>Description: Finance processes invoices for expenditures related to the administration of the EHR Incentive Program and HIT efforts. Invoiced expenditures include OIT expense, contractors' invoices/expenses, travel costs, and indirect costs. When an invoice is received, Finance reviews the account strings to apply the FFP funding and process the invoice.</p> <p>Resources: MaineCare Finance and Accounting</p> <p>Proposed Technology to leverage: AdvantageME</p>
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APPENDIX C-22

SOV-040-040: State Personnel report tie

Description:	<p>Description: State employees record all time spent on HIT/EHR Incentive Program to the HIT project. Supervisors review and sign State employee timesheets to ensure that employees are charging their HIT time appropriately. Time is reported weekly and the pay period encompasses two weeks.</p> <p>Resources: State Personnel</p> <p>Proposed Technology to leverage: State time reporting system (TAMS)</p>
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SOV-040-050: Finance runs query

Description:	<p>Description: Finance runs a query to gather all data on expenditures for the administration of the EHR Incentive Program and HIT efforts. Expenditures include state personnel expense, OIT expense, contractors' invoices/expenses, travel costs, and indirect costs. This query occurs monthly.</p> <p>Resources: MaineCare Finance and Accounting</p> <p>Proposed Technology to leverage: State time reporting system (TAMS), GQL</p>
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SOV-040-060: Account for EHR Incentive Program Personnel Time

Description:	<p>Description: Finance and Accounting analyzes State Personnel time reporting and manually journals State Personnel time appropriately so that all personnel expenditures for the EHR Incentive Program are applied to the HIT/EHR Incentive Program account string/code and matched by ARRA funds at the rate of 90%.</p> <p>Resources: MaineCare Finance and Accounting</p> <p>Proposed Technology to leverage: State time reporting system (TAMS)</p>
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APPENDIX C-22

SOV-040-070: Draw down ARRA funds

Description:	<p>Description: Finance and Accounting uses the query of all EHR Incentive Program expenses to draw exactly 90% of the EHR Incentive Program expenses from the Federal Payment Management System.</p> <p>ARRA funds are drawn from the Federal Payment Management System monthly for State Personnel expenditures through the journal process. ARRA funds are drawn as invoices are received by Finance for the administration of the EHR Incentive Program. The invoice is then sent to Accounts Payable for processing.</p> <p>Resources: MaineCare Finance and Accounting</p> <p>Proposed Technology to leverage: Medicaid Budget and Expenditure System, Federal Payment Management System</p>
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SOV-040-080: Compile monthly report

Description:	<p>Description: Finance and Accounting use the data from invoices and State personnel time journals to compile all EHR Incentive Program expenditures for the administration of the EHR Incentive Program and HIT efforts. Expenditures include State Personnel expense, OIT expense, contractors' invoices/expenses, travel costs, and indirect costs. The report of monthly expenditures for the Administration of the EHR Incentive Program is sent to the HIT Program Manager for insertion in the CMS monthly report. Furthermore, on the form CMS-64, which is submitted on a quarterly basis, MaineCare will report actual expenses incurred. This will be used to reconcile the Medicaid funding advanced to States for the quarter on the basis of the Form CMS-37.</p> <p>Resources: HIT Program Manager, Finance and Accounting</p> <p>Proposed Technology to leverage: Medicaid Budget and Expenditure System</p>
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SOV-040-090: Send Report to CMS

Description:	Description: The HIT Program Manager sends the monthly report on the EHR Incentive Program to CMS which includes information on the expenditures that were paid using FFP from CMS. Resources: HIT Program Manager Proposed Technology to leverage: None identified at this time
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Events in this process:

SOV-030-050: Submit IAPD to CMS

Footnote 67: Manage FFP for Providers

Tasks in this process:

SOV-050-010: Reconcile payments

Description:	<p>Description: MaineCare reconciles the payment to the EP/EH with the payment from CMS verifying that 100% FFP match funding was received.</p> <p>Resources: Finance and Accounting</p> <p>Proposed Technology to leverage: AdvantageME, Medicaid Budget and Expenditure System</p>
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SOV-050-020: Compile monthly report

Description:	<p>Description: Finance and Accounting run a query to gather all EHR Incentive Program Payments to EPs and EHs. This query occurs monthly.</p> <p>The report of monthly expenditures for EHR Incentive Program Payments to EPs and EHs is sent to the HIT Manager for insertion in the CMS monthly report.</p> <p>Resources: HIT Manager, Finance and Accounting</p> <p>Proposed Technology to leverage: GQL, Medicaid Budget and Expenditure System</p>
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SOV-050-030: Send Report to CMS

