



California State Medi-Cal Health Information Technology Plan

March 23, 2011

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1 CALIFORNIA'S "AS-IS" HIT LANDSCAPE

1.1 OVERVIEW

California not only boasts the largest population of the 50 states in the union – approximately 37 million residents – it is also the third largest state geographically. Though 80% of California is rural, 85% of the population lives in urban areas. Health care services are delivered to Californians through more than 400 hospitals and over 120,000 active physicians.

With more than 100,000 medical professionals and over 400 hospitals, California's large and diverse health care delivery system is characterized by provider organizations of varying sizes, ranging from very large (e.g. Kaiser Permanente), large (e.g., Sharp Healthcare), medium (e.g. Palo Alto Medical Foundation), to small (e.g. small and solo physician practices). Outpatient providers in a community may be tightly integrated (e.g. via integrated delivery networks [IDNs]), loosely affiliated (e.g. in IPAs), or entirely independent. Hospitals may be part of regional, statewide, or multi-state chains, or they may be independent local facilities. Several large health systems including Adventist, Catholic Healthcare West, Sutter Health, and Tenet provide services in multiple regions and many operate in more than one state.

Hospitals and community outpatient physicians may be tightly integrated into combined business entities (such as an IDN, like Kaiser Permanente), or they may be related only by virtue of physician admitting privileges. Provider organizations that are part of larger commercial entities may be well capitalized and capable of sophisticated infrastructure projects, whereas independent provider organizations and organizations treating underserved populations may be undercapitalized, thus less able to develop and support complex infrastructures.

California has a robust safety net infrastructure comprised of more than 800 community clinic and health center sites. More than 500 are Federally Qualified Health Centers (FQHCs) or FQHC look-alikes. The remaining number are free-standing community clinics that, like FQHCs and FQHC-LA's, are nonprofits that offer care on a sliding fee scale. These clinics and health center corporations range in size from single-site entities to multi-site organizations that span multiple counties and geographic areas. In 2008, California's clinics served 4.7 million patients, of which 1.6 million were Medi-Cal beneficiaries, for a total of 5.6 million Medi-Cal encounters. There are approximately 3,500 eligible professionals providing services across the safety net of community clinics and health centers. The safety net serves over 1.5 million uninsured patients. Many of these clinics and health centers have sophisticated health information technology systems. This is largely due to the infrastructure of regional clinic associations, many of which provide technical support to the clinics through the Health Center Controlled Network grants from the Health Resources and Services Administration (HRSA).

Health care in California is funded through a mosaic of payment mechanisms. National, statewide, and regional commercial insurers operate in California. The state and local governments finance care for the underserved through a variety of mechanisms, including Medi-Cal (both fee-for-service and managed care), Healthy Families (the state's CHIP program), and the county medical service programs, with a separate mechanism for managing the state's large prisoner health system. To add to this complexity, Medi-Cal carves out its behavioral health management to county medical service programs in 52 counties. Forty-nine percent of Californians receive health insurance through their employers, 16% are covered by Medi-Cal, 9% by Medicare, and 7% by individual plans. The remaining 19% of the population is uninsured. Insurance payment models include network-based fee-for-service plans (Preferred Provider Organizations [PPOs]), network-based capitation plans (Health Maintenance Organizations [HMOs]), and indemnity, as well as a wide variety of payments at facilities including percent of billed charges, case rates, per diem charges and hospital capitation. Delegation of risk and other insurance functions via HMOs is more common in California than most other states. Medicare and Medi-Cal delegate risk and claims payment functions to commercial insurance carriers through Medicare Advantage and managed care plans. Commercial insurers delegate risk and claims payment functions to contracted IPAs or medical groups.

Quality improvement efforts, while robust in some segments of commercial health care, through pay-for-performance and other similar programs, are largely limited in Medi-Cal to managed care plans. Medi-Cal managed care plans are required to report annually on a set of twelve Healthcare Effectiveness Data and Information Set (HEDIS) measures and engage in two quality improvement projects (QIPs). In Medi-Cal fee-for-service, which currently services slightly less than 50% of Medi-Cal recipients, quality improvement efforts are limited to several disease management pilot projects. The largest quality improvement effort in the Department of Health Care Services (DHCS), known as CalMEND, is a partnership initiative with the Department of Mental Health to improve quality and outcomes for publicly funded mental health services. The clinical data that practitioners and hospitals will be required to report to DHCS for meaningful use (MU) of Electronic Health Records (EHRs) beginning in 2012 will represent a large and new resource for planning and implementing quality improvement efforts in Medi-Cal and statewide.

1.2 EHR ADOPTION LANDSCAPE

The EHR adoption landscape described in the following pages was derived from a variety of sources over the last several months. Where possible, information has been derived from existing sources in both published and unpublished literature. This approach has been taken for a number of reasons. Providers and health care institutions report a high degree of "survey fatigue" from being asked to respond to multiple surveys from multiple sources. This has resulted in declining response rates that threaten the validity of any findings. It is not uncommon to now find 20% or 30%

response rates in major surveys. Another major reason is cost. Unlike smaller states, conducting a scientifically valid survey of providers in a state the size of California can be very expensive, especially if one employs the intensive follow-up techniques necessary to attain an acceptable response rate above 50%.

Appendix 1 describes in detail the data sources used in the pages that follow in this landscape assessment of EHR use in California. Where data sources are out-of-date, or inadequate for some other reason, we have made plans to augment these using new sources that will be published in the next 4 to 6 months. DHCS intends to complete this process within the six month timeframe, including new data collection and use of new published results for incorporation into our landscape assessment. The results will also be used to update other relevant sections of the SMHP as appropriate. At this point DHCS anticipates updating sections 1.3, 1.4, 2.1, 2.3, 2.4, and 5.1.3. A summary of sources and plans is contained in **Table 1** that follows. Details of each source and plans are described in the pages that follow this table.

TABLE 1: EHR ADOPTION SURVEYS – SOURCES AND PLANS

| | SOURCES | PLANS |
|---|---|---|
| PRACTITIONERS | | |
| Physicians | 2010 NAMCS 2007-2009 NSSMP | 2011 Feb-March: Survey of Physicians (UCSF with Medical Board) Planned survey by SK&A for ONC may also provide useful data on physicians |
| Dentists | 2010 CHCF | 2011 Feb-July: A version of the Medical Board physician’s survey will be modified by UCSF and administered through other licensing boards or professional associations. |
| Nurse Practitioners & Midwives | 2010 Board of Registered Nursing Survey | |
| Physician Assistants | None | |
| HOSPITALS | | |
| All | 2006-2007 AHA | 2011 Feb: AHA Survey 2011 Feb-July: UCSF Survey |
| CAHs | 2010 CSRHA | Consider re-administering in 2-3 years or incorporate into UCSF Survey |
| Children’s Hospitals | 2010 CCHA | Consider re-administering in 2-3 years or incorporate into UCSF Survey |
| CLINICS & GROUPS | | |
| Community Clinics | 2010 CPCA | 2011-2012: UCSF researchers will develop and field a combined survey. |
| Medical Groups and IPAs | 2006-2007 NSP02 2010 Cattaneo & Stroud | |

1.3 EHR ADOPTION BY PRACTITIONERS

The Office of the National Coordinator (ONC) commissioned the National Center for Health Statistics, National Ambulatory Medical Care Survey (NAMCS), 2008-2010 to assess adoption of EHRs by office-based physicians nationally. In results released in January 2011, 21.8% of office-based physicians have adopted at least a “basic”

electronic health record. This represents growth of nearly 50% since 2008. Growth in electronic health record adoption was strongest among primary care physicians last year, 29.6% of whom have now adopted at least a basic EHR. In addition, 41.1% of office-based physicians plan to apply for EHR incentive payments and of those physicians, 79.1% plan to apply in 2011 or 2012. California’s rates, according to the same survey, are not significantly different from the national averages. Approximately 22% of office-based physicians have at least a “basic” EHR in their practices. The estimated adoption rate among primary care physicians is 28%. An estimated 40% of office-based physicians plan to apply for EHR incentive payments.

| TABLE 2: IT CAPABILITIES AND EMRs IN SMALL PHYSICIAN PRACTICES | |
|--|---|
| | Small Physician Practices (N=71) |
| Electronic documentation | |
| Progress notes | 17% |
| List of patient medications | 23% |
| Electronic access to clinical data | |
| Laboratory test results | 80% |
| Specialist referral notes | 14% |
| Emergency department notes | 73% |
| Hospital discharge notes | 80% |
| Record of prescriptions filled | 13% |
| Clinical decision support | |
| Alerts for potential drug interactions | 8% |
| Alerts for abnormal tests | 8% |
| Prompts at time of visit | 7% |
| Physician order entry | |
| Physician electronic prescribing | 14% |
| Electronic registry for chronic illness | |
| Diabetes | 24% |
| Asthma | 7% |
| Chronic heart failure | 8% |
| Depression | 7% |
| Electronic connectivity for patients | |
| Physicians use e-mail with patients | 11% |
| Patients can access part of EMR online | 3% |
| Quality measurement | |
| EMR used to measure quality | 13% |
| NOTE: Preliminary Data from: National Survey of Small and Medium-sized Physician Practices (NSSMPP), July 2007-March 2009, including practices with 19 or fewer physicians. | |

Preliminary data from the National Study of Small and Medium-sized Physician Practices (NSSMPP), reporting 2009 data and including practices with 19 or fewer physicians, is the most currently available source of EHR adoption data in California (see **Table 2**). For these small and medium-sized practices, 33% of practitioners used at least some form of electronic medical record. However, only 17% used progress notes and 23% kept a list of patient medications. This suggests a great discrepancy between reports of provider adoption of EHR with the actual meaningful use of specific EHR functionalities. Most

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small practices reported electronic access to laboratory test results (80%), hospital discharge notes (80%), and emergency department notes (73%). However, for some types of connectivity, access was much lower: 13% reported access to a record of prescriptions filled and 14% reported access to specialist referral notes. Considering electronic communication to patients, 11% of practices exchanged e-mail with patients and only 3% allowed patients online access to their EHRs.

The NAMCS and NSSMPH data is limited in quality and is not specific to Medi-Cal physicians. To fill this gap and provide a scientifically valid ongoing survey of provider use of EHRs in California, DHCS is partnering with researchers at the University of California, San Francisco, to design and conduct an annual survey of physicians through the Medical Board of California's re-licensure process (see UCSF researcher bios in **Appendix 2**). The survey, which will be first administered in March 2011, is attached as **Appendix 3**. The ONC has recently contracted with SK & A to conduct a national survey of physicians. This has the potential to be an ongoing source of information for DHCS about physician EHR use.

Current data on non-physician practitioner use of EHRs (including Medi-Cal providers) is very limited. In 2010 the California HealthCare Foundation published a survey of dental practices in California that only attained a 3.7% response rate. This survey found that 23% of respondents reported having a fully functional dental EHR. Among Denti-Cal dentists, 37% reported being likely to participate in ARRA incentive programs, with an additional 27% somewhat likely. The California Board of Registered Nursing conducts a brief survey every two years that includes limited information about EHR adoption. The results for the 2010 survey will be available in March 2011 and will be analyzed by researchers at UCSF for DHCS.

In order to fill the gap of knowledge about EHR use by non-physician providers, DHCS will contract with researchers at UCSF to modify the survey they have developed for the Medical Board of California for use with non-physician providers. This will be administered when possible through licensing boards, but in some cases, such as with physician assistants, it may be necessary to administer it through professional associations.

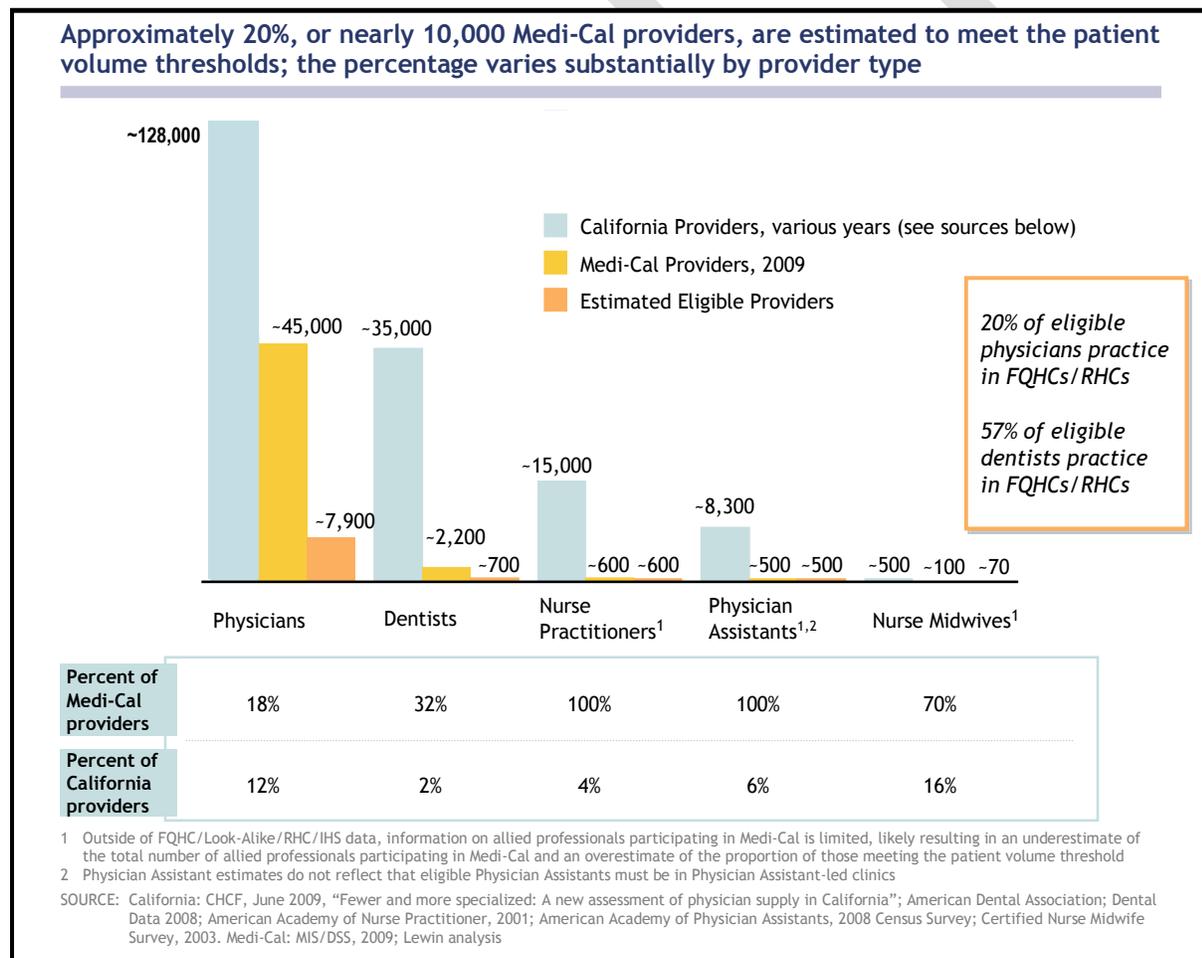
In April 2010, the Lewin Group and McKinsey & Company completed an assessment of the potential size and complexity of the Medi-Cal EHR Incentive Program for DHCS. Using several available data sources, including externally published data and the Medi-Cal eligibility and claims databases, they estimated that approximately 10,000 practitioners providing care to Medi-Cal patients in California will be eligible to receive incentive payments. This constitutes 20% of all Medi-Cal providers. Providers in counties with a higher proportion of Medi-Cal members are more likely to meet the patient volume threshold, as are providers in rural areas. In rural areas, nearly half (45%) of providers meeting the patient volume threshold will practice in clinics. Of these eligible providers, 7,900 will be physicians, 700 dentists, 600 nurse practitioners, 500 physician assistants, and 70 nurse midwives. According to the Final Rule and

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California’s State Plan, optometrists may also be eligible for incentive payments but their potential number has not been determined (see **Appendix 4** for a letter from DHCS attorney on this topic).

Lewin Group and McKinsey & Company also interviewed a targeted sample of providers and stakeholders. Providers interviewed uniformly expressed frustration with several important aspects of EHR adoption including: confusion on the best vendor choices, the ability of vendors to facilitate achievement of meaningful use, and how best to interpret vendor offers and commitments (e.g., meaningful use guarantees, financing options). Providers also consistently reported their most trusted sources of information to be regional medical associations, trade associations, local medical societies, medical groups/IPAs, and their peer providers.

FIGURE 1: ESTIMATED NUMBER OF MEDI-CAL ELIGIBLE PROVIDERS



1.4 EHR ADOPTION BY HOSPITALS

Initial results from the 2009/2010 American Hospital Survey were released in February 2011. This study, which attained a 25% response rate, found 15.1% of acute care non-federal hospitals have adopted at least a “basic” EHR. This represents growth of nearly 75% since 2008. In addition, 80.8% of acute care non-federal hospitals plan to apply for EHR incentive payments and of those hospitals, 80.1% plan to apply in 2011 or 2012. In California, according to the same source, approximately 21% (+/-4%) of acute care non-federal hospitals report having at least a “basic” EHR in place and approximately 82% (+/-4%) plan to apply for EHR incentive payments. In partnership with the California Hospital Association, DHCS anticipates being able to receive a more detailed breakdown of these survey results for California hospitals.

Detailed data on adoption of HIT by hospitals is primarily available from the 2006/2007 survey conducted by the American Hospital Association reported in a California HealthCare Foundation “snapshot” report published in 2008. The response rate for this survey was 30%. Looking at the big picture for hospitals, 55% were fully or partially implemented in 2007. However, digging deeper to look at specific aspects of HIT, figures of non-implementation (not implemented and not considering implementation) drops between 3% to 7% depending on the “use.” For example, 90% of all California hospitals had either fully or partially implemented the function “review lab results” into their electronic health records, another 8% are considering implementing, and 3% have not. Accessibility of the EHR across the hospital, however, is less developed. On these metrics, non-implementation ranged from 6% for hospital inpatient departments to 25% for post-acute care settings. The rate of hospital sharing of electronic patient information with outside physicians and other organizations such as labs, pharmacies and free-standing imaging centers varied widely. Most hospitals electronically shared patient information with physician practices (76%) and labs (74%), but very few shared information electronically with other hospitals (22%), retail pharmacies (9%) or school clinics (4%).

All Veteran Administration Hospitals in California use the highly successful Vista EHR system. The Veterans Administration San Diego Medical Center (VASDMC) recently launched an electronic medical data exchange and instant access program with Kaiser Permanente. This represents the first time a federal agency and a private healthcare organization have linked their computerized patient-records systems. In addition, the Naval Medical Center and VASDMC have established Virtual Lifetime Electronic Records (VLER) to share data. The VASDMC is a member of the Beacon Community collaborative led by the University of California, San Diego.