Description:	<p>Description: The HIT Program Manager sends the monthly report on the EHR Incentive Program to CMS which includes information on the EHR incentive payments that were sent to EPs and EHs using 100% FFP from CMS.</p> <p>Resources: HIT Program Manager</p> <p>Proposed Technology to leverage: None identified at this time.</p>
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Events in this process:

P-030: Adjudicate Payment

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FOOTNOTE 68:

CMS SMHP TEMPLATE CROSSWALK

The following is a crosswalk between the questions posed by CMS to the States:

Question Number	CMS Guidance	Audit Strategy Report Section
1.	What will be the SMA's methods to be used to avoid making improper payments? (Timing, selection of which audit elements to examine pre or post-payment, use of proxy data, sampling, how the SMA will decide to focus audit efforts, etc.)	Section D
2.	Describe the methods the SMA will employ to identify suspected fraud and abuse, including noting if contractors will be used. Please identify what audit elements will be addressed through pre-payment controls or other methods and which audit elements will be addressed post-payment.	Section D
3.	How will the SMA track the total dollar amount of overpayments identified by the State as a result of oversight activities conducted during the FFY?	Section D
4.	Describe the actions the SMA will take when fraud and abuse is detected.	Section D

Question Number	CMS Guidance	Audit Strategy Report Section
5.	Is the SMA planning to leverage existing data sources to verify meaningful use (e.g. HIEs, pharmacy hubs, immunization registries, public health surveillance databases, etc.)? Please describe.	Section D
6.	Will the state be using sampling as part of audit strategy? If yes, what sampling methodology will be performed?* (i.e. probe sampling, random sampling)	Section D has high level information; Detail Deferred to DDI Phase
7.	**What methods will the SMA use to reduce provider burden and maintain integrity and efficacy of oversight process (e.g. above examples about leveraging existing data sources, piggy-backing on existing audit mechanisms/activities, etc.)?	Section D has high level information; Detail Deferred to Implementation Phase
8.	Where are the program integrity operations located within the State Medicaid Agency, and how will responsibility for EHR incentive payment oversight be allocated?	Section D

* The sampling methodology part of this question may be deferred until the State has formulated a methodology based upon the size of their EHR incentive payment recipient universe.

**May be deferred

APPENDIX D-1

Fraud, Waste and Abuse

Maine must comply with all Federal laws and regulations designed to prevent fraud, waste, and abuse, including, but not limited to applicable provisions of Federal criminal law, the False Claims Act (32 U.S.C. 3729 et seq.), and the anti-kickback statute (section 1128B(b) of the Act). Upon completion of an audit of eligibility determinations, attestation, or incentive payments, an Auditor will evaluate the data provided by the eligible professional or hospital and compare it to the data submitted to MaineCare via registration, attestation, or in a payment request.

Fraud is defined as intentional deception or misrepresentation, oral or written, which an individual knows to be false, or does not believe to be true, made with knowledge that deception or misrepresentation could result in some unauthorized benefits. The requisite intent is present if the misrepresentation was made knowingly or with a reckless disregard for the truth. The following is a list of what Maine would consider to be fraud and abuse indicators:

Fraud and Abuse Indicators

Professionals who claim a disproportionate number of MaineCare members compared to other providers of the same service

Professionals who report a sudden increase in Medicaid utilization compared to prior years

Fraud and Abuse Indicators

Misrepresentations of dates and reporting periods, or the identity of the individual who participated in the program

Counting expenses not incurred or which were attributable to non-program activities, other enterprises, or personal expenses for the purpose of meeting program requirements

Professionals or hospitals who cannot provide supporting documentation for claimed purchases

Any claims of AIU or Meaningful Use of certified EHR technology which are not supported by the provider's actions

Professionals requesting payments from both the Medicare and Medicaid EHR Incentive Payment Programs

Deliberately providing attestations, or receiving incentive payments on account of another individual;

Arrangements by professionals or hospitals with employees, independent contractors, suppliers, and others that appear to be designed primarily to meet the conditions of program participation

Concealing business activities that would prevent compliance with applicable requirements

Falsifying records in order to meet or continue to meet the conditions of program participation

APPENDIX D-

1

Professionals or hospitals that hold a history of committing health care fraud or abuse are considered high risk audit targets by the State. The State will pursue the identified high risk audit targets as a focus point for early review of program compliance.