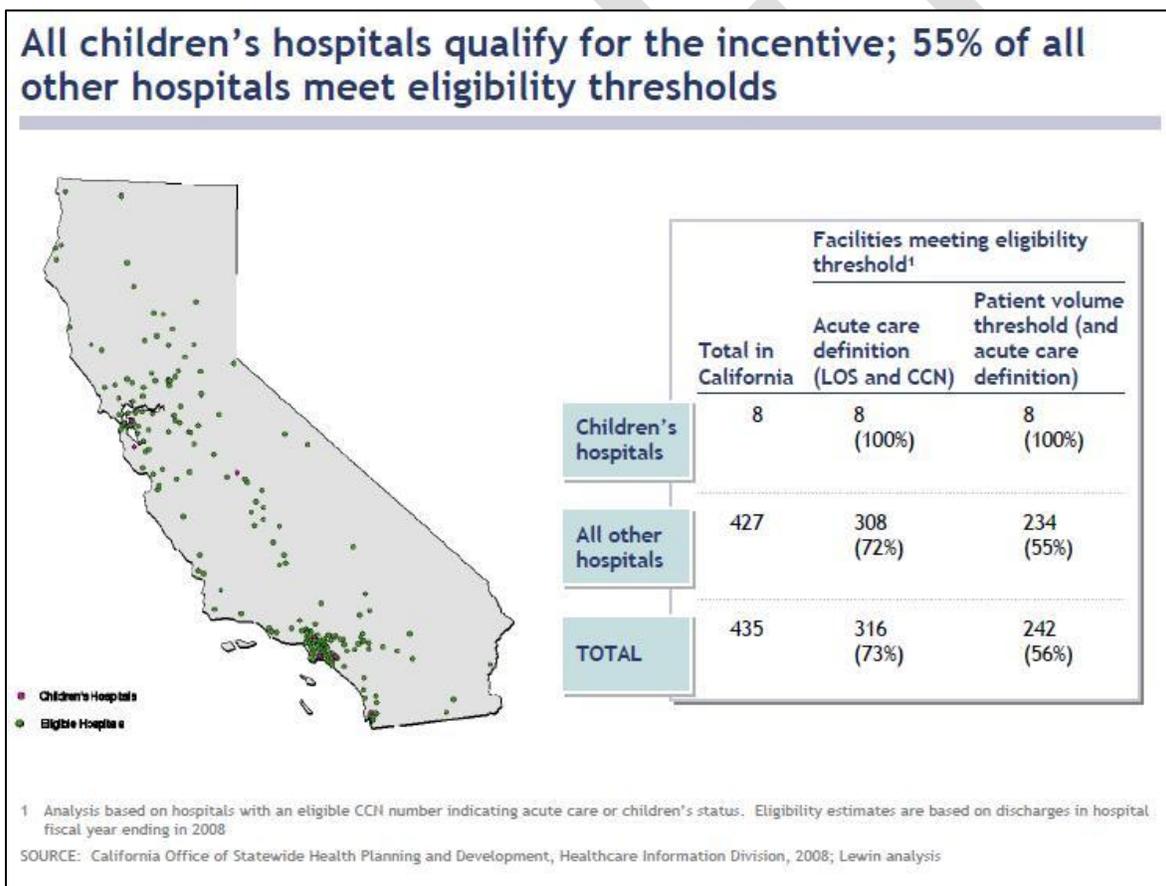
A mixed-methods study conducted by Robert Miller, Ph.D., and colleagues in 2008 reported on public hospitals and provided the following information:

“Although all public hospitals had basic clinical information system (CIS) capabilities, advanced CIS implementation varied greatly – for example,

hospitals in nine counties had electronic order entry used by support staff, eight had some form of clinical data repositories that enabled reporting, and seven had picture archiving and communication capabilities for digital imaging. Despite considerable CIS progress in some hospitals, none had implemented CPOE, considered to be among the most advanced CIS capabilities. Public hospitals in a few counties focused on implementing EHRs in their ambulatory care clinics, although none had fully done so.”

The work by the Lewin Group and McKinsey & Company found that 242 of 435 (55%) of the hospitals in California will be potentially eligible for Medi-Cal incentive payments based on Medi-Cal discharge volumes and other eligibility factors. Eight of these are Children’s hospitals; the remaining 234 are general acute care facilities. Statewide, these eligible hospitals will account for more than 93% of all Medi-Cal discharges and 72% of all acute care hospital bed days.

FIGURE 2: PERCENTAGE OF HOSPITALS QUALIFYING FOR INCENTIVE PAYMENTS



1.4.1 CALIFORNIA'S CRITICAL ACCESS HOSPITAL LANDSCAPE

In March 2010, the Rural Health Information Technology Consortium received a grant from California Health and Human Services (CHHS) to develop assessment tools and perform pilot studies to assess the technology readiness of five Critical Access Hospitals (CAH) in California to achieve the "Meaningful Use" measures proposed by the Centers for Medicare and Medicaid Services (CMS). Upon successful completion of the pilot, the consortium organized under the California State Rural Health Association (CSRHA) and received a grant from United Health Group in June 2010 to complete assessments on the remaining 25 CAHs and one pending CAH.

The technology assessment consisted of interviewing CAH staff and reviewing their internal documents and reports. Web based survey questionnaires were emailed to executive, finance, nursing, laboratory, radiology, pharmacy and IT managers at each facility. Questionnaire responses were reviewed, and a site visit allowed follow-up interviews with each manager to understand the hospital's readiness or plans for demonstrating meaningful use. Following the site visit, a draft technology assessment was circulated to the CAH staff for review and correction. Further staff comments were then included in the report. All reports were reviewed by the project director for completeness and summarized for stakeholder comment. Financial analysis of each CAH was also completed, including indicators of financial performance, estimating incentive payments and cost-reimbursement for HIT deployment, outpatient laboratory profitability, Medicare patient populations and Medi-Cal share of acute inpatient days.

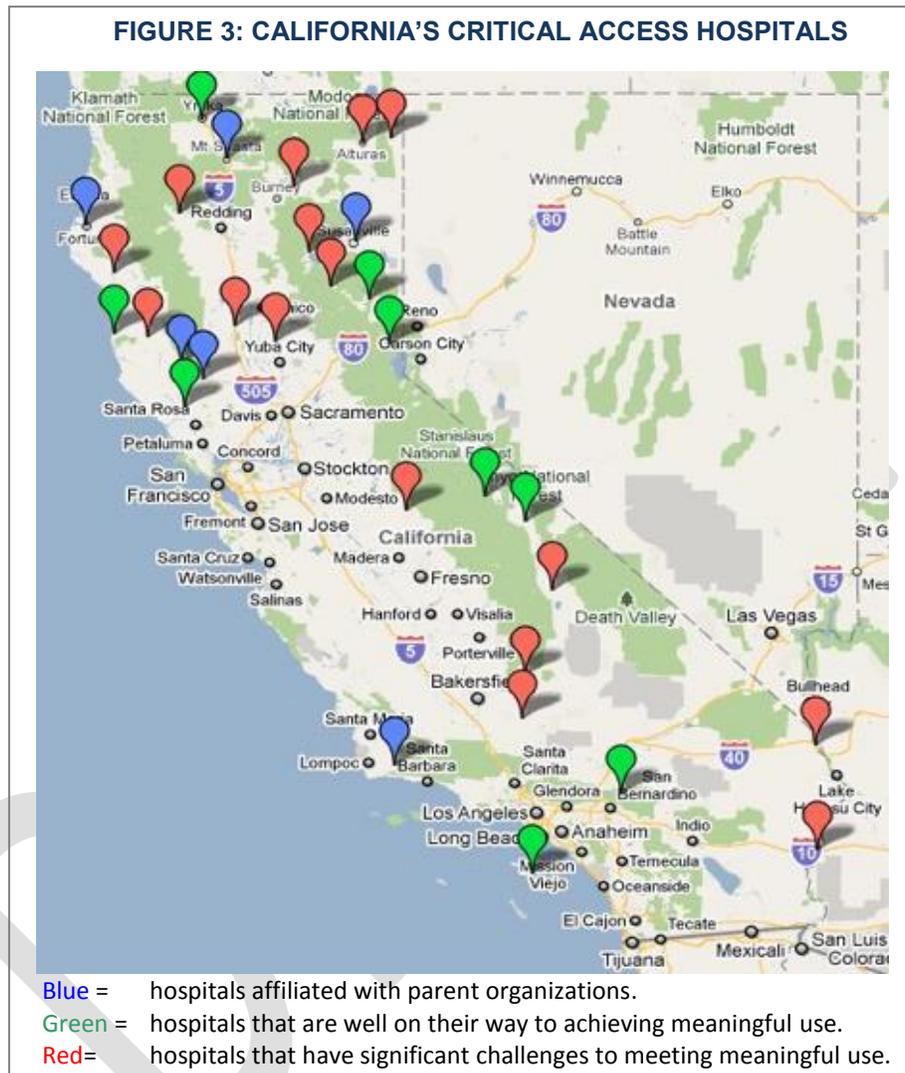
Stakeholder meetings were held in person at CSRHA offices and in Fresno, by teleconference and by Webinar. Stakeholders that participated in these meetings included Lisa Ashton of the Medi-Cal Office of Health Information Technology, Andie Martinez of the California Primary Care Association, Richard Swafford and Speranza Avram of CalHIPSO, Alana Ketchel of Cal eConnect, Ray Hino of the California Critical Access Hospital Network, Peggy Wheeler and Pam Lane of the California Hospital Association, Eric Brown of the California Telehealth Network, Earl Ferguson from the Southern Sierra Telehealth Network, Lee Barron from Southern Inyo Hospital, Alan Burgess of Tehachapi Hospital, Gail Nickerson of the California Association of Rural Health Clinics, Kim Salamone from Health Services Advisory Group (HSAG, the Rural Local Extension Center) and Desiree Rose and the Board of Directors of the California State Rural Health Association (who represent Rural Health Clinics, Community Clinics and Rural and Critical Access Hospitals).

In August 2010, the California HealthCare Foundation gave CSRHA a planning grant to write a report of the findings of these assessments and to make recommendations to accelerate the meaningful use of electronic health records in the state's CAHs.

California's CAHs serve rural Medicare patients on cost-based reimbursement for Medicare services and traditional fee-for-service for private payers and Medi-Cal. A CAH must provide 24-hour services, must be a minimum of 35 miles away from another

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hospital (15 miles in the case of mountainous terrain or in areas with only secondary roads available), must not exceed an average length-of-stay of 96 hours in the hospital business unit, and have a maximum of 25 beds, including “swing” beds that can transition from acute to skilled nursing.



According to the 2010 survey conducted by CSRHA, 10 of 31 CAHs have implemented EHRs, with another six in the process of implementation. The most common barrier cited by CAH chief executive officers (CEOs) to achieving meaningful use was funding. Most CAHs struggle financially, with only 13 of the 31 CAHs reporting a profit according to the most recent financial audit information. However, CSRHA projects that most CAHs will receive reimbursement adequate to achieve meaningful use. The estimated total of incentive payments for California’s CAHs will be \$73 million, compared to total anticipated AIU costs of \$55 million. However, these costs do not take into account ongoing operational costs, including HIE and increased information technology staffing

costs. According to CSRHA many rural hospitals, particularly those not affiliated with larger parent organizations, will need technical assistance if they are to make the right decisions to achieve and sustain meaningful use. **Figure 3** shows the location of California's CAHs and their potential status in achieving meaningful use.

DHCS is completing a contract with CSRHA to conduct on-site assessments of 38 rural hospitals and surrounding communities to provide a detailed landscape assessment of HIT readiness. These assessments, funded through the P-APD update process, will complete the baseline EHR adoption landscape assessment in California's critical access, rural and frontier hospitals.

1.4.2 EHR ADOPTION BY CHILDREN'S HOSPITALS

California's eight children's hospitals will all qualify for incentives under the Medi-Cal EHR Incentive Program regardless of Medi-Cal discharge volume. Based on 2008 data, the children's hospitals are expected to receive an estimated \$45 million in incentive payments. In a survey of the eight hospitals conducted by DHCS and the California Children's Hospital Association, six hospitals indicated that they will be participating in the hospital incentive program, one hospital (Loma Linda) will be applying in conjunction with their main hospital, while one hospital (Oakland Children's) is not sure about participation. In regards to the six hospitals who will be participating in the incentive program:

- Six hospitals currently have an operating EHR
- One hospital believes that it can meet the current meaningful use criteria
- Six of the hospitals indicated that they will achieve meaningful use by 10/1/2011

Successful health information exchange is a priority for the majority of children's hospitals and adequate funding is reported as their primary barrier to the adoption of new EHR technology.

1.5 EHR ADOPTION BY COMMUNITY CLINICS

In September 2010, the California Primary Care Association (CPCA) surveyed 181 clinic and health center corporations in California about health information technology related issues. One hundred and twenty-seven corporations responded, a 70% response rate. Seventy-five percent of the respondents were FQHCs or FQHC look-alike clinics. This survey found that 21% of clinic corporations have fully implemented EHRs, 19% have partially implemented EHRs and 60% do not have an EHR. Eighty-three percent of the clinics intend to work with its providers to participate in the Medi-Cal EHR Incentive Program, with 73% intending to do so in the first year. Sixty percent of clinics reported a need for additional staff for EHR support in the next two years. Two EHR products dominate the marketplace for community clinics and health centers –

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25% have eClinicalWorks and 25% have NextGen. In regards to organizations that have not yet implemented, 60% intend to purchase NextGen and 24% intend to purchase eClinicalWorks.

The main type of health information exchange clinics and health centers are engaged in is lab, followed by e-prescribing and radiology. Seventy-three of the 127 respondents had built and were actively using a lab interface, 25 a pharmacy interface, and only 12 a radiology interface. When asked what type of information would be most beneficial to exchange, 66% of respondents ranked eReferral and scheduling for specialty care as the most important. Following in importance was immunization registry, labs, patient summary, and lastly e-prescribing.

Fifty-two of California's FQHCs have been successful in obtaining funding from the HRSA Capital Improvement Project grants for health information technology and/or electronic health records. **Appendix 5** displays the names, locations, and grant types for these FQHCs. Additionally, there are 13 Health Center Controlled Network grantees in California with nearly \$24 million in dedicated funding for health information technology.

TABLE 3: HEALTH CENTER CONTROLLED NETWORK GRANTEES

| Grantee | Grant Number | Program Director | Financial Assistance |
|---|--------------|---|----------------------|
| ALLIANCE FOR RURAL COMMUNITY HEALTH | H2LIT16580 | Cathy Frey 707-462-1477 x101 | \$506,859.00 |
| ALLIANCE FOR RURAL COMMUNITY HEALTH | H2LCS18137 | Cathy Frey 707-462-1477 x101 | \$866,031.00 |
| ALTA MED HEALTH SERVICES CORPORATION | H2LIT16834 | Castulo de la Rocha 323-889-7310 | \$746,250.00 |
| ASSN OF ASIAN/PACIFIC COMM HLTH ORGANIZATIONS | H2LIT16610 | Rosy Weir 510-272-9536 x107 | \$191,250.00 |
| ASSN OF ASIAN/PACIFIC COMM HLTH ORGANIZATIONS | H2LCS18132 | Rosy Weir 510-272-9536 x107 | \$1,000,000.00 |
| CLINICA SIERRA VISTA | H2LIT16836 | Stephen W Schilling 661-635-3050 | \$1,865,625.00 |
| CLINICAS DEL CAMINO REAL, INC. | H2LCS18168 | Roberto S Juarez 805-659-1740 | \$3,000,000.00 |
| COMMUNITY ACCESS HCCN, LLC | H2LCS18174 | John Williams 415-391-9686 | \$2,519,875.00 |
| COMMUNITY HEALTH CENTER NETWORK | H2LCS18136 | Ralph Silber 510-297-0200 x266 | \$3,000,000.00 |
| FAMILY HEALTH CENTERS OF SAN DIEGO, INC. | H2LIT16855 | Andres Gutierrez 619-515-2539 | \$1,865,625.00 |
| FAMILY HEALTH CENTERS OF SAN DIEGO, INC. | H2LCS18161 | Andres Gutierrez 619-515-2539 | \$3,000,000.00 |
| GOLDEN VALLEYHEALTHCENTER | H2LCS18131 | Michael O Sullivan 209-383-1848 x351 | \$2,998,013.00 |
| REDWOOD COMMUNITY HEALTH NETWORK - REDWOOD COMMUNITY HEALTH COALITION | H2LCS18142 | Nancy O Oswald 707-792-7900 x216 | \$2,079,598.00 |

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There are a large number (over 200) of non-FQHC clinics in California licensed as 1204a clinics under state law. As such they must be non-profit entities that charge patients based on ability to pay, utilizing a sliding fee scale. If deemed too financially restrictive for the patient, they cannot charge the patient directly for services rendered or for medications, appliances, or apparatuses furnished. These clinics constitute an important component of the state's safety net for the most vulnerable of our population. A large number of providers in these clinics may not qualify for Medi-Cal EHR Incentive Program payments due to the inability to count uninsured and other needy patient encounters toward their patient volumes.

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1.6 EHR ADOPTION BY LARGE MEDICAL GROUPS AND INDEPENDENT PRACTICE ASSOCIATIONS

The National Study of Physician Organizations, reporting 2007 data, found a relatively low adoption rate for medical groups and IPAs in California – only 32% of medical groups and 6% of IPAs made an EHR available for progress notes, and even fewer for lists of patient medications (see **TABLE 4**). However, looking at electronic access to clinical data, medical groups and IPAs had much better utilization rates, especially for laboratory test results (59%), though less so for a record of prescriptions filled (13%). Twenty-nine percent of organizations reported that providers exchanged e-mail with patients and only 3% allowed patients online access to their EHRs.

In 2009, the Integrated Healthcare Association (IHA) surveyed 193 medical groups and IPAs in California with at least one commercial HMO contract, asking: “Please indicate your organization’s Electronic Medical Record status.” Responses were as follows: 28.1% “Fully Operational;” 33.3% “Implementation Underway;” 20.8% “Implementation Planned;” and 15.1% “No Implementation Planned.” Only 2.7% did not respond. The same question was asked of all 28 reporting units for Kaiser Permanente – they all responded “fully operational.” IHA also includes HIT criteria in their pay-for-performance program and therefore has audited data for measurement years 2003-2009 on several aspects of HIT adoption. In 2009, 62.7% reported having computerized registries; 26.9% electronic prescribing; 53.4%

| TABLE 4: IT CAPABILITIES AND EHRs IN LARGE MEDICAL GROUPS AND IPAS IN CALIFORNIA | | |
|--|----------------|-------|
| | Medical Groups | IPAs |
| | N=71 | N=113 |
| Electronic documentation | | |
| Progress notes | 32% | 6% |
| List of patient medications | 25% | 8% |
| Electronic access to clinical data | | |
| Laboratory test results | 69% | 52% |
| Radiology test results | 63% | 39% |
| Specialist referral notes | 37% | 9% |
| Emergency dept. notes | 42% | 19% |
| Hospital discharge notes | 55% | 33% |
| Record of prescriptions filled | 18% | 10% |
| Clinical decision support | | |
| Alerts for potential drug interactions | 24% | 5% |
| Alerts for abnormal tests | 20% | 10% |
| Prompts at time of visit | 21% | 10% |
| Physician order entry | | |
| Physician electronic prescribing | 32% | 17% |
| Electronic registry for chronic illness | | |
| Diabetes | 62% | 51% |
| Asthma | 39% | 48% |
| Chronic heart failure | 44% | 41% |
| Depression | 23% | 19% |
| Electronic connectivity for patients | | |
| Physicians use e-mail with patients | 39% | 23% |
| Patients can access part of EMR online | 4% | 3% |
| Quality measurement | | |
| EMR used to measure quality | 19% | 39% |
| NOTE: National Study of Physician Practices (NSPO2), March 2006–March 2007, including practices with 20 or more physicians. | | |

electronic lab results; and 47.2% electronic messaging. Also, 51.8% were able to access clinical notes of other practitioners; 50.3% provided physician reminders for preventive and chronic care; and 31.6% could order lab tests electronically. These numbers do not include Kaiser Permanente.