If fraud, waste, or abuse is suspected, the case will be forwarded to the State of Maine's Healthcare Crimes Unit in the Attorney General's Office. Additionally, the State will seek to recover any and all funds not used in accordance with the program requirements or standards. Provider requests for payment for any benefit, including incentive payments, are subject to Maine criminal and civil fraud statutes and will be enforced. As written in the Administrative Policies and Procedures of the Maine State Services Manual, Maine's False Claims Act imposes restitution and treble penalties on anyone who defrauds DHHS by obtaining payment for any false, fictitious or fraudulent claim.

AUDIT STRATEGY

The table below outlines the inputs used to define the State's Audit Strategy.

Inputs to Developing the State's Audit Strategy
Review of the MITA State Self-Assessment and current-state audit processes
Review of CMS' EHR Incentive Program Final Rule
Review of the CMS SMHP template
Review of the interface control document for the National Level Repository (NLR)
Review of the State Medicaid Directors Letter issued by CMS on August 17, 2010

The table below shows the activities completed to develop the State's Audit Strategy.

Activities to Develop the State's Audit Strategy
Developed MaineCare's Audit process, sub-processes, and activity flows
Reviewed and validated the Audit process with business and technology SMEs from MaineCare, OIT, Finance, and Operations
Created the State's Audit Strategy for the EHR Incentive Program
Reviewed and finalized the State's Audit Strategy for the EHR Incentive Program

3

Footnote 73: Audit Eligibility

Tasks in this process:

AUD-010-010: Initiate Audit

Description:	<p>Description: After the HIT Team determines eligibility, the Audit Division initiates a review of EP and EH eligibility determinations.</p> <p>Resource: Audit Division</p> <p>Proposed Technology to leverage: OIT Developed HIT System and other existing systems.</p>
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AUD-010-020: Review Policy for Audit Criteria

Description:	<p>Description: Audit reviews the State regulations and policies that govern the EHR Incentive Program to determine if an EP/EH violated the policy and if that violation merits an audit that can be pursued and supported by State policies.</p> <p>Resource: Audit Division</p> <p>Proposed Technology to leverage: OIT Developed HIT System and other existing systems</p>
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AUD-010-030: Extract data from data sources

Description:	<p>Description: MaineCare extracts data from data sources to complete eligibility determination calculation.</p> <p>Resource: HIT Team</p> <p>Proposed Technology to leverage: OIT Developed HIT System and other existing systems</p>
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AUD-010-040: Run State Eligibility Calculation

Description:	<p>Description: MaineCare will apply the State defined eligibility determination methodology to calculate patient volume thresholds.</p> <p>Resource: HIT Team</p> <p>Proposed Technology to leverage: OIT Developed HIT System and other existing systems</p>
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3

AUD-010-050: Send notification to EP/EH

Description:	<p>Description: MaineCare sends a letter to the EP/EH alerting them that MaineCare has determined that the EP/EH is not eligible for the EHR Incentive Program. The EP/EH has 60 days to respond to the letter.</p> <p>Resource: MaineCare Services</p> <p>Proposed Technology to leverage: None identified at this time</p>
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AUD-010-060: Receive notification from MaineCare

Description:	<p>Description: The EP or EH receives the letter from MaineCare alerting them that MaineCare has determined they are not eligible for the EHR Incentive Program. The EP/EH has 60 days to respond to the letter.</p> <p>Resource: MaineCare Services</p> <p>Proposed Technology to leverage: None identified at this time.</p>
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Gateways in this process:

Eligibility determination?

Description:	<p>Based on the State eligibility calculation, the State determines if an EP/EH is eligible for the EHR Incentive Program.</p>
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Appeal MaineCare decision?

Description:	<p>The EP/EH has the opportunity to appeal the decision from MaineCare.</p> <p>If the EP/EH initiates an appeal, the EP/EH will go through the Appeals process for the EHR Incentive Program.</p> <p>If the EP/EH does not appeal the decision, MaineCare will initiate the Manage Recoupment sub-process to recover incentive funds from the EP/EH.</p>
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Events in this process:

RE-020-050: Send Eligibility Status to EP/EH

P-050: Manage Recoupment

APP-010: Appeal Eligibility, AIU, MU, and Payment Determinations

P-030: Adjudicate Payment

4

Footnote 75: Auditing AIU

Tasks in this process:

AUD-020-010: Initiate Audit

Description:	<p>Description: Audit initiates a review to verify that an EP or EH has adopted, implemented, or upgraded certified EHR technology for the payment year.</p> <p>Resource: Audit Division</p> <p>Proposed Technology to leverage: OIT Developed HIT System and other existing systems</p>
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AUD-020-020: Review EP/EH Attestations and Policy for Audit Criteria