In 2010, Cattaneo & Stroud conducted a survey of the California medical groups (excluding Kaiser Permanente) accepting managed care contracts and having at least six primary care providers. The 155 groups responding reported 18% of primary care providers use EHRs. A relatively high percent of respondents (33%) reported not knowing the rate of EHR use by their providers. The reported rate of use of EHRs by specialists was only 8%. The reported rates of group support for e-prescribing, local HIE, and electronic lab reporting were 57%, 37%, and 41%, respectively.

Although there is current knowledge of EHR use by clinics and groups, it is not complete or consistent across settings. For this reason DHCS will be contracting with researchers at UCSF to design a unified survey that will be conducted at the end of 2011 and repeated periodically in the future. The PIs on this project will be Drs. Miller and Rittenhouse. Please see bios in **Appendix 2**.

1.7 EHR ADOPTION BY INDIAN HEALTH CLINICS

There are 64 small and independent Tribal Health Programs in rural and isolated communities in the state which are hard to reach and have high provider turnover. Most do not currently use EHRs although some use the Indian Health Services' Resource and Patient Management System (RPMS) which is an electronic health information technology solution used to manage clinical, business practices and administrative information in order to meet stringent Indian Health Services (IHS) reporting requirements, including the Government Performance and Requirements Act (GPRA) reporting.

A network of primary care clinics throughout the state is funded by IHS to provide care to American Indians and other underserved populations as identified in the clinic charter/mission. These clinics can participate in Medi-Cal as a Tribal Health Provider (THP) funded under the authority of Public Law (PL) 93-638, 25 USC 450 et seq., FQHC, Rural Health Clinic (RHC), or Community Health Center if they meet all of the federal and state statutory requirements for each provider type.

In 1998, DHCS implemented a Memorandum of Agreement (MOA) between the federal IHS and the Health Care Financing Administration (HCFA). HCFA was later renamed the Centers for Medicare & Medicaid Services (CMS). The MOA established a new provider type and reimbursement rate for services provided to Medi-Cal recipients at tribal health clinics funded under PL 93-638. The MOA established the THP provider type. Clinics subsequently had the option to change their provider type. Most of the tribal health clinics changed their provider status from FQHC to THP at that time to take advantage of the new reimbursement system although they did not change operations.

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As of March 2010, there were 16 FQHCs and 48 THP Indian health clinic providers enrolled in the Medi-Cal program.

THP clinics are operated by tribes and tribal organizations as primary care clinics in California under the authority of PL 93-638 and funded by the IHS to continue to provide a significant level of health care services at no cost to individual American Indians. These services meet the description of services provided to needy patients established in 42 CFR 495.306 and the THP clinics have requested to be considered as FQHCs for the purposes of the Medi-Cal EHR Incentive Program. In compliance with CMS' recently published FAQ on this issue, DHCS will not treat the THP clinics as equivalent to FQHCs for this purpose. However, DHCS recommends that CMS continue to consider this issue since many THP clinics will probably not be able to qualify for the program without being considered equivalent to FQHCs.

There is a strong need for tribal and urban Indian health programs to interface with RPMS, the systems used by IHS to manage clinical, business practice, and administrative information. Despite large amounts of federal funding for IHS, there is little support for the Tribal and Urban Health Programs in California to implement non-RPMS EHRs. When establishing HIE in rural communities, Cal eConnect will promote connections established between the tribal clinics and the rural hospital to which they are referred to for care.

1.8 REGIONAL EXTENSION CENTERS

A key component in transforming the use of EHRs is the change in workflow within providers' offices. EHRs are only implemented successfully when there is sufficient support and experience related to the changes in workflow and the understanding of the technology. In recognition of this, the ONC implemented the Regional Extension Center (REC) program to assist providers in the many steps necessary to adopt EHRs and to use them effectively to meet meaningful use. California is well-positioned through its REC programs to help providers through these steps.

The California Health Information Partnership and Services Organization (CalHIPSO) is an organization founded by clinical providers, for clinical providers, to help them successfully navigate through the complicated world of EHR implementation. CalHIPSO covers the majority of the state through its network of Local Extension Centers (LEC) as shown in the map below. CalHIPSO has funding to support 6,187 providers and has registered over 50% of those (3,510) to date.

In Los Angeles County, HITEC-LA is the REC charged with helping doctors and primary care providers purchase, implement and use electronic health records in a meaningful way. HITEC-LA will help providers assess their technology needs, as well as offer education, training, and on-site technical assistance.

In Orange County, the CalOptima Regional Extension Center (COREC) will collaboratively work with physicians and other eligible providers to integrate HIT into

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their offices and bring them to meaningful use. COREC will work with service partners who will deliver on-site support and assistance to Orange County physicians and providers. Although any Orange County provider can participate, COREC's first focus will be on primary care physicians, physician assistants and nurse practitioners who operate in individual or small group practices, community clinics or public and/or critical access hospitals.

The California Rural Indian Health Board (CRIHB), as a partner with the National Indian REC, will ensure that CA tribal and urban Indian health programs and their eligible providers achieve meaningful use of electronic health records by facilitating EHR adoption. They will collaborate with IHS, tribes, urban Indian health programs, and tribal organizations to develop and disseminate best practices and education to facilitate EHR adoption and enhance the Indian healthcare system in California.

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FIGURE 4: CALHIPSO LOCAL EXTENSION CENTER LOCATIONS



Local Extension Centers



1.9 VULNERABLE POPULATIONS

1.9.1 CHILDREN IN FOSTER CARE IN CALIFORNIA

There are approximately 62,000 children in foster care in California. As is the case nationally, these children tend to have more complex health care needs than other children and account for a disproportionate share of Medi-Cal expenditures. Nearly half of all children living in foster care in California suffer from chronic illnesses, and children in foster care are three to six times more likely than those in the general population to have significant psychological or behavioral problems. Yet children in foster care receive less than optimal care for a number of structural reasons.

On average, children placed in foster care in California experience two to three changes in foster placements each year. Placement changes are often accompanied by changes in health providers. The existing system for sharing information about a child in foster care is, to a large extent, based on the passing of duplicate paper forms among caseworkers, public health nurses, foster parents, and health providers. Often providers do not receive forms, or receive forms that are missing crucial information about the child. Inadequate medical records for children in foster care contribute to poor quality health care that, in some instances, can be life-threatening. This can include duplication of immunizations, over-prescription of psychotropic medications, misdiagnoses, and subsequent medical errors and omissions based on faulty paperwork. According to Children's Action Network, "doctors often have no reliable birth or immunization records, don't know who has previously treated the child, and have no facts about current and past diagnoses, treatments, or prescriptions."

Electronic exchange of key information for this highly mobile, high-needs population of children can result in greater coordination of care between providers and caretakers. This can increase efficiency, reduce program costs at the state and local levels and significantly improve outcomes for youth in foster care. Early findings from related efforts indicate that the information management and coordination of care enabled by a system of electronic information-sharing can result in improved preventive care, decreased hospital stays, improved clinical conditions, and decreased cost of care. After implementation of electronic information exchange in Milwaukee, Wisconsin, the number of youth in residential programs declined from 364 to 140 per day, psychiatric hospitalizations declined by 80%, and the cost of care per child dropped from \$5,000 per month to less than \$3,300. Children in foster care also experienced a variety of improvements in clinical conditions.

DHCS recognizes the great potential to improve coordination across the many programs and services available to children in foster care through the use of EHRs and electronic data-sharing and has been working with stakeholders to develop interventions and pilot projects. The long-term goal is provide access to information to foster parents, caseworkers, health providers (physical, mental, and dental), public

health nurses, educators, attorneys, judges, and older youth in foster care. The California information technology architecture involved may include the statewide health information exchange (HIE) infrastructure, the Medicaid Management Information System (MMIS), and the State Automated Child Welfare Information System (SACWIS), as well as local systems that vary by county. The goals of this long-term effort is to provide comprehensive information about a child, facilitate communication among providers so they can more effectively coordinate and deliver care to children, afford foster parents and older youth in foster care access to information, and provide youth in foster care with a record of conditions and services received.

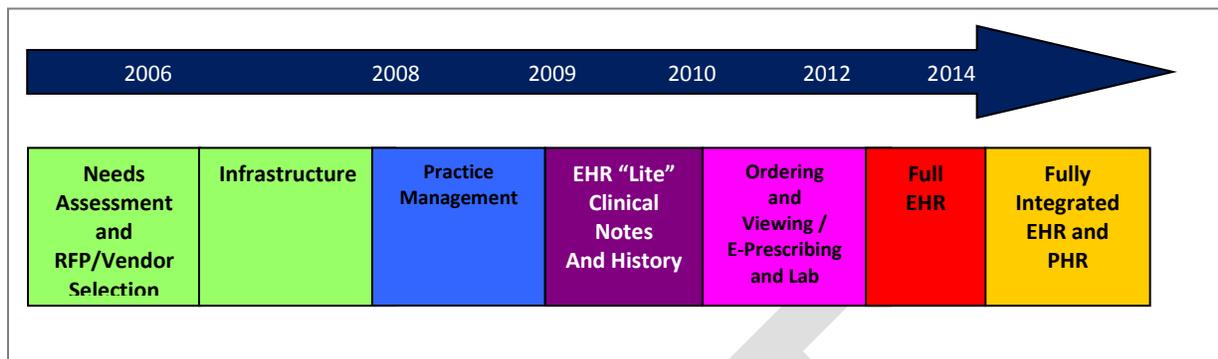
1.9.2 MENTAL HEALTH AND SUBSTANCE USE DISORDERS

Persons with severe mental health and/or substance use (MH/SU) disorders have traditionally been unable to access the proper coordination of physical and mental health services necessary to promote recovery and wellness. This contributes to multiple chronic medical illnesses for these persons with increased costs for the medical system, and eventually results in much earlier deaths. A critical issue in the current health reform and economic climate is that Medicaid has become the single largest payer of mental health services for low-income people, accounting for about 40% of all public-sector spending on mental health services in 2001 compared with 21% in 1971. An October 2009 report from the Center for Health Care Strategies found that nationally, 49% of Medicaid beneficiaries with disabilities have a psychiatric illness. A recent study of Californians in the fee-for-service Medi-Cal system prepared by JEN Associates compared the 11% of Medi-Cal enrollees with a serious mental illness (SMI) to all Medi-Cal fee-for-service enrollees. The SMI group's spending was 3.7 times higher than the total population (\$14,365 per person per year compared with \$3,914).

The California Department of Mental Health (DMH) has been very forward-thinking by utilizing Mental Health Service Act of 2004 (MHSA) funds to support the deployment of EHRs in county mental health facilities throughout the state.

DMH has developed a HIT Roadmap for HIT/HIE implementation that reflects a collaboration between DMH, county mental health services and numerous behavioral health stakeholders throughout California. **Figure 5** displays DMH's five HIT roadmap functions. **Appendix 6** provides a chart displaying the HIT projects of each county according to these roadmap functions including a map that displays the progress of each county mental health department toward implementation of a fully-functional EHR.

FIGURE 5: DMH'S FIVE ROADMAP FUNCTIONS



DMH's HIT/HIE efforts preceded the current Medi-Cal EHR Incentive Program. Since a large percentage of mental health patients are also Medi-Cal recipients, DHCS has identified the need to build upon DMH's efforts toward bridging the gap between medical and mental health/substance use care and physical health provided by primary care providers. MHPA funds, which are entirely state derived, may be used to match Medi-Cal EHR Incentive Program federal administrative funding. DMH has identified three potential areas of collaboration in the future:

- Development of health information exchange that includes behavioral health data
- Development of a behavioral health continuity of care document
- Provision of technical assistance to county mental health departments to assist in the implementation of EHRs and HIE activities

1.10 BROADBAND INTERNET ACCESS

In January 2008, the California Broadband Taskforce concluded that ubiquitous broadband services are "...an integral part of improving the overall health of Californians and driving down the cost of care." California has moved forward with this vision through a successful Federal Communications Commission (FCC) grant award of \$22.1 million through the Rural Health Care Pilot Program - with the goal of significantly increasing access to acute, primary and preventive health care in rural California. This funding is building the California Telehealth Network (CTN- www.caltelehealth.org) a high-speed broadband network that will allow for the expansion of an eHealth network with an emphasis on rural and underserved populations. This network will connect over 850 sites statewide. It is expected that the network may expand to over 2,000 sites through other funding opportunities, such as those provided by the American Recovery and Reinvestment Act of 2009 (ARRA). California's \$3.6 million in matching funds is provided by California Emerging Technology Fund.

In addition to the CTN, California has another broadband network, the Corporation for Education Network Initiatives in California (CENIC), which provides broadband

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infrastructure to educational and research communities. Many of these facilities could be involved in the provision of clinical education programs.

Most recently, the University of California, Davis and the CTN were awarded a \$13.8 million Broadband Technology Opportunities Program (BTOP) Grant. This grant supports the adoption of broadband and technology enabled healthcare throughout the state by delivering multi-faceted training through partnerships with libraries, community colleges, health organizations and public safety sites. The project also intends to establish a best practice Model eHealth Community to demonstrate and facilitate the transition to technology enabled health delivery. It is funded by the federal government (\$9.1 million) with a match of \$4.7 million from California partners, namely the National Coalition for Health Integration, the California HealthCare Foundation and United HealthCare. This comprehensive training partnership is an innovative collaboration between academia, community-based educators, instructional design experts and tribal representatives. On-site and on-line courses will be developed or adapted to support the following curricula: Change Management, Broadband Adoption, CTN Broadband Orientation, EHR/HIE adoption, Telehealth Certificate Program, Consumer Health Informatics, and Clinician Health Informatics. Curricula will be leveraged for consumer education through public libraries, community colleges and local extension centers.

These networks are a product of California’s longstanding commitment and investment in broadband and Telehealth. California is a national leader in the development of technology-supported health care, having passed the California Telemedicine Act in 1996. The California Legislature, Governor and voters have demonstrated their commitment to eHealth through the passage of bond funding, legislation and executive orders that support the continued expansion of broadband and eHealth applications.

California also has an HRSA designated Telehealth Resource Center (TRC) that provides program guides, best practices, technical assistance, and other supporting services to newly developing Telehealth programs funded by HRSA. The California Telemedicine and eHealthCenter (CTEC) is one of only six designated TRCs throughout the country. CTEC has developed a comprehensive set of written program development materials, video education and training, best practice guides, policy guides, Telehealth training programs and technical assistance.

TABLE 5: BROADBAND ACCESS FUNDING

| Program | Federal Funding | CA Match | Total |
|--|------------------------|-----------------|----------------|
| FCC Rural Health Care Pilot Program | \$22.1M | \$3.6M | \$25.7M |
| Broadband Technology Opportunities Program Grant | \$9.1M | \$4.7M | \$13.8M |
| Total Broadband Funding | | | \$39.5M |

1.11 HEALTH INFORMATION EXCHANGE

1.11.1 STATE HIE/HIT COORDINATION

DHCS has long been in a readiness state to engage in health information exchange. In 2004, President Bush signed an executive order calling for the implementation of interoperable electronic health records in 10 years. On March 14, 2007, Governor Schwarzenegger signed an executive order reflecting his commitment to value-driven health care. As articulated by Michael Leavitt, Secretary of the U.S. Department of Health and Human Services at the time, value driven health care encompasses health information technology, health care price and quality transparency, and quality and efficiency improvement. Similarly, Governor Schwarzenegger's Health Care Reform Proposal, unveiled January 2007, identified Health Information Technology (HIT) as an integral component of comprehensive health care reform. The Governor's proposal was based on the ability of HIT to achieve more affordable, safe and accessible health care for Californians and called for the establishment of:

- 100% electronic health data exchange in the next 10 years
- Universal e-prescribing by 2010 to improve patient safety

Medi-Cal submitted CMS Transformation Grant applications in 2007 and 2008 with the intent to launch the Medi-Cal Health eSolutions project for the purpose of improving quality, reducing medication errors and reducing costs through the exchange of standardized clinical information between Medi-Cal and its providers. Though the state was not successful in securing grant funding, the process brought Medi-Cal into the Multi-State HIT Collaborative efforts that continue to share lessons learned from the Transformation Grant awardees and, more recently, share best practices for meaningful use. The Transformation Grant process also led to collaborative projects with the Northern Sierra Rural Health Network, the California e-Prescribing Consortium, Redwood MedNet, Long Beach Network for Health, CalRHIO and numerous other HIE/HIT efforts throughout the state.

The Office of Health Information Technology (OHIT) has been established in DHCS to develop goals and metrics for the program, establish policies and procedures, and to implement systems to disburse, track, and report the incentive payments. OHIT works closely with the Office of the Deputy Secretary for Health Information Technology in the California Health and Human Services Agency to coordinate the Medi-Cal EHR Incentive Program with wider health information exchange efforts throughout California and the nation. Over the past two years, California has engaged a diverse landscape of stakeholders that are supporting the adoption of EHRs and HIE infrastructure. This diverse landscape is represented in **Appendix 7**. A critical piece of the landscape is the eHealth Coordinating Committee which is convened by CHHS to facilitate collaboration and partnership among all entities that are working to implement health information exchange within the state. Representation includes government, ARRA/HITECH

grantees, and major California organizations and associations. The eHealth Coordinating Committee is a state policy entity that is focused on health information technology and health information exchange for all of California’s citizens. DHCS works closely with the eHealth Coordinating Committee, however DHCS does not convene the committee.

DHCS has established the Medi-Cal EHR Incentive Program Advisory Board for stakeholders specific to the Medi-Cal EHR Incentive Program. Monthly meetings of the Advisory Board serve to present and vet policy issues as well as solicit feedback for inclusion in the SMHP and development/enhancement of the SLR. Dialogue relative to these issues extends beyond the meetings, into day-to-day dialogue with stakeholders impacted by the issues. The OHIT staff and subject matter experts from various DHCS divisions participate at the Advisory Board meetings and workgroups as determined by program needs.

TABLE 6: THE ADVISORY BOARD STAKEHOLDERS

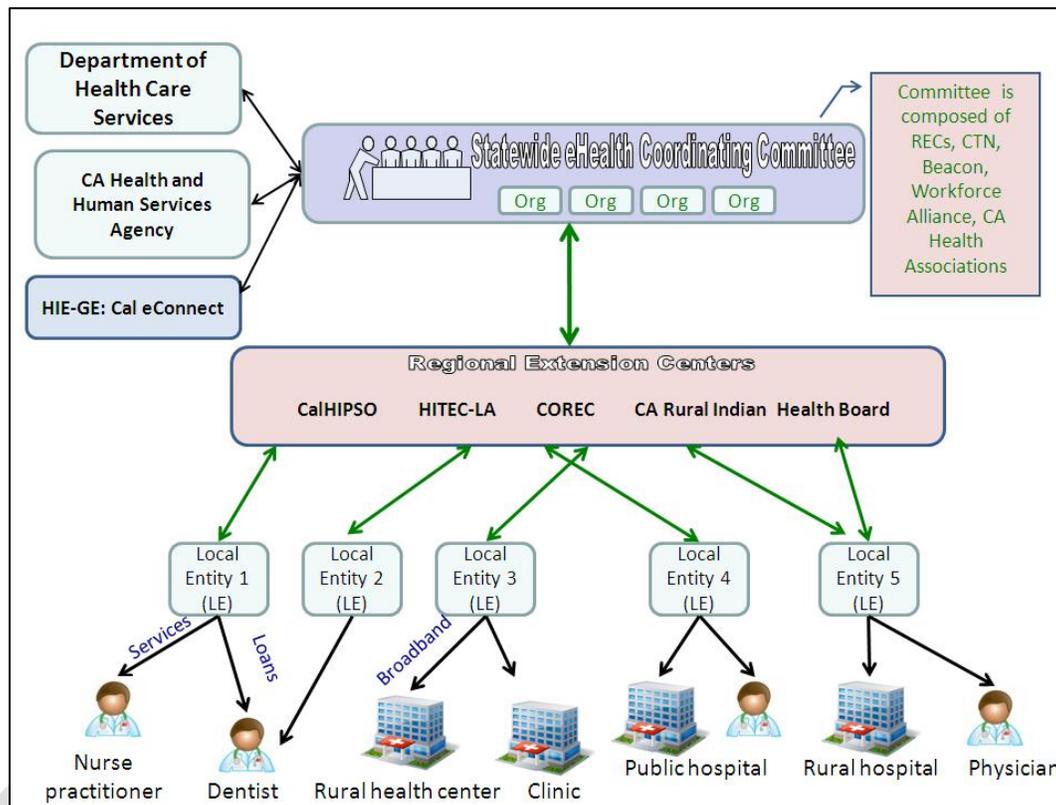
| Stakeholder | Advocacy |
|---|------------------------------|
| California Association of Physician Groups | Physicians |
| California State Rural Hospital Association | Rural Hospitals and Clinics |
| California Association of Public Hospitals | Public Hospitals |
| California HealthCare Foundation | Public Health |
| California Medical Association | Physicians |
| California Primary Care Association | FQHCs, RHCs and Patients |
| California Hospital Association | Hospitals |
| California Children’s Hospital Association | Children’s Hospitals |
| California Rural Indian Health Board | Indian Health Services |
| COREC | REC |
| LA Care | REC |
| CalHIPSO | REC |
| Community Health Clinic Ole Napa | Local Underserved Population |
| Redwood Community Health Coalition | Regional Patient Advocacy |
| Consumers Union | Patient Advocacy |
| Harbor-UCLA Medical Center | Acute Care Facilities |
| Inland Empire Health Plan | Regional Health Plan |
| Kaiser Permanente HealthConnect | Statewide Health Plan |
| Long Beach Network for Health | Regional HIE |
| Mercy Medical Group | Regional Healthcare Provider |
| Santa Clara Valley Health and Hospital System | Regional Healthcare Provider |
| Western Health Information Network | Regional HIE |

To facilitate a more robust collaboration effort and to cover all of the groups mentioned by CMS in their question, DHCS will augment its Advisory Board to include a broader group of stakeholders as recommended by CMS.

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California's approach to HIT/HIE is one of collaboration. DHCS has a direct line of communication with the HIT Coordinator as well as with the leadership of the RECs, Cal eConnect and others. There is a cross-pollination of staff participation and work products among the organizations.

FIGURE 6: HIE/HIT COLLABORATION



DHCS, using Planning Advanced Planning Document (P-APD) funding, has entered into a contract to cover 50% of the cost for consulting services to facilitate the work of the eHealth Coordinating Committee and establish the framework for aligning the work of the state governance entity (Cal eConnect) and the RECs with the Medi-Cal EHR Incentive Program. The remainder of the costs will be covered by CHHS utilizing funding from the state HIE Cooperative Agreement. The consultant will coordinate multiple and diverse HITECH and eHealth initiatives to support the efforts of California's Medi-Cal providers and hospitals to become meaningful users of EHRs. The goals of the California eHealth Coordinating Committee are:

- To create a common eHealth coordinating entity in California that makes operational policy recommendations to those organizations participating in eHealth activities

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- To identify services that may be leveraged by participants, and propose plans to fund and coordinate their delivery
- To identify barriers to success for the various partners and propose solutions, providing direct assistance where possible and desired
- To identify appropriate metrics for tracking EHR/HIE adoption and use statewide
- To garner support, consensus and buy-in from California stakeholders

Represented entities are as follows:

Government:

- California Health & Human Services Agency
- Department of Health Care Services
- Department of Public Health
- Office of Health Information Integrity (OHII)
- California Senate Health Committee
- California State Assembly Committee on Health
- California State Treasurer
- California Business, Transportation and Housing Agency
- California Technology Agency
- CMS, Region IX (Ex Officio)

ARRA/HITECH Grantees:

- Cal eConnect
- Regional Extension Centers (Cal HIPSO, COREC, HITEC-LA)
- California Rural Indian Health Board
- California Telehealth Network
- Western Regional HIT Consortium
- California eHealth Workforce Alliance
- Beacon Grantee UC San Diego

Statewide Organizations/Associations:

- California Academy of Family Physicians
- California Association of Health Plans
- California Association of Physician Groups
- California Association of Public Hospitals & Health Systems
- California Critical Access Hospital Network
- California Hospital Association
- California Medical Association
- California Primary Care Association
- California State Rural Health Association

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- California Conference of Local Health Officers
- United Health Group

DHCS and all CA eHealth partners are committed to reaching as many Californians as possible. The partners' policy of "No Wrong Door" led to the current development of an eHealth Portal whose governance structure and format allows all partners to post and publish news, funding opportunities, educational and other calendar events to one location, enhancing visibility and providing a one-stop portal for Californian's needs. The website, still under development, can be found at the following demonstration URL: <http://demo2.symsoftsolutions.com/ehealth/Home.aspx>. Through the support of Cal eConnect and collaborative efforts of the eHealth Coordinating Committee members, it is expected that the eHealth Portal will be operational in spring 2011. This web portal will complement and link to the State Level Registry (SLR) hosted by Affiliated Computer Services, Inc (ACS).

The Medi-Cal EHR Incentive Program Advisory Board meets monthly, as does the eHealth Coordinating Committee. Independently, DHCS OHIT, Cal eConnect, the eHealth Coordinating Committee and Regional Extension Centers have independent communication/outreach committees to target their specific stakeholder groups with appropriate messaging and communication modes. Charters for the committee and workgroups are attached in **Appendix 8**. The group seeks to launch a statewide campaign to raise awareness of the Medi-Cal EHR Incentive Program among providers and the value of HIT among consumers as a means of expanding our individual education and outreach efforts. Empowering providers and consumers through the dissemination of information is a key part of our HIT strategy. This joint effort will be funded through contributions made by each of the respective partners including DHCS.

1.11.2 STATE DESIGNATED ENTITY

The HITECH Act includes state grants to promote health information technology and health information exchange. Grants have been awarded through the state Health Information Exchange (HIE) Cooperative Agreement Program to states and qualified State Designated Entities (SDEs) to develop and advance mechanisms for information sharing across the health care system. The SDEs are expected to develop a strategic plan and use their authority and resources to:

- Develop and implement up-to-date privacy and security requirements for HIE
- Develop directories and technical services to enable interoperability within and across states
- Coordinate with Medicaid and state public health programs to enable information exchange and support monitoring of provider participation in HIE

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- Remove barriers that may hinder effective HIE, particularly those related to interoperability across laboratories, hospitals, clinician offices, health plans and other health information exchange partners
- Ensure an effective model for HIE governance and accountability is in place
- Convene health care stakeholders to build trust in and support for a statewide approach to HIE

California Health and Human Services Agency (CHHS) is the state designated entity and Cal eConnect, under a cooperative agreement with CHHS, serves as the governance entity responsible for executing the strategic and operational plan for HIE. Cal eConnect is an independent, non-profit, public benefit corporation. California's State Medicaid Director and the CHHS Deputy Secretary for HIT sit on the Cal eConnect governing board and DHCS staff participate in Cal eConnect activities, including the Cal eConnect Policy, Technology, and Consumer Engagement Advisory Groups. Cal eConnect is responsible for establishing the ground rules by which health information can be shared appropriately among clinicians, hospitals, health plans, patients, and government agencies. It also oversees and manages implementation of HIE services throughout the state through funds delivered by the HIE Cooperative Agreement Program.

Cal eConnect is implementing an HIE Trust Framework and Connectivity Services, including Entity and Individual-Level Provider Directories, that will complement existing regional HIE services by facilitating the directed and secure exchange of electronic patient health information statewide and across state borders. Medi-Cal providers will constitute a key target population for utilization of Cal eConnect's core services. Cal eConnect is designing these services and associated programs so that they enable Medi-Cal and Medicare providers to meet HIE-related meaningful use criteria, beginning with e-prescribing, laboratory data exchange, and public health reporting.

Cal eConnect has also launched a grant program to help regional HIEs enable providers to meet meaningful use criteria, to connect to Cal eConnect's statewide HIE infrastructure, and to improve health outcomes.

DHCS recognizes that the success of Cal eConnect is crucial to the success of the Medi-Cal EHR Incentive Program, particularly in Stages 2 and 3 of meaningful use when wide sharing of health information between providers and settings will be required.

The state's contract with the new Medi-Cal fiscal intermediary, ACS, includes an option for establishment of an HIE hub within the MMIS to facilitate health data exchange, including laboratory data and e-prescribing. The state is collaborating with Cal eConnect to evaluate how implementing such an HIE hub within the MMIS would fit into the state's

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overall strategic HIE plans. This evaluation will include consideration of alternatives such as the production of a Medi-Cal continuity of care document (CCD), combined with the alignment of Medi-Cal e-prescribing data fields and formulary information with state HIE practices.

1.11.3 COMMUNITY HEALTH INFORMATION EXCHANGES

California's HIE activity is characterized by a wide range of local initiatives supported by Cal eConnect at the state level. There are 20 community HIEs throughout the state with informal jurisdictions largely based on a regional or geographic boundary. The efforts are predominantly overseen by Boards of Directors comprised of local stakeholders and health care leaders, and representatives of organizations who are or plan to be participating in the HIE.

TABLE 7: COMMUNITY HIE EFFORTS

| HIE | Year | Region | Org | Technology | Operational* | NHIN | Clinical Priorities | Financing to Date | Sustainability Model |
|-------------------------------|------|---------------------------|----------------------|--------------------------------------|--|------|---|-------------------|--------------------------------|
| Access El Dorado (ACCEL) | 2004 | El Dorado County | None | Federated | NA | NA | Care Coordination; Public Health | Grant | In Development |
| CalRHIO | 2006 | Statewide | 501(c)3 2009 | Regional overlays; HIE backbone | NA | NA | ED | Grant, Loan | Shared Savings |
| EKCITA | 2004 | Eastern Kern County | 501(c)3 2009 | Hybrid open source system | 3 clinics; 2 private practices; 1 hospital | NA | Diabetes & Regional Public Health | Grant | Minimum Volume of Users |
| Health-e-LA | 2004 | Los Angeles County | None | Federated | NA | NA | Safety Net | Grant, Private | In Development |
| Long Beach Network for Health | 2003 | Long Beach | 501(c)3 2007 | Hybrid federated model | NA | Yes | ED & Patient Safety | Grant | Minimum Volume of Users |
| OCPRHIO | 2007 | Orange County | None | Federated | NA | NA | ED | Grant | In Development |
| Redwood Mednet | 2003 | Mendocino & Lake Counties | 501(c)3 2005 | Federated with decentralized network | 24 providers, 5k transactions/month | Yes | Clinical Data | Grant | Minimum Volume of Users |
| Santa Cruz HIE | 1995 | Santa Cruz | IPA & Hospital Based | Push model; vendor outsourced | Local hospital; county clinics; IPA 90k transactions/month | Yes | Clinical Messaging; Results Delivery; eRX | IPA Support | Hospital and IPA Contributions |

Community HIE efforts have historically been driven and motivated by the perceived health care needs of their local communities. These efforts are often closely linked with the predominant provider organizations in the community who pay special attention to the community's unique health needs (e.g. diabetes, behavioral health). The majority of

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efforts have planned their initial implementation around a use case or specific health outcome priority identified through a collaborative process among both participating organizations and other community stakeholders.

While community HIE efforts often share a common mission to improve health care in their communities through HIE and health IT, the efforts do not all share a common technical approach and are in various stages of technical development. Some efforts are foundational, organizing stakeholders and developing an approach to HIE; others are pre-implementation, selecting vendor partners and obtaining the necessary agreements among participants to enable HIE; others are mid-implementation, pilot testing the exchange of limited administrative data among a small number of users; and only a few are operational and exchanging clinical data. The majority of community HIE efforts are pursuing some variation of a federated technology model and are working to be compliant with anticipated federal standards to enable interoperability.

The majority of community HIE efforts operate as charitable organizations with 501(c)(3) or state-recognized non-profit status, and have traditionally been funded by philanthropic grants. The reliance on grant funding and lack of long-term funding commitments has limited the ability of many HIEs to hire and retain staff, relying on heavy use of volunteers' time and resources. The pursuit of ongoing funding and development of a sustainable business model is a priority of most, if not all, community HIEs that are operating or planning operations today. Many efforts assert that they will pursue some form of either a transaction-based or shared savings model once they are operational, and they articulate an upfront need to measure and document actual savings to potential participants.

Cal eConnect, the HIE governance entity, plays a key role in coordinating and supporting local exchanges. As referenced above, a portion of Cal eConnect's dollars will be allocated to these local and regional efforts to expand their capability to support meaningful use of electronic health information. Several of the operational HIEs as well as those in the planning stages participate in Cal eConnect's governing bodies. Two seats on Cal eConnect's Board of Directors are reserved for operational HIEs and many are represented on Cal eConnect's Advisory Groups, weighing in on state strategy related to HIE sustainability planning, consumer engagement, policy, and technical infrastructure. Cal eConnect maintains open communication with these regional HIEs in an ongoing effort to assess their needs and identify the resources to support their activities. Cal eConnect is developing a process to gather current information on regional HIE services and reach, and will share updated information with the State HIE Coordinator and DHCS within the next 3 months.

Several of California's HIE efforts have participated in the Nationwide Health Information Network demonstrations, successfully testing the exchange of clinical information using Nationwide Health Information Network standards and protocols. Those organizations that have participated in Nationwide Health Information Network demonstrations include Kaiser Permanente, Western Health Information Network

(WHIN), ER Connect-Orange County, Redwood MedNet and Santa Cruz HIE. Some of these HIE efforts have not only demonstrated the capability to connect via the Nationwide Health Information Network gateway to other California HIE efforts, but also to efforts outside of California. The ability of community HIE efforts to successfully participate in and test the Nationwide Health Information Network gateway demonstrates their commitment to interoperability and national data exchange standards. Cal eConnect, though generous support from the California HealthCare Foundation, is also funding regional efforts to conduct implementations of the HIE standards and protocols developed by the Federal Direct Project.

1.11.4 HIE INFRASTRUCTURES OF LARGE PROVIDER ORGANIZATIONS

Several of California's integrated health systems currently exchange data between and among their affiliated physicians and hospitals. Many of these systems have multiple locations and facilities spread across Northern and Southern California, with some systems extending into neighboring states. While many of these systems offer a suite of HIT applications and modalities to their hospital-based clinicians, health systems vary in their provision of HIT outside of the hospital walls. Over the past decade, these health systems have made significant investments in their HIT infrastructure and staff. While technical approaches and vendors vary among health systems, all of the health systems follow national standards and many participate in technical workgroups at the state and national levels. Today health systems vary in their interactions with and participation in community HIE efforts, ranging from no involvement to participation in collaborative activities.

Health systems largely operate as closed networks and their information will largely remain proprietary and locked within those networks unless addressed through statewide collaboration. Their investments in these integrated systems should be leveraged as statewide HIE advances but their business interests must be protected at the same time. Their implementations are being considered and incorporated into state HIE efforts in a collaborative and opportunistic way to ensure interoperability across all of California's providers.

1.11.5 COMMUNITY-BASED ORGANIZATIONS

A number of more loosely affiliated, community-based provider organizations, such as Independent Physician Associations (IPAs), have also developed HIE capabilities. IPAs provide additional HIE resources, such as data interfaces to local hospitals, administrative web portals that facilitate eligibility checking (especially for capitation patients), and patient web portals that provide patients access to their health information and messaging capabilities with their providers. For example, Hill Physicians Medical Group and John Muir Health Network (along with Eisenhower Medical Center) are exchanging clinical information for overlapping patient populations.

Although no specific patterns of integration exists across the many different and diverse IPAs, many are providing some or all of these capabilities, with plans to expand these services as the meaningful use incentives create increased demand for HIE.

1.11.6 CALIFORNIA PRIVACY AND SECURITY ADVISORY BOARD (CalPSAB)

California Privacy and Security Advisory Board (CalPSAB) established by the Secretary of the California Health and Human Services Agency (CHHS), is a private and public collaboration working with California Office of Health Information Integrity (CalOHII) to prepare and submit privacy and security recommendations to the Secretary of the CHHS for review and approval.

The activities of CalPSAB, as managed by CalOHII, are supported by the structure of committees, advisory groups, and task groups that meet regularly to analyze issues and develop corresponding solutions. The committees have included privacy, IT security, legal and education with multiple task groups associated with each committee. CalPSAB has conducted an inventory and analysis of the existing state laws in California that apply to privacy and security of personal health information, and has established a set of initial priority targets to harmonize existing policies and requirements that often conflict with one another and are not uniformly applied. A recent accomplishment of CalPSAB has been arriving at a recommendation to the Secretary for an affirmative patient consent policy for the electronic exchange of their health information in California.

As the movement toward the electronic exchange of health information gains momentum, it is imperative to develop widely-accepted legal and business rules and uniform consent forms and procedures that will enable the exchange of health information for clinical purposes while assuring confidentiality and security. The existing mechanisms and procedures that have been developed in California have not yet achieved this objective and there is a risk that efficient and effective exchange of health information will be delayed or impeded as a result. The Cal eConnect will assist in implementing these policies to gain essential community support for the process of developing the necessary policy and legal framework.

Meanwhile, California is taking a number of innovative steps to better frame the privacy and security framework to enable health information exchange and the need for state law harmonization. First, CalOHII in conjunction with the University of California Hastings college of Law, has developed the California Health Information Law Index (CHILI) which is posted data base of all current federal and state statutes relevant to health information. CHILI cross sections these laws and provides users with both the relevant federal and state laws in a particular area. CHILI serves California's health care policy makers and stakeholders and serves as an important tool in the law harmonization work. Additionally, in 2010, California legislature gave CalOHII the authority to establish and administer demonstration projects to evaluate potential solutions to facilitate health information exchanges that promote quality of care, respect

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the privacy and security of personal health information, and enhance the trust of the stakeholders. Specifically, as authorized by AB 278 (**Appendix 9**), CalOHII is to establish and administer demonstration projects (**Appendix 10**) funded by federal grants and other sources. The demonstration projects are to do all of the following:

- Identify barriers to implementing health information exchanges.
- Test potential security and privacy policies for the safe and secure exchange of health information, including, but not limited to, issues related to access to, and storage of, individual health information.
- Identify and address differences between state and federal laws regarding privacy of health information.

Additionally, as authorized, CalOHII will adopt regulations to ensure that all approved health information exchange service participants and demonstration project participants follow consistent rules and work within consistent parameters as they are engaged in the exchange of health information. It is also essential that through these demonstration projects we capture the business needs and costs of complying with these rules while ensuring transparency and accountability for consumers and other stakeholders who are volunteering to participate. Information about CalOHII's various activities are found at www.ohi.ca.gov.

These privacy and security requirements for HIE are being created in an iterative fashion over a very limited time frame. The goal is to increase transparency and knowledge of the use of personal health information and to build a set of requirements for HIE that can evolve as the technology evolves. There is a need for a flexible approach in protecting privacy while enabling innovation and discovery in the area of healthcare and for developing privacy-enhancing technologies. These requirements and those to follow are intended to provide a ground floor to provide incentive for further development and deployment of privacy enhancing technologies.

DHCS will work with CalPSAB to address these policy issues by participating in a statewide collaborative process that will result in a framework by which participants in HIE in California will participate in the development of and agree to adhere to privacy and security rules that are coordinated with CalPSAB's requirements and processes.