Description:	<p>Description: MaineCare then reviews the State regulations and policies that govern the EHR Incentive Program to determine if an EP/EH violated the policy and if that violation merits an audit that can be pursued and supported by State policies. MaineCare also reviews the attestations from the EP/EH attesting whether they have adopted, implemented, or upgraded EHR technology. MaineCare will verify that the certified EHR technology code provided by the EP or EH in their attestation appears on the list of certified EHR technology provided via the ONC Web Service. EPs/EHs are required to provide the following information:</p> <ul style="list-style-type: none"> Attestation date EHR incentive payment year – Year 1 EHR participant participating year EHR reporting period dates NPI CCN <p>The type of Certified EHR Technology that the provider uses and attestation that the Technology is including on the certified technology list of CMS. This information will be verified against the EP/EHs attestation.</p> <p>Resource: Audit Division</p> <p>Proposed Technology to leverage: OIT Developed HIT System and other existing systems</p>
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AUD-020-030: Request EP or EH EHR technology verification

Description:	<p>Description: EPs or EHs must have proof that they have adopted, implemented, or upgraded certified EHR technology. They will be instructed that they need to retain written proof that is acceptable by MaineCare and CMS as regularly accepted proof for accounting and audit purposes for six years. Audit will verify that the technology that the provider attested to is on the CSM list of certified technology and for desk audits or on-site audits the provider must provide that proof. (MaineCare and Audit will develop the list of acceptable proof early this summer.</p> <p>Resource: Audit, MaineCare Services</p> <p>Proposed Technology to leverage: ONC Web Service</p>
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AUD-020-060: Send notification to EP/EH

Description:	<p>Description: If the provider fails to show acceptable proof, Audit will send a letter to the EP or EH alerting them that MaineCare has determined that the EP/EH has not adopted, implemented or upgraded certified EHR technology in the relevant payment year. The EP/EH has 60 days to respond to the letter. The Provider’s HIT “file” will be noted to show the Audit findings.</p> <p>Resource: MaineCare Services, Audit</p> <p>Proposed Technology to leverage: OMS OIT developed HIT system.</p>
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AUD-020-070: Receive notification from MaineCare

Description:	<p>Description: The EP or EH receives the letter from Audit/MaineCare alerting the provider that MaineCare has determined that the EP/EH has not adopted, implemented or upgraded certified EHR technology in the relevant payment year and that the EP/EH must remit funds to MaineCare. The EP/EH has 60 days to respond to the letter.</p> <p>Resource: MaineCare Services, Audit</p> <p>Proposed Technology to leverage: None identified at this time</p>
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Gateways in this process:

AIU of EHR Technology?

Appendix D-4

Description:	<p>Based on the review of the documentation provided by the EP/EH during an audit/review, the State determines if the EP/EH has adopted, implemented, or upgraded certified EHR technology in compliance with the policies for the EHR Incentive Program.</p>
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Appeal MaineCare decision?

Description:	The EP/EH has the opportunity to appeal the decision from MaineCare. If the EP/EH initiates an appeal, the EP/EH will go through the Appeals process for the EHR Incentive Program. If the EP/EH does not appeal the decision, MaineCare/Audit will initiate the Manage Recoupment sub-process to recover incentive funds from the EP/EH.
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Events in this process:

P-030: Adjudicate Payment

APP-010: Appeal Eligibility, AIU, MU, and Payment Determinations

P-050: Manage Recoupment

Footnote 77: Auditing Incentive Payments

Tasks in this process:

AUD-040-010: Initiate Audit

Description:	Description: Audit initiates an audit on incentive payments to EPs and EHS. Resource: Audit/MaineCare Services Proposed Technology to leverage: AdvantageME
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AUD-040-020: Review EP/EH Attestations and Policy for Audit Criteria

Description:	Description: Audit reviews the State rules and policies that govern the EHR Incentive Program to determine if an EP or EH violated the policy and if that violation merits an audit that can be pursued and supported by State policies, namely overpayment of incentive funds. MaineCare will also review any attestations provided by the EP or EH. Resource: Audit/MaineCare Services Proposed Technology to leverage: None identified at this time
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AUD-040-030: Extract payment data from data sources

Description:	Description: Audit extracts data from State systems and data sources to complete the audit on incentive payments. Resource: Audit/MaineCare Services Proposed Technology to leverage: OIT Developed HIT System and other existing systems, MIHMS, AdvantageME
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5

AUD-040-040: Request data from EP/EH

Description:	<p>Description: Audit requests data from the EP or EH to identify if an overpayment to the EP or EH occurred. Information requested could include a contract that shows proof of adoption, implementation, or upgrade of EHR technology and a copy of the EP/EH attestations. Hospitals may be asked for their hospital cost data including discharge information for a 12-month period related to inpatient bed days by payer type.</p> <p>Resource: Audit</p> <p>Proposed Technology to leverage: None identified at this time</p>
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AUD-040-050: Receive data request from MaineCare