1.12 ADDITIONAL HIE FUNCTIONS

1.12.1 E-PRESCRIBING

E-prescribing has been identified as one of the three HIE capabilities to be addressed and enabled by the state HIE governance entity, Cal eConnect, in 2011. Recognizing that e-prescribing is often a “first step” to full EHR adoption, DHCS recognizes the sense of urgency associated with enabling e-prescribing among Medi-Cal providers. An executive order from the Governor in 2006 set the goal of achieving universal e-prescribing in California by 2010. The incentives provided through this program will help DHCS get there, along with the work being done by the multiple stakeholders with a vested interest in improving e-prescribing rates.

DHCS has matched Surescripts subscribers against Medi-Cal provider files with an algorithm using name, address, phone number and other factors. In this way DHCS has determined that in 2010 approximately 9.3% of Medi-Cal providers were connected for e-prescribing. This is somewhat lower than the 11.3% of all providers in California reported by Surescripts in 2009. Surescripts data does not include Kaiser Permanente and the Veterans Administration, two large healthcare delivery systems that are fully electronic. Medi-Cal providers connected to Surescripts represent only 5% of Medi-Cal’s prescription claims volume for FFY2010. There are at least two variables which may affect the validity of this data: 1) the estimated accuracy rate of provider information is 80% at best relative to pharmacy claims; and 2) not all of the prescriptions from the providers will be sent electronically. It should be noted that being Surescripts certified does not ensure actual use.

Although the percentage (76%) of community pharmacies capable of e-prescribing within California is comparable to the national percentage, the percentage of total number of e-prescriptions, and the percentage of physicians sending e-prescriptions are still low compared to national values. Only 6.8% of the prescriptions routed electronically in the nation come from California, a state with 12% of the nation’s population.

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1.12.2 MEDI-CAL PROVIDERS AND PHARMACIES

The following table shows e-prescribing utilization and the Medi-Cal patient to provider ratios in the state by region:

TABLE 8: E-PRESCRIBING UTILIZATION AND PATIENT/PROVIDER RATIOS

| Region | Population | % of e-Prescribing Providers | Medi-Cal Population | % of e-Prescribing Medi-Cal Providers | Medi-Cal Patient: Provider Ratio |
|------------------------------|------------|------------------------------|---------------------|---------------------------------------|----------------------------------|
| Northern Sierra ¹ | 485,836 | 24.5% | 44,883 | 23% | 50 |
| Sacramento | 1,422,789 | 43.2% | 64,355 | 17% | 18 |
| San Francisco | 810,078 | 8.1% | 45,859 | 18% | 63 |
| Silicon Valley ² | 2,541,407 | 16.1% | 59,616 | 13% | 22 |
| Central Valley ³ | 1,281,545 | 13.3% | 57,089 | 7% | 56 |
| Los Angeles | 10,385,372 | 8.3% | 502,716 | 7% | 50 |
| Inland Empire ⁴ | 4,215,536 | 10.2% | 142,568 | 6% | 106 |
| Orange | 3,152,642 | 18.3% | 52,340 | 10% | 17 |
| San Diego | 3,138,382 | 21.8% | 89,932 | 17% | 24 |

¹Northern Sierra: Siskiyou, Modoc, Shasta, Trinity, Lassen, Tehama, Plumas, Sierra, Nevada Counties

²Silicon Valley: San Mateo and Santa Clara Counties

³Central Valley: Kern and Tulare Counties

⁴Inland Empire: Riverside and San Bernardino Counties

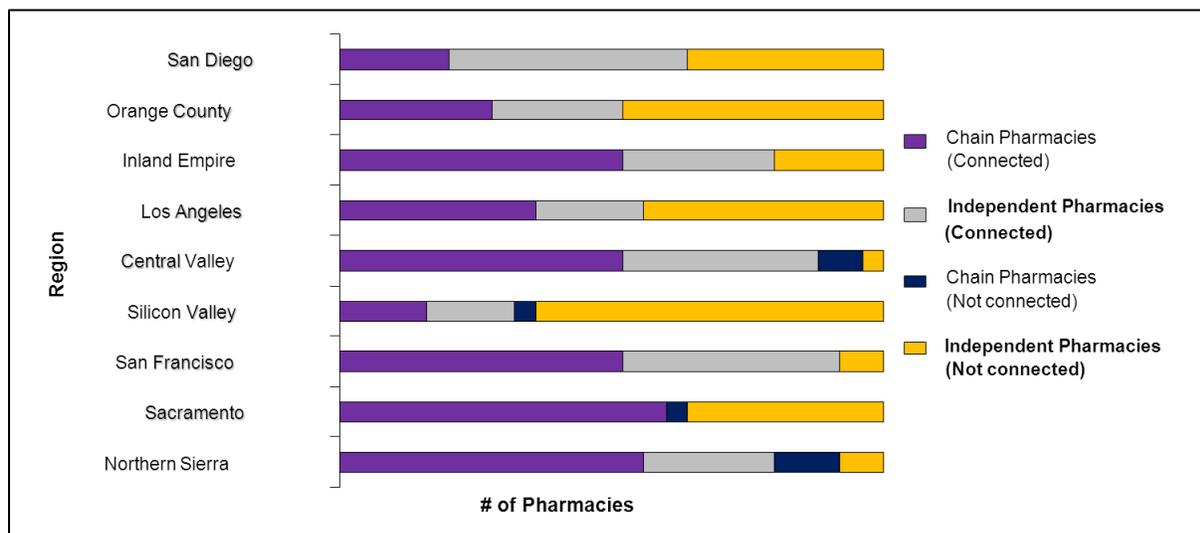
Currently, the Medi-Cal patient-to-provider ratio is very high in certain regions of California, mainly the Inland Empire, San Francisco County, the Central Valley, Los Angeles County, and the Northern Sierra. These counties make up 62% of the Medi-Cal population. With the exception of the Northern Sierra region, these areas also have the lowest percentage of e-prescribing providers in all of California. In 2006, the L.A. Care Health Plan implemented a pilot project among Medi-Cal providers in Los Angeles County. By implementing the project, over 60,000 prescriptions were sent electronically during the one year trial period. Safety net providers had higher adoption and implementation rates than small or solo practice providers. The current data would indicate that activities to promote the adoption of e-prescribing in Los Angeles County should continue through the Medi-Cal EHR Incentive Program efforts.

PARTICIPATING MEDI-CAL PHARMACIES AND E-PRESCRIBING CONNECTIVITY

Medi-Cal pharmacies, particularly independent pharmacies, have a low rate of connectivity (see **Figure 7**). The Silicon Valley has the fewest number of connected pharmacies overall; including the largest number of independent pharmacies that are not connected to receive e-prescriptions. Orange County and Los Angeles ranked right behind the Silicon Valley in terms of having the fewest number of connected pharmacies as well as having the highest number of independent pharmacies not

connected to receive e-prescriptions. A focus on getting these independent pharmacies connected will be vital for the successful transmission of e-prescriptions.

FIGURE 7: E-PRESCRIBING CONNECTIVITY OF MEDI-CAL PHARMACIES



*Above data represents the 25 highest Medi-Cal volume pharmacies in each of the nine regions

Roughly 50% of Medi-Cal’s participating pharmacies are independents as opposed to chain pharmacies. While 97% of retail pharmacies affiliated with large chains are connected to Surescripts, only 62% of independent pharmacies are connected. The relatively low rate of connection of independent pharmacies to e-prescribing is an area of particular concern for DHCS because of the relatively high number of Medi-Cal beneficiaries served by these pharmacies. Understanding their needs will be a priority for DHCS.

1.12.3 CALIFORNIA’S e-PRESCRIBING PILOTS

There have been a number of innovative e-prescribing projects in California in the last five years stimulated by the Governor’s 2006 executive order for universal e-prescribing. Efforts include the following projects:

Cal eRx REGIONAL DEMONSTRATION PROJECTS

In October of 2009, Cal eRx started e-prescribing pilot projects in Sacramento, San Diego, and Tulare counties. The Regional Demonstration Projects were selected based on different levels of adoption of e-prescribing in the specific regions. The regions were to be representative of different practice settings with common challenges in adopting e-prescribing. Participation was based on willingness to share best practices with like practices throughout the state. There were no incentives offered for participation. Sacramento is currently the leading county in California in terms of the number of e-prescribing providers, with 43.2% of providers registered for e-prescribing through

Surescripts. Tulare County, in contrast, has only 11.2% licensed providers registered for e-prescribing. San Diego County has 21.8% registered for e-prescribing. The results of these demonstration projects may provide a better understanding of how e-prescribing can be facilitated in regions of varying levels of adoption.

TABLE 9: CAL ERX REGIONAL DEMONSTRATION PROJECTS

| Pilot Region | Description | Goals |
|--------------|---|--|
| San Diego | Two large medical groups implementing Allscripts EMR. | Evaluate a common vendor/system approach to addressing adoption issues across medical group settings. |
| Sacramento | Mature e-prescribing region with very little electronic renewal processing. No collaboration between groups and pharmacies. | Identify technical issues preventing the efficiency of processing renewals and handling of controlled substances. Regional strategy for data matching in the routing of renewals and handling of controlled substances. |
| Tulare | Rural, solo practices; limited support. No adoption of e-prescribing. | Ground up approach involving local pharmacies from the outset. |

Demonstration project results will be reported later this year.

CALIFORNIA PUBLIC EMPLOYEES’ RETIREMENT SYSTEM E-PRESCRIBING INITIATIVE

In June of 2009, the California Public Employee’s Retirement System teamed up with Anthem Blue Cross, Medco Health Solutions, and Blue Shield of California to launch an e-prescribing initiative to demonstrate that e-prescribing can improve patient safety and health outcomes. The project facilitated the use of e-prescribing vendor programs by providers to better serve CalPERS members. Participating providers were from Hills Physicians Medical Group, John Muir Physician Network, PrimeCare Medical Network, Inc./North American Medical Management of California, San Jose Medical Group, and Santé Community Physicians.

Findings from this initiative included:

- Two-thirds of participating physicians reported improved efficiency during patient visits
- Physicians reported saving time on pharmacy follow-up calls

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- Participating physicians increased their e-prescribing use by 68%. Two participating physician groups reported an e-prescribing increase of more than 100%
- Participating physicians prescribed 4.1 million new medications electronically during the second quarter of 2010, compared with 1.7 million in the first quarter of 2009
- The number of doctors using e-prescribing in the pilot increased 79%
- Electronic prescription renewals were up 104%
- The participating physicians reported being somewhat to extremely satisfied with the use of the technology

The use of generic drugs increased 7%, reaching 77.4% among those who used e-prescribing versus those who did not during the second quarter of 2010. This represented a significant opportunity for CalPERS and its members to save on medication spending

MEDI-CAL PROOF-OF-CONCEPT PROJECTS

In partnership with the Northern Sierra Rural Health Network (NSRHN) and the California Healthcare Foundation, DHCS participated in a proof-of-concept project to support the state of California with its statewide e-prescribing initiative to evaluate the use of e-prescribing programs amongst providers and pharmacies in the northern Sierra region. The projects have identified several barriers for providers and pharmacies which are outlined in **TABLE 10** and **TABLE 11**.

TABLE 10: MEDI-CAL SPECIFIC BARRIERS TO E-PRESCRIBING EXPERIENCED ON BEHALF OF PROVIDERS

| Barrier | Description |
|---|--|
| Opt-In Consent at the point of care (POC) | The Opt-In consent process required by Medi-Cal at the point of care proved to be too cumbersome for the workflow of the clinic staff. Unlike other payers serving medication histories to the POC, Medi-Cal required an additional explanation and signature of consent from the patient before accessing the medication history data. |
| Inability to access patients' medication history list or incomplete lists being delivered | Providers cannot access Medi-Cal patients' medication history list either because these patients were not matched by eligibility and do not have documentation of their prescriptions or the system timed out before a match could be determined. It was also reported that incomplete medication lists were being delivered when matched to the active medication list in the patient's profile maintained by the provider. |
| Problems with e-prescribing connectivity | Many providers that serve Medi-Cal patients come from solo or small practice settings. Therefore, the technological support they receive is very minimal. Medi-Cal providers reported problems with sending e-prescriptions due to the internet connection, problems printing their prescriptions, and problems using their PDAs to submit electronic prescriptions. |
| Inefficient Workflow and Commitment | Medi-Cal providers often have to see many patients as there are so few providers and a huge volume of patients. At times, providers reported being too busy to e-prescribe as the process could become time-consuming when connectivity is not on par. |
| Difficulty interpreting Medi-Cal formulary | Providers had difficulty interpreting formulary information of Medi-Cal patients especially because providers were unaware that they had to fill out a treatment authorization request (TAR) for certain prescriptions or if a patient needed more than six prescriptions per month. This kind of information was not provided by the e-prescribing programs. Formularies were also either not updated or not available. |
| Other general barriers to e-prescribing experienced on behalf of Providers | |
| Difficulty using the interface of e-prescribing programs | |
| Constant drug alert pop-ups | |
| Inefficient refill communication between providers and pharmacies | |
| Inability to electronically prescribe controlled substances | |
| Budget limitations that prevent smaller practice providers from getting technological support | |

TABLE 11: MEDI-CAL SPECIFIC BARRIERS TO E-PRESCRIBING EXPERIENCED ON BEHALF OF PHARMACISTS

| Barrier | Description |
|--|---|
| Lack of interoperability of prescribing programs and Medi-Cal database | Many pharmacies have difficulty accessing data of Medi-Cal patients simply because the prescribing programs, such as eRxNow and RxHub, and the Medi-Cal database have data fields that do not match. |
| Independent pharmacies cannot process e-prescriptions | Many independent pharmacies who serve Medi-Cal patients don't have the financial or technical support to install an e-prescribing vendor program. As a result, even if a provider were to send a prescription electronically, pharmacies may not receive the prescription electronically: computer-to-computer. |
| Other general barriers to e-prescribing experienced on behalf of Pharmacists | |
| Difficulty interpreting e-prescriptions that have been converted to fax | |
| Inability to send refill requests to providers because providers did not designate themselves as Surescripts enabled | |
| Electronic queues that have not been responded to because providers work in various offices | |
| Unable to link e-prescriptions to patient profiles | |
| Independent pharmacies that lack the financial and technological support to receive e-prescriptions | |

THE SAFETY NET INSTITUTE

In October of 2008, the Safety Net Institute partnered with Contra Costa Regional Medical Center, Kern Medical Center, and San Mateo Medical Center to implement an e-prescribing pilot project aimed at ensuring safe and efficient e-prescribing practices for the underserved and uninsured in California's public hospital clinics. Medi-Cal made its eligibility, formulary and medication history information available to EHR vendors at these pilot locations through Surescripts. As in the NSRHN pilot, providers were required to obtain patient consent at the point-of-care. Although this consent process required a different workflow than patients from other payers, San Mateo Medical Center and Kern Medical Center were ultimately able to implement a separate workflow for Medi-Cal beneficiaries. Contra Costa Regional Medical Center never implemented their pilot. The results of the two Safety Net pilots (available in 2011) will be important as a majority of patients seen within these hospitals are Medi-Cal fee-for-service patients or Medi-Cal managed care patients.

Throughout the projects Medi-Cal usage reports from Surescripts showed a substantial drop-off in provider usage of e-prescribing and medication history requests after kick-off and implementation at a specific site. Of the nearly 1,000 providers participating in the

combined proof-of-concept sites, there were a mere 180 medication history requests reported for the month of June 2010. On September 30, 2010, DHCS made the decision to discontinue its delivery of eligibility, formulary and medication history files to its pilot sites through Surescripts. This decision was made for two reasons: 1) privacy and security concerns regarding medication history delivery to providers outside of the Medi-Cal pilot programs and 2) low utilization rates as documented on Surescripts monthly reports.

The findings from the Medi-Cal pilot projects and continued participation in Cal eRx will further inform the development of Medi-Cal's own policies to support the adoption of certified EHR technology. Understanding the reason(s) for not allowing electronic data interchange after the cost of connecting has been incurred will be a vital component to overcoming the barriers for "meaningful use" of e-prescribing in California. There is still much work to be done to realize the potential benefits of e-prescribing in improving quality and reducing the costs of health care in the Medi-Cal population. The Medi-Cal EHR Incentive Program provides an unprecedented opportunity to continue efforts to overcome barriers and improve the adoption and efficiencies of e-prescribing while leveraging the collaborations with its external partners.

1.12.4 E-PRESCRIBING OF CONTROLLED SUBSTANCES

The finalization of the Electronic Prescribing of Controlled Substances (EPCS) Rule by the DEA in June 2010 will not immediately change e-prescribing practices in Medi-Cal providers. Specifically, the rule requires technology changes to both the provider and pharmacy systems that will not be available for at least another 12 to 18 months. DHCS has worked with the RECs to ensure that their selected vendor contracts allow for the modification of certified EHRs to meet the new controlled substances rules at no additional charge.

DHCS also provided formal feedback in conjunction with the Cal eRx during the comment period for the EPCS rulemaking. DHCS also provided training on controlled substances best practices at the Annual Meeting in November 2010.

1.12.5 ELECTRONIC LABORATORY REPORTING

Under the Final Rule for the EHR Incentive Program, EEs and EPs will be required to incorporate more than 40% of lab test results into their EHRs as structured data. In addition, hospitals will be required to provide electronic submission of reportable lab results to public health agencies. These requirements represent some of the biggest challenges for ambulatory providers and hospitals to attaining meaningful use. In California there are 20,000 Clinical Laboratory Improvement Amendment (CLIA) certified labs. However, 50%-60% of outpatient laboratory tests in California are performed by one of two large laboratories: LabCorp or Quest Diagnostics. The remaining tests are performed by over 17,000 hospital, regional, public health and

provider office laboratories. Unlike laboratories with national scope, many of these smaller laboratories are not prepared to send structured electronic laboratory data to outpatient physicians. Many hospitals depend on income from hospital-based laboratories for support. Early studies by the California State Rural Health Association (CSRHA) indicate that this income may be particularly important for sustaining rural hospitals. Hospitals, particularly in rural areas, may be in need of assistance in establishing electronic connectivity for their laboratories to enable their community providers to attain meaningful use of EHRs. DHCS has identified the need to support hospital laboratories in quickly preparing for HL7-compliant transmission of results to be a priority for future funding requests.

California commissioned Sujansky and Associates to conduct an assessment of the issues related to ambulatory and public health lab reporting in 2010. The results of this study found that labs currently have limited capacity to electronically report lab results to ordering providers and public health agencies. It was recommended that the state establish:

- 1) A clear and comprehensive strategy for increasing access to structured lab results
- 2) Statewide standards that align ambulatory and public health reporting requirements
- 3) A process that will minimize the administrative burden of managing labs and that will encourage the use of structured and standardized electronic lab reporting tools
- 4) Policies, regulations, and operational processes that support electronic lab reporting

As a result of the work conducted by Sujansky and Associates on the public health related lab issues, DHCS has utilized funding from the P-APD to partner with Cal eConnect to perform a similar study of the issues faced by Medi-Cal providers in sending and receiving structured lab results. Cal eConnect will perform a laboratory landscape assessment that will help define the barriers that EPs and EHs will experience when incorporating lab test results into their EHRs. Having a clear understanding of current electronic lab reporting capabilities, identifying labs that provide critical services to Medi-Cal providers, developing a technical and policy roadmap to increase lab results reporting through the use of a uniform standard, such as the EHR-Lab Interoperability and Connectivity Specifications (ELINCS), and aligning with public health lab reporting requirements are critical to the success of the EHR Incentive Program and will require close collaboration with DHCS operational efforts. The lab assessment will result in the development of a statewide roadmap for lab interoperability, as well as an implementation guide that will be used to ensure providers have the data and information required to adopt lab standards that will enable them to interface with public health and others who request or require electronic lab orders and results. Cal eConnect is contributing resources from the state HIE Cooperative Agreement to support this collaborative effort between DHCS and Cal eConnect during

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the planning process and anticipates providing additional support to the implementation of the statewide roadmap to ensure access to the tools developed during the planning period by non-Medi-Cal providers.