Description:	<p>Description: The EP/EH receives the request for additional information from Audit/MaineCare to determine if the incentive payment amount was accurate.</p> <p>Resource: Provider</p> <p>Proposed Technology to leverage: None identified at this time</p>
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AUD-040-060: Send records and explanation to MaineCare

Description:	<p>Description: The EP/EH responds to the request for additional information from Audit/MaineCare by sending the requested data to identify if the incentive payment amount was accurate.</p> <p>Resource: Provider</p> <p>Proposed Technology to leverage: None identified at this time.</p>
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AUD-040-070: Receive EP/EH Response

Description:	<p>Description: Audit/MaineCare receives the requested data and explanation to identify if the incentive payment amount was accurate.</p> <p>Resource: Audit/MaineCare Services</p> <p>Proposed Technology to leverage: None identified at this time</p>
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AUD-040-080: Review data and calculate payment amount

Description:	<p>Description: Audit/MaineCare reviews the documentation sent by the EP/EH and calculates the EHR incentive payment to identify inaccurate payment or non-compliance with the EHR Incentive Program.</p> <p>Resource: Audit/MaineCare Services</p> <p>Proposed Technology to leverage: None identified at this time</p>
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AUD-040-090: Send notification to EP/EH of overpayment

Description:	<p>Description: Audit/MaineCare sends a letter to the EP or EH alerting them that MaineCare miscalculated their incentive payment to the EP/EH for the EHR Incentive Program and that the EP/EH must remit funds to MaineCare or will receive an incentive payment totaling the correct payment amount. The EP/EH has 60 days to respond to the letter.</p> <p>Resource: Audit/MaineCare</p> <p>Proposed Technology to leverage: None identified at this time</p>
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AUD-040-100: Receive notification from MaineCare

Description:	<p>Description: The EP or EH receives the letter from Audit/MaineCare alerting the provider that MaineCare has miscalculated their incentive payment. The EP/EH has 60 days to respond to the letter.</p> <p>Resource: Provider</p> <p>Proposed Technology to leverage: None identified at this time</p>
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Gateways in this process:

Verify payment amount?

Description:	<p>If the payment amount is verified, the audit is rescinded and the process ends.</p> <p>If the payment amount was incorrect, a notification is sent to the EP/EH that they received an incorrect payment amount.</p>
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5

Appeal MaineCare decision?

<p>Description:</p>	<p>The EP/EH has the opportunity to appeal the decision.</p> <p>If the EP/EH initiates an appeal, the EP/EH will go through the Appeals process for the EHR Incentive Program.</p> <p>If the EP/EH does not appeal the decision, MaineCare will initiate the Manage Recoupment sub-process to recover incentive funds from the EP/EH.</p> <p>If the EH/EP was underpaid, MaineCare will adjudicate the correct payment and issue incentive funds to the EP/EH.</p>
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Events in this process:

P-040: Manage Recoupment

P-030: Adjudicate Payment

APP-010: Appeal Eligibility, AIU, MU, and Payment Determinations

P-030: Adjudicate Payment

1
Footnote: 78

CMS Crosswalk Questions

The following questions were posed by CMS to the states providing direction on what content should be included in the State's HIT Roadmap:

1. Provide CMS with a graphical as well as narrative pathway that clearly shows where MaineCare is starting from ("As-Is") today, where it expects to be five years from now ("To-Be"), and how it plans to get there.
2. What are MaineCare's expectations regarding provider EHR technology adoption over time? Annual benchmarks by provider type?
3. Describe the annual benchmarks for each of MaineCare's goals that will serve as clearly measurable indicators of progress relative to plan.
4. Discuss annual benchmarks for audit and oversight activities.

Footnote 79:

Terms used in Gap Analysis

Column Title	Description
Gaps	A gap or difference identified after evaluating the “As-Is” against the “To-Be.” Activities and work is required to close the differences and achieve the “To Be.”
Implications	The potential impact of not addressing and closing the gap.
Recommendations	Actions identified gaps to close the difference and address the gap.
EHR Incentive Program	Program under the HITECH act for eligible hospitals and professionals that make available incentive payments for achieving adoption, implementation, or upgrade of EHR technology and Meaningful Use.
Long-Term HIT Vision	Program that achieves long-term HIT vision of MaineCare in order to exchange patient information, achieve quality goals in compliance with CMS’ requirements, and provide better health outcomes for citizens.
Calendar Year	Calendar year that represents when the gap needs to be considered and addressed.

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