Additionally, in collaboration with Medi-Cal, public health, labs and local HIEs, Cal eConnect convened a Laboratory Services Task Group to develop a strategy for adoption of standards and development of services to support electronic lab data exchange. Specific attention was given to:

- Working with the state to develop a roadmap for enabling lab exchange with Medi-Cal, public health and other state funded providers and entities
- Conducting a survey of messaging and transport standards (ELINCS and LOINC) currently utilized among providers and labs
- Supporting labs and local HIEs in filling identified gaps
- Ensuring Cal eConnect grant program priorities include efforts that foster utilization and innovation in lab services

Following its work, the Laboratory Services Task Group reported its recommendations which included promoting consistent messaging standards and specifications and determining a strategy to provide lab result routing services (push) among other potential services.

These strategies, together with the functionality created through the development of Cal eConnect's core services, intend to enable entities (e.g. state and county labs) to exchange data such as lab results through directed exchange or query/look-up. Medi-Cal plans to leverage these Cal eConnect core services to enable the electronic exchange of laboratory, eRx, and other data among stakeholders across the state enterprise.

The state will leverage the state HIE grant funds, in-kind support from Public Health, the I-APD and other resources to implement a lab solution that benefits Medi-Cal providers and other stakeholders. Additional core activities include working with the RECs to establish lab reporting requirements that can be incorporated into the contracts between the EHR vendors and the providers adopting their technology; investigation of policy options that may include standard requirements that labs and providers must adhere to for electronically reporting lab results; and exploring contractual provisions with the Medi-Cal managed care entities that address the use of electronic lab reporting tools.

1.13 PUBLIC HEALTH REPORTING AND SURVEILLANCE

1.13.1 LABORATORY AND DISEASE REPORTING

DHCS received P-APD administrative funding to support the work of the California Department of Public Health (CDPH) in partnership with Cal eConnect and other stakeholders in completing the development of an implementation guide that will support meaningful use submission of laboratory results from EHRs to public health. Because of budgetary issues, work on this will begin in March 2011. This will build on assessments that began with other funding sources and will help align reporting standards and implementation specifications to minimize the work required of hospitals and public health departments across California and support Medi-Cal eligible providers (EPs) and eligible hospitals (EHs) in their achievement of meaningful use.

DHCS is partnering with CDPH to leverage existing state and local infrastructure that currently supports laboratory reporting in developing capacity that will support meaningful use requirements. Current systems and infrastructure, while having significant capacity to receive electronic data, were established prior to requirements to send and receive using HL7 standards as specified by ONC. Public health systems are conducting planning and system modification activities to adapt to these new federal standards for data transmission however there are significant resource gaps that limit the speed at which these activities can occur. A brief description of public health systems and their interfaces with meaningful use requirements are described below.

- The Division of Communicable Disease Control through its California Reportable Disease Information Exchange (CalREDIE) will support the electronic submission of lab results for reportable diseases via the Electronic Lab Reporting (ELR) system, as well as web-based Confidential Morbidity Reporting. CalREDIE will specifically target the eighty reportable diseases and conditions cited under Title 17 of the California Code of Regulations. When fully implemented, the ELR project will provide for electronic data submissions, using HL7 standards, from approximately 2,200 commercial labs (hospitals, reference, public health, etc.) and 15,000 licensed physician-operated labs. State legislation (AB 2658) requires labs to electronically transmit lab reports to the state of California. CalREDIE is designed to improve the efficiency of surveillance activities and the early detection of public health events through the collection of more accurate and timely surveillance information. Although the state focus on the ELR component has been on laboratory reporting to public health, this component will also be able to receive HL7 messages from EHRs in support of meaningful use. Development and piloting of the ELR component is planned for 2011 and it is currently anticipated that this functionality will be fully functional in 2012.

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The Childhood Lead Poisoning Prevention Branch, through its web-based surveillance system (RASSCLE II), currently receives over 800,000 blood lead tests per year from over 250 laboratories via HL7 messaging. This program is participating in ongoing discussions with departmental programs and committees to allow continued receipt of laboratory samples and results from eligible providers and laboratories.

- The Cancer Surveillance and Research Branch manages the California Cancer Registry, which collects information about all cancers diagnosed in California (except basal and squamous cell carcinoma of the skin and carcinoma in situ of the cervix). This program plans to expand electronic reporting of cancer pathology and to adapt ELINCS laboratory specification guidelines into their existing system.

In addition to receiving laboratory results, public health also receives specimens and generates results. Public health programs that provide results are described below. These programs will partner with DHCS and other eHealth stakeholders to leverage the CPOE meaningful use requirement.

- The California Laboratory Information Management System (CaLIMS) implements a common data structure and user interface across the Medical Diagnostics Labs (MDL), Venereal Disease Research Laboratories, and other CDPH laboratories in order to centralize tracking of patient records and laboratory specimens. This system has the capacity to send HL7 messages although there have not been resources to implement this functionality to date.
- The Genetic Disease Screening Program (GDSP) which includes the Prenatal Screening Program and Newborn Screening Program screens newborns and pregnant women for genetic and congenital disorders in a cost-effective and clinically effective manner. The screening programs provide testing, follow-up and early diagnosis of disorders to prevent adverse outcomes or minimize the clinical effects. The GDSP is working towards the electronic submission of screening results to hospitals and clinicians as well as the receipt of clinical provider order entries for newborn and prenatal screenings.
- The Lab Field Services (LFS) provides oversight for clinical and public health laboratory operations and for the licensed and certified scientists and other testing personnel who perform testing in clinical laboratories. To assist department-wide and statewide efforts to meet meaningful use requirements, LFS is working to disseminate information regarding these federal regulations to California laboratories and to collaborate with interagency efforts to administer lab assessments.

one regional registry to another) or to search across multiple registries at this time, thus limiting these benefits to both providers and patients on a region-to-region basis and more generally, statewide. At the present time, there is no interoperability between CAIR and Public Health Surveillance reporting databases.

The majority of exchange between immunization registries and EHRs involves the transfer of updated immunization data, for which prompt, rather than immediate or real-time, exchange is usually sufficient. Approximately 150 organizations with at least 20 EHR systems have secure, current or pending data exchange with CAIR, primarily through data exports in a standardized flat file format. With the exception of San Diego County, California's regional immunization registries do not currently have the capacity to accept immunization data via HL7 messaging directly from EHRs. For this reason, only providers in San Diego County will be able to fulfill the objective for transmitting information to an immunization registry.

DHCS is supporting the development of immunization registry capacity to receive HL7 messages in support of meaningful use through a previously approved P-APD-funded assessment. Due to the late passage of a state budget in October 2010 and the elimination of \$18 million of state general funding for the entire Immunization Program in the budget, DHCS has requested a no-cost extension through the I-APD to conduct this project from July to December 2011 contingent on associated budget actions. CDPH is working with Cal eConnect and others to identify funding to continue the planning process.

1.14 IT INFRASTRUCTURE AND MITA

1.14.1 MMIS

ACS has developed a Medicaid Management Information System (MMIS) based on the Medicaid Information Technology Architecture (MITA) 2.0 Framework Initiative of the Center for Medicaid & State Operations (CMSO). The solution was developed from the ground up using service oriented architecture (SOA). This advanced application is the transfer system upon which CA-MMIS Health Enterprise system is delivered. It derives its functional design from a combination of MITA and best in class CMS-certified and operational MMIS solutions. ACS developed its system closely following MITA technical principles to deliver an MMIS that is:

- Business-driven
- Platform-independent
- Adaptable, extensible, and scalable
- Based on open technology and standards
- Highly interoperable

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A major benefit of a properly designed SOA is that the resulting system more readily supports the changing needs of the business by providing the ability to modify and “rewire” existing components in response to changing processes and policy. CA-MMIS Health Enterprise is composed of many reusable components that can be combined to perform specific business functions or even entire business workflows. The architecture incorporates new custom or commercial off-the-shelf (COTS) components far more readily than can be done in older legacy systems, even those that are client-server-based. Additional key benefits of the ACS implementation of an MITA-aligned, SOA solution include:

- An architectural foundation that aligns technology with business needs
- A workflow management engine that increases automation and decreases reliance on manual processes
- Self-service web features including prior authorization and eligibility verification
- Strategic use of COTS components and applications
- Significantly improved maintenance, enhancement and operational efficiencies
- Separation of business logic from complex program code by using a COTS rules engine that allows changes quickly and easily without the need for technical programming skills
- Increased ability to proactively analyze and plan based on enhanced reporting capabilities
- Configuration of business rules and benefit plans without requiring coding changes

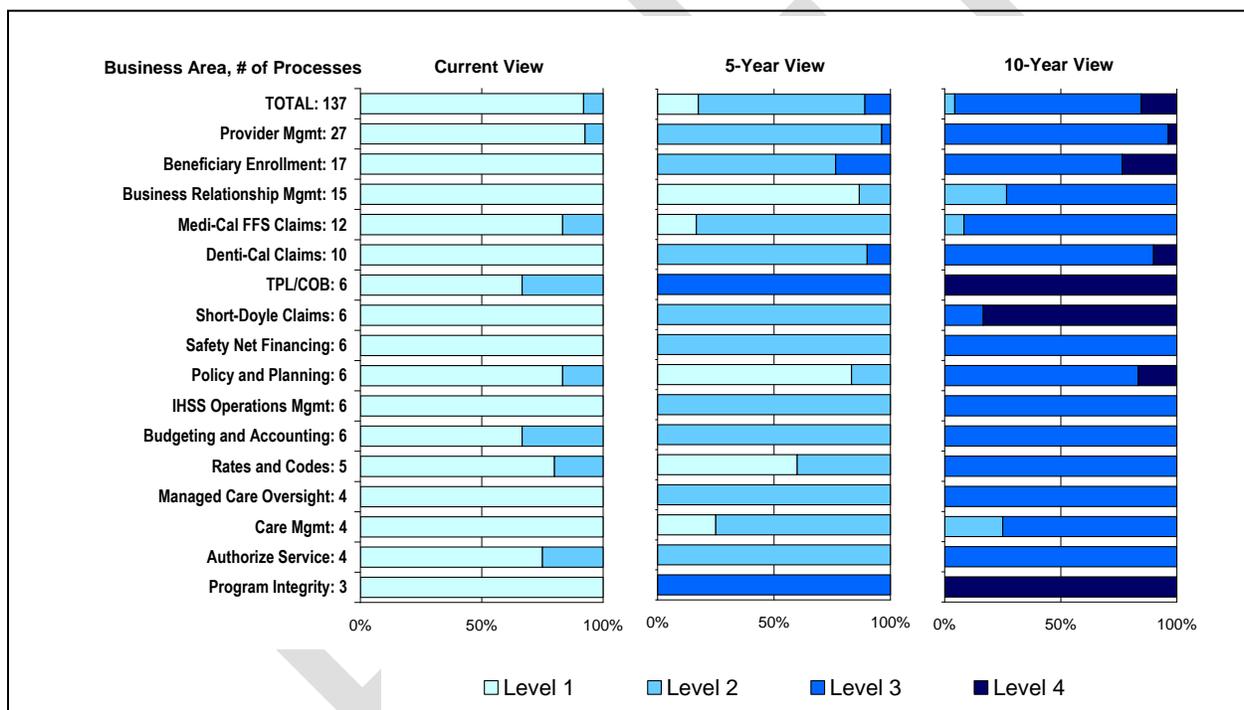
The CA-MMIS Health Enterprise is a web browser-based application that utilizes a relational database management system and fully leverages SOA. The solution appropriately blends platform-independent MITA-aligned software components with industry-leading COTS products. Some implementations of SOA place “wrappers” around legacy procedure oriented code; the CA-MMIS Health Enterprise Solution is built on a true SOA foundation. SOA is implemented through the use of the Service Component Architecture (SCA). SCA is an open standard that implements SOA in a way that brings rigor to the development process. It does so by providing tools and enabling structure that encourages and enforces component re-use. It provides the means to wire together service components to meet the business needs of DHCS, so that business drives information technology rather than the other way around. This flexibility will be leveraged to meet the needs of DHCS.

CA-MMIS Health Enterprise will support DHCS’ move towards HIE/HIT by improving health outcomes and quality services for Medi-Cal beneficiaries. Bridging the traditional split between the clinical and financial content of health care data requires an integrated, person-centered view of information. The Enterprise System will provide a solution that supports unification of the financial and clinical data.

1.14.2 MITA

The State Medicaid HIT plan will be implemented in accordance with the MITA principles as described in the Medicaid Information Technology Framework 2.0. DHCS conducted a MITA State Self-Assessment (SS-A) for the Medi-Cal program in 2008, identifying the “as-is” and “to-be” maturity levels of the Medi-Cal program across all major business processes. DHCS is using the SS-A today to support major projects such as its MMIS replacement within DHCS. Upcoming MITA activity by DHCS will create a roadmap for transforming Medi-Cal to a service-oriented program with enhanced capabilities for its customers and business partners. The DHCS MITA Transition and Implementation Plan (M-TIP), which will document how DHCS intends to advance along the maturity continuum, is currently under development. DHCS will ensure that HIT planning efforts are consistent with and incorporated into the M-TIP.

FIGURE 9: MATURITY OF MEDI-CAL BUSINESS PROCESS GROUPS IMPACTED BY MITA (FROM DHCS MITA SS-A)



1.15 IT WORKFORCE DEVELOPMENT

As the HIT landscape changes a transformation of the IT workforce will be necessary. This will include both existing staff as well as new staff that will be supporting technology as it is adopted. DHCS is actively working through its outreach and education efforts as well as through the workforce development programs to encourage and employ this transforming workforce. Within California, two key initiatives that are

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advancing the workforce capabilities in HIT and HIE are the Western Region Health IT Program (WRHealthIT) and the California Health Workforce Alliance (CHWA).

The WRHealthIT is a consortium made up of community colleges from Arizona, Nevada, California and Hawaii. The program is funded out of the ONC under the auspices of the Federal HITECH Act. The Western Region Consortium is one of five regions in the National project funded by this two-year ONC project. The purpose is to prepare Health IT workforce to assist hospitals, clinics, and doctors' offices with the installation, maintenance, and deployment of EHR systems. Workers prepared in one of the target roles will receive education in short-term, six month or less certificate programs from one of the member colleges in the consortium. These roles are in one of six skill sets defined by ONC: 1) Practice Workflow/Information Redesign; 2) Clinician/Practitioner; 3) Implementation Support Specialist; 4) Implementation Managers; 5) Tech Software Support; and 6) Trainers.

The CHWA was launched on June 11, 2009, and has selected a number of near term priorities, including:

- Developing a health workforce data clearinghouse and identifying gaps in data and information to be addressed
- Researching and coordinating efforts to fill gaps in student readiness
- Identifying and communicating emerging innovations in delivery systems and matching academic production and employer needs
- Fostering shared learning across sectors through partnerships and technical assistance with current and emerging workforce initiatives to build efficiency
- Coordinating and providing support for the CA Health IT workforce initiative to improve an effective IT workforce approach

1.16 INTERSTATE EXCHANGE ACTIVITIES

California shares borders with Oregon, Nevada and Arizona. DHCS has heard from one rural hospital in Northern California that wishes to use Medicaid discharges for beneficiaries who reside in the state of Oregon. For EHR Incentive Program eligibility purposes DHCS has decided to allow hospitals to choose between counting only discharges for California residents, or discharges for residents of both California and another state – whichever will result in the highest percentage of Medicaid discharges for the hospital. The CMS Cost Reports will be used to capture data on out-of-state discharges from hospitals. Since cost reports do not break out data by state, in the case where a hospital chooses to establish patient volume only using California patients and cost report data do not correspond to that reported by the hospital, DHCS will require the hospital to submit other supporting documents such as audited annual hospital disclosure reports. It is important to note that hospitals will not be allowed to

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claim EHR incentive funds in both states. DHCS does not anticipate a significant number of providers using beneficiaries across state lines to establish eligibility.

DHCS participates in the National Association of State Medicaid Directors (NASMD) Multi-State HIT Initiative on a weekly basis. In partnership with Cal eConnect, DHCS also participates in the Statewide HIE Coalition. This collaboration produced an e-prescribing request for proposal (RFP) to potential vendors to facilitate electronic data interchange activities. The RFP was lead by TennCare and supported by nearly 20 states. Through Cal eConnect's participation in several other multi-state exchange coalitions and ONC communities of practice, they keep DHCS abreast of developments in interstate HIE issues relevant to DHCS' HIT Plan and serve as an advocate for DHCS' needs.

In particular, Cal eConnect is a participant in the Interstate Consent Engine Collaborative (ICEC), a proposal put forth by multiple states, health plans, labs and e-prescribing vendors. The proposal, submitted to the Research Triangle Institute (RTI), would develop requirements for an interstate tool to facilitate compliant exchange of personal health information in a manner that is legally compliant and engenders public trust. To date this proposal has not been funded but the collaborators have pledged to continue the work, ultimately reducing policy barriers to exchange for Medi-Cal and other providers.

1.17 THE LEGAL LANDSCAPE

In Fall 2009 California passed legislation (Health and Safety Code 130251 – 130255) to support health information exchange as described in the federal American Recovery and Reinvestment Act of 2009 (ARRA) (Public Law 111-5) which includes within it the Health Information Technology for Economic and Clinical Health (HITECH) Act. The legislation included the establishment of the California Health Information Technology and Exchange Fund for the purposes related to health information technology and exchange. It also provided for the designation of a nonprofit entity to be the state-designated entity for the purposes of health information exchange with oversight from the CHHS. The state-designated entity, as described in other portions of this document, is Cal eConnect.

AB 278, enacted in 2010, allows CalOHII to conduct annual pilot projects to test alternative solutions for privacy and security policies. CalOHII is currently reviewing applications for the program and developing policy guidelines the pilot projects will test. The pilot projects will submit feedback to CalOHII on how the policies support or pose a barrier to safe and secure HIE in the community and that feedback will be used to refine state HIE policy recommendations that will ultimately go to the CHHS Secretary and Legislature for rulemaking.

2 CALIFORNIA'S "TO-BE" HIT LANDSCAPE

2.1 CALIFORNIA'S 5-YEAR PLAN

DHCS' "To-Be" landscape is a critical component of the overall roadmap which addresses the state's plan for widespread provider adoption and meaningful use of certified EHRs. The specific steps to be taken by DHCS in the next 12 months will largely support the core business processes (enrollment, attestation, verification, payment and audit processes) and provider outreach and education. Without the adoption of certified EHR technology by Medi-Cal's providers and hospitals, DHCS recognizes that its overall vision for improved health care cannot be attained. Planning for a comprehensive outreach and education campaign to providers will only become more robust as the "As-Is" landscape is further defined and a more targeted approach can be executed based on specialty, location, practice size and, perhaps, even patient mix. The usefulness of the landscape assessments, the strength of our eHealth partnerships and the state's ability to revise its approach in future iterations of the SMHP are all driving factors towards California's "To-Be" HIT Landscape.

In January 2010, DHCS convened a statewide group of experts to design the vision for the Medi-Cal EHR Incentive Program (**Appendix 11**). The vision elements defined by this group are ambitious and set an aggressive agenda for successful achievement of meaningful use criteria by Medi-Cal providers. These vision elements are:

- By 2011, the state will ensure that Medi-Cal beneficiaries, on request, have access to their HIE disclosures.
- By 2011, California will establish policies that balance protection of patient privacy with the appropriate sharing of health information
- By 2013, statewide provider performance standards are used to improve health outcomes.
- By 2013, patient and population health data from EHRs will be shared bi-directionally between providers, California's Departments of Health Care Services and Public Health, OSHPD and other approved institutions to support the essential functions of public health for effective quality, access and cost of care.
- By 2015, 90% of Medi-Cal providers eligible for Incentive Payments will have adopted certified EHRs for meaningful use in their practices in a secure and interoperable manner.
- By 2015, 90% of Medi-Cal providers will have implemented clinical decision support tools with their EHRs.
- By 2015, all Medi-Cal beneficiaries of providers with EHRs will have access to their Personal Health Record and self-management tools.

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- Upon EHR adoption, Medi-Cal providers and beneficiaries will be able to use available electronic health information from the beneficiaries' other providers employing EHRs to make information health care decisions at the point of care.

In addition to these vision elements, DHCS has defined a number of operational goals for the Medi-Cal EHR Incentive Program:

- In April 2011, the SLR will be operational and accepting information from the National Level Registry and from practitioners and hospitals.
- By May 2011, the Medi-Cal EHR Incentive Program will have begun issuing incentive payments to practitioners and hospitals.
- By March 2011, all Medi-Cal practitioners and hospitals will have received information about eligibility requirements for the EHR Incentive Program and how to apply for participation.
- By December 31, 2011, at least 35% of Medi-Cal practitioners and hospitals eligible for Medi-Cal EHR Incentive Program funds will have registered and received an incentive payment for adopting, implementing, or upgrading certified EHR technology.
- By December 31, 2011, 100% of practitioners and hospitals receiving Medi-Cal EHR Incentive Program funding will have received information on using their EHRs to achieve meaningful use.
- By December 31, 2012, at least 70% of Medi-Cal practitioners and hospitals eligible for Medi-Cal EHR Incentive Program funds will have registered and received an incentive payment for adopting, implementing, or upgrading certified EHR technology.
- By December 31, 2012, 50% of practitioners and hospitals that received Medi-Cal EHR Incentive Program funding in 2011 will have achieved meaningful use and received funding for this accomplishment.
- By December 31, 2013, 80% of Medi-Cal practitioners and hospitals eligible for the Medi-Cal EHR Incentive Program will have registered and received an incentive payment for adopting, implementing, or upgrading certified EHR technology.
- By December 31, 2013, 70% of Medi-Cal practitioners and hospitals receiving funding in 2011 will have achieved meaningful use and received funding for that accomplishment.

In addition to these operational goals, DHCS has defined a number of special goals based upon the landscape assessment presented in Section 1 and input from stakeholders:

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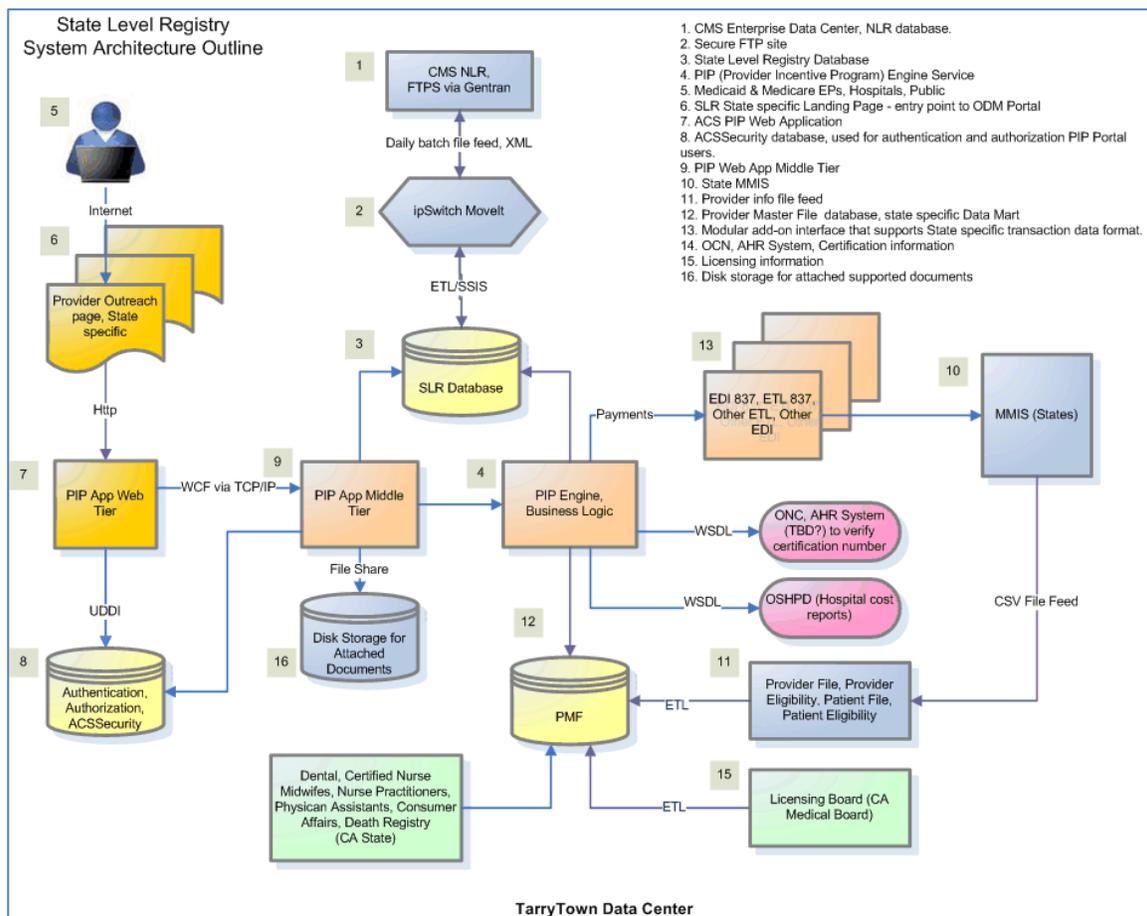
- By December 31, 2014, a portable, EHR-based health record will have been developed and tested for California's foster children.
- By December 31, 2015, an interoperable EHR for medical and behavioral health will have been developed and tested for California's mental health population.
- By December 31, 2015, a continuity of care document that includes behavioral health will have been developed and tested for California's mental health population.
- By December 31, 2015, 90% of independent pharmacies in California will be connected to an e-prescribing network
- By December 31, 2015, 80% of community clinics will have fully implemented certified EHRs.
- By December 31, 2015, 50% of providers in California will be able to electronically transmit immunization information to an immunization registry.
- By December 31, 2015, 90% of hospital, regional, and public health laboratories will be able to electronically transmit laboratory results to providers.
- By December 31, 2015, 80% of providers and hospitals will be able to transmit reportable disease information to the local and state public health departments.

2.2 IT ARCHITECTURAL CHANGES

California will initiate significant changes and enhancements to the IT system architecture over the next five years with the change in fiscal intermediary (FI) from Hewlett-Packard Enterprise Services (HP) to ACS. As a part of the change, the MMIS will be converted to the ACS Enterprise application, which has a different architecture from the legacy MMIS system from HP. Because this is a stand-alone system, the SLR will not affect the HP MMIS. When ACS takes over the MMIS system, the SLR will be integrated into the MMIS design. ACS will assume operations as the FI in September 2011, maintaining the current architecture, and will begin conversion to the Enterprise application in January 2012.

California's State Level Registry (SLR), a new application, added to the existing IT system architecture. The current architecture of the SLR is depicted below.

FIGURE 10: SLR ARCHITECTURAL DIAGRAM



The architecture of the SLR will change as needed to support the electronic interfacing of clinical quality measures from provider EHR systems.

For the first year of the incentive program, Medi-Cal providers will interface with the SLR via the web portal user interface. The application is designed for manual entry of data for the first year. Providers are directed through a simple set of screens where information is entered that provides the state with the data necessary to determine Medi-Cal EHR Incentive Program payment eligibility. Providers also have the ability to attach supporting documentation in year one.

The system will be modified for 2012 to accept the electronic submission of clinical quality measures as specified in the Final Rule. Additional options are being explored to facilitate the data entry process for providers, including the ability to upload data via spreadsheet to report on the core objectives and menu set objectives for Stage 1. This will be adapted once Stage 2 and 3 criteria are available. We expect that the

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architecture of the SLR will change as needed to support the electronic interfacing of clinical quality measures from provider EHR systems.

The Medi-Cal EHR Incentive Program is being implemented as a standalone project outlined in the following multi-phased approach:

- **Phase 1** (4/1/11): SLR will be implemented to allow provider registration, manage interfaces to/from the NLR, and accept provider attestation of AIU or meaningful use. The state will also be able to conduct validation activities to confirm provider eligibility, verify Medi-Cal volumes, and review provider attestation data.
- **Phase 2** (5/1/11): Additional functionality will be developed to finalize payment calculations, allow provider appeals, document audit and investigation activities, and system reporting, in addition to receiving the remaining interfaces from NLR. Provider payments will be issued via a manual payment process through the HP MMIS.
- **Phase 3** (Q3/Q4 2011): After ACS assumes operations as the Fiscal Intermediary and the MMIS is stable, an interface with the MMIS will be developed to automate the payment processes. Phase 3 is scheduled to complete in late 2011.
- **Long-Term**: Ultimately, the current HP MMIS will be replaced by a new ACS MMIS. The interfaces between the SLR and the ACS MMIS will be included in the deployment of the new MMIS.

Minimal system modifications are expected in the deployment of this program. Modifications may be required to support the manual payment process to ensure providers are paid appropriately and in a timely manner, deductions are not taken from the incentive payment amounts, and the system ensures proper reporting to CMS regarding the Medi-Cal EHR incentive program.

ACS will host the application in a secure data center and manage the development of future functionality to ensure the system remains in compliance with CMS guidelines and rules for the incentive program, and develop interfaces with California's legacy MMIS after assumption of operations in September 2011.

California has successfully completed testing of the following initial four interfaces required for launch of the program:

- B-6 Provider registration data from NLR to SLR
- B-7 Registration confirmation data from SLR to NLR
- D-16 Bi-directional duplicate payment and exclusion data

- D-18 Incentive payment data from SLR to NLR

California has also satisfactorily tested the C-5 interface accepting dually eligible hospital attestation data from the NLR to the SLR. The state is currently testing the D-17 interface accepting dually eligible hospital cost report data from the NLR to the SLR.

The SLR will accept the registration data for Medi-Cal providers from the CMS NLR using Secure File Transfer Protocol Software (FTPS). The interface file is processed and loaded into the SLR as described in **FIGURE 10**.

2.3 PROVIDER TECHNICAL ASSISTANCE

There will be many Medi-Cal EPs in California that cannot receive services from the RECs. RECs are limited to providing technical assistance services to primary care providers working in practices of ten providers or less, community health centers, rural health clinics, and out-patient clinics at public hospitals. In addition, the RECs only have funding from the ONC to support providers through the first stage of meaningful use, even though all providers will require significant assistance to reach Stage 2 and Stage 3 MU.

Many Medi-Cal EPs not served by RECs will need assistance in workflow redesign and a number of issues in order to use the incentive funding to maximum benefit. DHCS is working with its stakeholders, including the RECs, professional associations, hospital associations, clinic associations and independent physician associations on developing methodologies for educating and assisting professionals in their adoption of EHRs and attaining meaningful use. DHCS estimates that approximately 5,000 Medi-Cal EPs will not be served by the RECs and will need assistance.

DHCS will request authorization through an IAPD-U to implement the Technical Assistance program. DHCS will issue a Request for Proposal (RFP) to provide Technical Assistance to eligible professionals and hospitals related to the adoption, implementation and upgrade of certified EHR. DHCS anticipates wide distribution of the RFP and expects interest from the RECs, various provider associations and others with the capability to provide such support. The RFP will clearly describe that the work being conducted under the contract cannot duplicate work being done by RECs under their ONC contract. Furthermore, the RFP will require RECs submitting proposals to provide a plan which clearly delineates how such services will not be duplicative of their ONC funded activities. Due to the size of the state and the number of Medi-Cal eligible providers, the RFP will allow for multiple awards to vendors for technical assistance within defined geographical regions. The state expects to leverage existing infrastructure and resources for provider support, such as that which may currently be available from RECs or Independent Physician or Hospital Associations, to address the following needs of all Medi-Cal EPs:

- **Readiness and Workflow Assessment:** Assess current state of resources – human, technical, capital – that can be leveraged to support EHR adoption, identify gaps and obtain a snapshot of the provider’s data exchange partners and unique needs.
- **Assist with Vendor Selection:** Help providers match their needs to one of several EHR vendor “bundles” offered through group purchasing programs, or other vendor options that are unique to the Medi-Cal providers served.
- **Project Planning:** Develop a high-level project schedule to prepare providers for sequencing of events and manage expectations about roles and responsibilities for implementation activities.
- **Project Monitoring/Management:** Coaching the practice/clinic through the phases of implementation and advocating for client with vendor(s).
- **Workflow Redesign:** Assist providers and organizations in adapting and transitioning paper-based processes to technology enabled processes.
- **Meaningful Use Reporting:** Ensure that providers are making progress towards meaningful use and collecting data appropriately so that the MU measures are accurate and reportable.

DHCS will reimburse the technical assistance contractors using a similar “milestone-based” formula as currently used by the ONC to support the RECs that factors in the need for technical assistance throughout all three stages of MU. The RECs will be eligible to apply for this additional funding.

In addition to the technical assistance described above, DHCS plans to implement a pharmacist-supported implementation program using the Research and Development Corporation (RAND) Pharmacy Toolset recently developed for independent pharmacies. DHCS will also develop and implement a statewide train-the-trainer program to educate e-prescribing and medication safety experts throughout California’s schools of pharmacy. This would include curriculum development in health informatics and medication safety, cross-training with other professional programs (e.g. medical and nursing programs) and outreach activities to EHR adopting communities during advanced pharmacy practice experience rotations.

2.4 PROVIDER AND BENEFICIARY OUTREACH CAMPAIGN

DHCS is developing a comprehensive provider and beneficiary campaign, outreach, and education program that will benefit adoption and meaningful use of EHRs. The plan is to define the shift in provider and beneficiary behaviors and beliefs regarding EHRs and HIEs, develop goals and metrics for recognizing success, define the targets of our efforts and the messages that will be delivered in the various media available, execute the plan and perform ongoing monitoring against the metrics, and adjust the program as needed to meet the goals. The focus and targets will be on eligible professionals,

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eligible hospital IT and administrative leadership personnel, and Medi-Cal beneficiaries. DHCS' intention is to individually address eligibility of providers that are close to meeting the requirements by working with them. For example, using a different representative reporting period may enable a provider to meet eligibility. For providers, values to be promoted will be better overall patient care, time savings of EHR, accurate data and reporting, and the financial support from incentive payments. For beneficiaries, values to be promoted will be improved health care, convenience and access to medical data, control and influence due to access to medical data, and the privacy and security available through Certified EHR systems.

Specifically, outreach will be accomplished through a coordinated campaign with the existing network of healthcare stakeholders such as the RECs, medical and trade associations, hospitals, clinics, managed care plans, FQHC's, IPAs, the CMS Regional Office, ONC, the state eHealth Coordinating Committee and Cal eConnect. The state recognizes that designation of adoption entities may be another path to providing technical assistance to providers. For this reason, DHCS will convene an advisory group to study the adoption entity issue.

The focus of the state's efforts will be engagement of all stakeholders in the campaign program, including the RECs, Cal eConnect, managed care plans, beneficiaries, medical and trade associations, internal state divisions and staff, and public health-related partners who will all play a critical role in enabling adoption EHRs. The campaign will convey a suite of messages to both providers and beneficiaries, and each will be engaged in a two-way dialogue in order to reform and refine the message. The message to the providers will speak to patient care, accurate data and reporting, and the financial support provided by the program. The state will use a broad set of communication methods and tools including: a website, webinars, help desk support, subject-specific one-sheets, talking point cards, pamphlets, and newsletters, as well as a public campaign to beneficiaries. DHCS has reached out directly to medical associations via email and phone calls. To those groups who are interested and open to receiving information, DHCS has begun sending pieces of information that they may use as needed. These items include short blurbs on time-sensitive topics with a link to the SLR information page (www.medi-cal.ehr.ca.gov), as well as longer articles on the Medi-Cal EHR Incentive Program. They have indicated they are using these in e-blasts to their member lists, on their websites, or in their newsletters (both electronic and hard copy versions). This open dialogue has enabled DHCS to quickly send out updates on the Medi-Cal EHR Incentive Program, as well as be able to provide information on pertinent topics including: availability of the Help Desk once providers have logged into the SLR, the availability of workbooks and a user guide to prepare for navigation through the SLR, etc.

In addition to Twitter, educational webinars are promoted directly through those groups with which they are presented: e.g. California Association of Physician Groups (CAPG) through CAPG member directory. DHCS will also post webinars that are open to all providers on the SLR information page, and social media.

The state will monitor the progress of the campaign plan against the state's vision for the program. The state will directly engage with key external stakeholders from the eHealth Coordinating Committee and the Medi-Cal EHR Incentive Program Advisory Board. Additionally, as mentioned in Section 1.3, DHCS will employ the recommendations of the Lewin Group and McKinsey & Company that indicate that outreach efforts be coordinated with medical associations, trade associations, local medical societies, and medical groups/IPAs since these are the most trusted sources of information by providers. Future information from provider and hospital surveys mentioned in Section 1.2, as well as information from the evaluation contractor as discussed in Section 5.1.3 will be used to refine our outreach efforts through these and other organizations and outreach channels.

The state will leverage the ability of the RECs to provide on-the-ground and logistical support for AIU of EHRs. The four RECs aim to enroll approximately 10,000 providers, and represent a critical avenue for the state to successfully educate all eligible Medi-Cal providers.

Each of the RECs has built a robust outreach, education and communication infrastructure that DHCS intends to leverage in order to create a comprehensive program that will reach every Medi-Cal provider in the state:

The California Health Information Partnership and Services Organization (CalHIPSO) serves 6,187 providers in California, except Los Angeles and Orange counties. CalHIPSO has an outreach partner program through which 18 statewide and local provider organizations provide outreach and education to their members to educate them about the REC program. Channels of communication utilized by the outreach partners include webinars, provider events, newsletters, and eBlasts. CalHIPSO RECs work closely with their outreach partners to ensure consistency of messaging, materials, and templates.

CalHIPSO also utilizes Local Extension Centers that deliver REC services in local communities across California. Local Extension Centers are organizations with strong ties to provider communities, including California's Quality Improvement Organization, health center controlled networks, and medical society chapters. The scope of services of the Local Extension Centers is focused on helping providers meet the three REC milestones outlined by the ONC. DHCS plans to partner with them to include more comprehensive education and training around the Medi-Cal Incentive program.

CalHIPSO's Physician Advisory Council is comprised of 22 physicians and one certified nurse midwife who practice in both urban and rural settings. The current focus of the Physician Advisory Council is to assist in engaging physicians across the state to enroll in CalHIPSO. Future efforts will focus on broader HIT education efforts. The state plans to promote the Medi-Cal EHR Incentive Program to the provider community by leveraging the committee's expertise and early buy-in to the program.

California Medi-Cal Health Information Technology Plan

HITEC-LA currently serves 3000 eligible providers in LA County and utilizes an extensive network to reach its providers. As a division of a managed care plan, LA Care places a high priority on using their established relationships and networks to reach Medi-Cal providers. HITEC-LA utilizes various LA Care channels to communicate their support services to providers which include: direct-to-provider, provider advisory groups, plan partners, and IPAs. Additionally, HITEC-LA has dedicated marketing, and outreach and education departments who work with an extensive network of IPAs, hospitals and associations to continuously reach target providers. The state intends to utilize the HITEC-LA channels to help accomplish education and outreach on the Medi-Cal EHR incentive payment program.

HITEC-LA's Provider Advisory Council is comprised of 15 physicians and office managers who represent a mix of provider segments (small practice, clinics, and county). The focus of the Provider Advisory Council is to persuade physicians to enroll with HITEC-LA, provide advice on education and outreach and help with other strategic issues affecting clinical improvement and EHR adoption. The state plans to promote the Medi-Cal EHR Incentive Program to the provider community by leveraging the committee's expertise and early buy-in to the program.

HITEC-LA has created a boot camp program to educate providers about various topics on an ongoing basis. Currently, the boot camp program is focused on EHR and MU readiness. Future topics available to providers in LA County will focus on later stage MU achievement, attestation, and compliance.

COREC serves 1,000 providers in Orange County and has strong relationships with contracted IPAs and medical groups. COREC is involved in multiple opportunities with CalOptima to engage with physicians in the community by making presentations at Physician Advisory Committee meetings and physician education meetings for continuing education.

California Rural Indian Health Board (CRIHB) will serve as one of the regional subcontractors for the American Indian/Alaska Native (AI/AN) National Indian Regional Extension Center based out of the National Indian Health Board in Washington, DC. NIHB is establishing the only National REC serving Tribes located in 35 states throughout the U.S. – the National Indian REC.

As a partner with the National Indian REC, CRIHB will ensure that CA Tribal and Urban Indian Health Programs and their eligible providers achieve meaningful use of electronic health records by facilitating EHR adoption; receive adequate resources to optimize use of health information technology; ensure Tribal and Urban Indian Health Programs are not penalized for a lack of information technology; and ensure that the Indian Health System can keep up with quality of care improvements that will be provided through enhanced use of health technology.

California Medi-Cal Health Information Technology Plan

CRIHB will work in partnership with the National Indian REC to target 3,000 providers throughout the Indian Health System to achieve ONC REC milestones and report requirements.

CRIHB will work with all Tribal and Urban Indian Health Programs in California regardless of whether they use the Resource Patient Management System (RPMS) EHR or a COTS EHR. In order to achieve this goal, CRIHB will collaborate with the Indian Health Service, Tribes, Urban Indian Health programs, and Tribal organizations to develop, train and deliver technical assistance services and tools to facilitate EHR adoption and enhance the Indian healthcare system in CA; develop and disseminate best practices and education; support integration of HIT and HIE into clinical practice and office practice management; achieve clinical and operational efficiencies and better health outcomes; support the Indian Health Care Delivery system (including interoperability activities); collaborate with the other CA RECs and state initiatives for HIE; be a valued asset to the National Learning Consortium; and support future workforce training programs within Indian country, tribal and community colleges in developing a cadre of future HIT and clinical application specialist workers.

In addition to working closely with the RECs, the state will also expand our outreach efforts by engaging additional key stakeholders to that include, but are not limited to, the following:

California State Rural Health Association (CSRHA) is a nonprofit organization governed by a board of directors elected by membership. CSRHA's signature electronic news publication, *The Rural Health Advocate*, connects readers to the efforts of others working in rural communities. CSRHA also provides regular email updates providing the most up-to-date information on emerging policy changes, funding opportunities, upcoming events and rural-relevant news. Webinars, distance learning workshops and regional rural roundtables are coordinated each quarter for its members to foster grassroots collaboration, information sharing and advocacy.

Cal eConnect plays a fundamental role in the success of the campaign. The state will coordinate with Cal eConnect to ensure providers are aware of the health information exchange resources that will help them achieve MU.

Medical and trade associations have deep and trusted relationships with specific provider groups and maintain robust channels for communicating to their constituents. The state plans to leverage these established relationships and is considering development of an RFP for the professional associations to facilitate and expand the state's outreach and education program.

Managed care plans have strong relationships with and serve approximately half of beneficiaries in the state. They stand to benefit from adoption and achievement of MU. The state intends to capitalize on managed care plans strong relationships with Medi-Cal beneficiaries in order to achieve MU.

2.4.1 OVERARCHING STRATEGIC PLAN

The first step in clearly defining the provider and beneficiary outreach campaign is to create the overarching strategic plan. DHCS has leveraged multiple sources of information and research to assess the best approach in messaging to both providers and beneficiaries, primarily from the work of The Lewin Group and McKinsey & Company. DHCS has divided the provider and beneficiary outreach campaign into the following sections: Overarching Strategic Plan, Perceptions & Barriers for Providers and Beneficiaries, Execution Phases of Plan, and Results.

| TABLE 12: OVERARCHING STRATEGIC PLAN | |
|---|---|
| GOALS: Define the Shift You Want to See | <ul style="list-style-type: none"> • What are the goals of the campaign? • Who are the targets of the campaign? • What are the current beliefs about EHR? • How does the state want these behaviors and beliefs to shift? |
| EXECUTION PHASES OF PLAN: Devise the Actions to Deliver the Shift | <ul style="list-style-type: none"> • What messages need to be conveyed to providers and beneficiaries? • How should these messages be conveyed? • How should these messages be timed? • How will the outreach plan be executed? • How can stakeholders be leveraged as partners to support the state's campaign? |
| RESULTS: Monitor the results | <ul style="list-style-type: none"> • How will the success of the campaign be measured? |

| TABLE 13: GOALS: DEFINE THE SHIFT YOU WANT TO SEE | |
|--|--|
| Goals | |
| Primarily promote the adoption and meaningful use of EHRs among eligible provider population | |
| Objectives | |
| Creates clarity about incentive funding and eligibility among ambulatory clinics and hospitals | |
| Encourages EHR adoption among eligible providers | |
| Increases knowledge of resources to support providers during EHR planning and implementation | |
| Campaign Plan Targets | |
| Potentially eligible providers | |
| Hospital IT and administrative leadership of potentially eligible hospitals | |
| Medi-Cal beneficiaries | |

2.4.2 PERCEPTIONS & BARRIERS FOR PROVIDERS AND BENEFICIARIES

The key to engaging providers in the Medi-Cal EHR Incentive Program is to overcome their barriers to adoption. Providers’ main barriers to adoption include several valid concerns. The first and biggest concern for most providers is the high cost of ownership and implementation of an EHR. The second two biggest areas of concern are both centered on confusion and lack of information: providers need accurate information about EHR products and vendors, and they need accurate information about best practices on how to execute an EHR implementation.

TABLE 14: CURRENT PROVIDER BARRIERS TO ADOPTION

| Provider Perspectives | Structural Barriers | Information/Perception Barriers |
|--|--|---|
| “I believe there is no long term return on investment in implementing EHRs” | 1) High cost of ownership of EHR solutions | Lack accurate information about EHR costs and benefits |
| “It is like going to the supermarket and standing in front of cereal boxes and never having eaten cereal before” | 2) Provider confusion and lack of in-house expertise to understand EHR products and vendor options | Lack of accurate information about EHR products and vendors |
| “Most of us don’t have any staff on board who know what you need to implement an EHR” | 3) Lack of in-house expertise to plan and execute an EHR | Lack of information about best practices to execute an EHR implementation |

TABLE 15: PROVIDER PERCEPTIONS

| Current Provider Perceptions: | Desired Perceptions After Campaign Plan: |
|--|---|
| <ul style="list-style-type: none"> I am unaware or confused about ARRA incentive funding and penalties | <ul style="list-style-type: none"> I understand the details about the program and know how to qualify for funding |
| <ul style="list-style-type: none"> I am confused about the EHR options available to me | <ul style="list-style-type: none"> I have enough information about my EHR options to make an informed choice for my organization |
| <ul style="list-style-type: none"> I don’t have time to go through information about meaningful use requirements, vendors, etc. | <ul style="list-style-type: none"> I have access to concise and complete information about funding and EHRs |
| <ul style="list-style-type: none"> Implementing an EHR will be expensive | <ul style="list-style-type: none"> Although an EHR will be a substantial investment, there are financing options available to my organization, and it will be a smart investment |
| <ul style="list-style-type: none"> I don’t know what the financial or clinical payback will be | <ul style="list-style-type: none"> I understand the potential costs and benefits of an EHR system |
| <ul style="list-style-type: none"> Implementing EHR is just too much of a hassle | <ul style="list-style-type: none"> There are resources and support available to help my organization during an implementation |
| <ul style="list-style-type: none"> I don’t know if the state is actually going to give me this funding like they say they will | <ul style="list-style-type: none"> I am confident that the stimulus funds will be awarded in a timely manner if I meet requirements |

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The State will adopt a multi-channel approach by utilizing a broad set of communication methods and tools. These include a website, webinars, help-line support, fact sheets and other print materials, and newsletters, as well as a public campaign to beneficiaries. The results will be monitored across various metrics with progress against the vision regularly tracked using annual provider, payor, and beneficiary surveys, in addition to data reviews from industry sources. California Health Care Foundation has recently entered into an agreement with Manatt Health Solutions to assist DHCS in the development of strategies for determining success.

These efforts will complement the efforts of the evaluation contract which is mentioned in Section 5.1 2011-2012 Roadmap of the SMHP, as well as the ongoing landscape assessments of providers and hospitals to be carried out by UCSF staff which are described in the same section of the SMHP.

BENEFICIARIES

To inform, educate and engage patients, beneficiaries and caregivers about the technology changes health care providers maybe adopting, the general purpose for the government initiative to adopt EHRs, the benefits of EHRs in disease management and prevention, the information and influence all users will have toward healthcare, and an understanding of the rights, protections and privacy of medical information. Messages to the beneficiaries will speak to improved health care, convenience, control, influence, privacy and security.

The key to engaging beneficiaries is to leverage messages that resonate most with them, to ensure that we employ the most appropriate approach in delivering those messages, and to deliver those messages in the different segments' languages and in a way that is culturally sensitive.

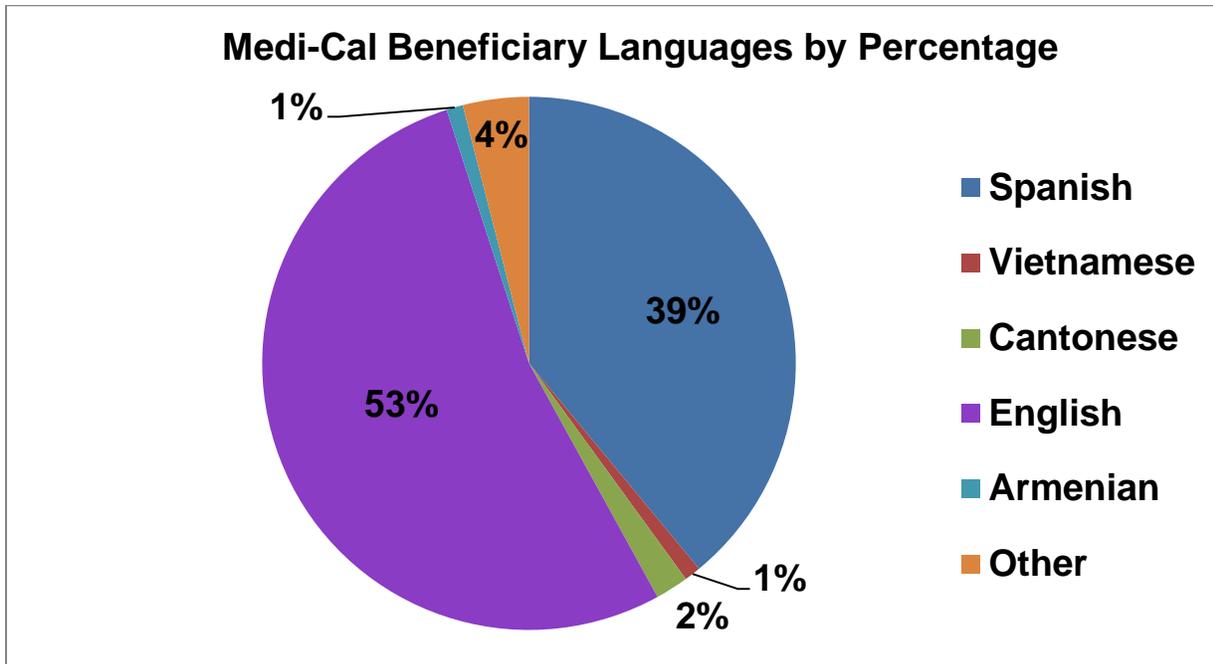
TABLE 16: MESSAGES THAT MATTER MOST TO BENEFICIARIES

| Improved Health Care | Convenience | Control and Influence | Privacy and Security |
|--|--|---|---|
|  <p>“EHRs improve care for you and your loved ones”</p> <p>This is the most important factor for beneficiaries</p> <p>Beneficiaries want to improve their health and the health of their family</p> <p>They strongly value receiving the highest quality of care, including safety</p> |  <p>“EHRs can offer easy access to your medical data”</p> <p>Beneficiaries, especially the primary care takers in families value convenience and quick access to information in case of an emergency</p> <p>Many find remembering different medical histories and managing referrals to be difficult</p> <p>Beneficiaries, especially those in the foster care system, would benefit significantly from access to their immunization history</p> |  <p>“EHRs let you partner with your provider and take control of your health”</p> <p>Beneficiaries place value on maintaining their independence and exerting control over their health care</p> <p>Beneficiaries are increasingly seeking additional information about their health</p> |  <p>“EHRs record your data in a secure digital format”</p> <p>Beneficiaries want their medical data to remain secure and private</p> <p>They have concerns about their information being used to raise premiums or deny coverage</p> <p>With EHRs, there is accountability about who see their data</p> |

TABLE 17: APPROACHES THAT WORK BEST FOR BENEFICIARIES

| |
|--|
| <ul style="list-style-type: none"> • Personal Experiences <ul style="list-style-type: none"> ○ Beneficiaries identify with individuals like them, and value their experiences |
| <ul style="list-style-type: none"> • A Consultative, Unbiased Approach |
| <ul style="list-style-type: none"> • Concise, Complete, and New Information |
| <ul style="list-style-type: none"> • Easily Actionable Information <ul style="list-style-type: none"> ○ Beneficiaries want to be able to easily follow-through with recommended actions |
| <ul style="list-style-type: none"> • An Understanding Of Their World <ul style="list-style-type: none"> ○ Beneficiaries identify with culturally and linguistically relevant information |

FIGURE 11: MESSAGES TO BENEFICIARIES NEED TO BE CULTURALLY APPROPRIATE AND IN THEIR LANGUAGE



Another key component of beneficiary outreach communication that will occur in years 2-3 and beyond is messaging that is directly tied to the meaningful use criteria for patient engagement. Messages to address this include:

- Raise consumer and family awareness and to educate and gain their trust in HIE services and motivate use of online tools.

The state should employ the following tactics in achieving successful messaging to beneficiaries:

- A straightforward campaign and message architecture that is based on consumer, patient and provider research that clearly communicates “what’s in it for me.” This will include message and proof points about privacy protections and checks/balances, and describe the participation process clearly in accessible language.
- A tiered approach determined by those with greater needs or interest in use of online health care tools. The first tier would target early adopters and consumers with complex medical conditions by utilizing appealing resources and tools to support making better choices. Below are some examples of target populations that would fall within this category of

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beneficiaries, and potentially provide the most success in the outreach and education efforts in consumer engagement:

- Groups with special medical needs
- Highly mobile populations
- Those already familiar with using online tools, for example, patients with diabetes
- Current users of EHRs
- The numerous communication channels for the computer-literate and those with ready access to the Internet, including:
 - Consumer-friendly website that provides downloadable resources, tools and videos
 - Electronic newsletters
 - Email blasts and campaigns
 - Select social media tools
 - Short message service (SMS) or text campaigns
- A mix of media to reach across generational lines and be culturally sensitive, while specifically segmenting and addressing the vulnerable and underserved population with messages tailored to their concerns and delivered via channels that are accessible to these populations.
- Address participation of the non-computer savvy population, as California's population mix is very diverse in its familiarity with technology. The emphasis on messages to this segment will be to develop trust and offer a variety of in-person resources for engagement. For those without computer or internet access, communication and educational materials may be provided through the following channels:
 - Public computer to log on (e.g. libraries, computers at doctors' offices, kiosks)
 - Senior center seminars and "ask the expert" sessions
 - Newsletters distributed via public libraries, and care settings that include community clinics, community centers and schools
 - Mass media channels such as television/radio/billboard/print advertisements and direct mail
 - Articles in local and physician group publications, small papers, and associations.
 - County Eligibility Offices (State Medi-Cal Enrollment Broker)

2.4.3 CAMPAIGN PHASES

The campaign and outreach plan employs a multi-phase approach. Both provider and beneficiary campaign plans will employ multiple communication channels; however provider efforts will be more efficient due to the fact that we have clear and direct channels by which to reach them, which will be detailed further below. The beneficiary audience is much larger, very diverse and represents a wide cross-section of demographics and will therefore require additional and more diverse efforts in order to reach all segments of this audience.

PHASE I

TIMEFRAME: SEPTEMBER 22, 2009 – FEBRUARY 23, 2011

The goal of Phase I was to use key encounters to lay a strong foundation for the next phases of the outreach campaign. This phase has employed direct face-to-face communication from OHIT and ACS to RECs, professional and hospital organizations and associations via webinars, and in person meetings and presentations. To date, these presentations have been very successful in educating and gaining support from these groups.

TABLE 18: PHASE I PRESENTATIONS

| DATE | ORGANIZATION |
|-------------|---|
| 9/22/09 | CalOptima |
| 11/16/09 | Cal eRx |
| 1/20/10 | Safety Net Institute |
| 1/28/10 | NoCal HIMSS |
| 3/14/10 | L.A. Care |
| 4/5/10 | California Association of Provider Groups |
| 7/23/10 | CHA Informatics Committee |
| 8/31/10 | California Hospital Association |
| 9/2/10 | California Hospital Association |
| 9/21/10 | CalHIPSO |
| 9/22/10 | CalOptima |
| 9/23/10 | CalHIPSO |
| 11/9/10 | Cal eRx |
| 11/10/10 | Cal eRx |
| 11/16/10 | CAeHC |
| 1/4/11 | Sutter Health |
| 1/11/11 | Mercy |
| 1/11/11 | Sutter Independent Physicians |

| DATE | ORGANIZATION |
|---------|---|
| 1/17/11 | CAPG |
| 1/17/11 | California Rural Indian Health Board |
| 1/19/11 | State eHealth Coordinating Committee |
| 1/20/11 | HIE Forum in Irvine |
| 1/21/11 | Cal eConnect Board Meeting |
| 1/25/11 | CAPG Overview |
| 1/25/11 | REC Webex on EP |
| 1/25/11 | HITEC-LA SLR Training on provider enrollment |
| 1/25/11 | CalHIPSO SLR Training on provider enrollment |
| 1/25/11 | CalOptima SLR Training on provider enrollment |
| 1/26/11 | Medi-Cal Incentive Program Advisory Board |
| 1/27/11 | REC Webex on Group Eligibility |
| 1/27/11 | HITEC-LA SLR Training on provider enrollment |
| 1/27/11 | CalHIPSO SLR Training on provider enrollment |
| 1/27/11 | CalOptima SLR Training on provider enrollment |
| 1/31/11 | CPCA |
| 1/31/11 | CARHC |
| 1/31/11 | Planned Parenthood |
| 1/31/11 | CA Schools Health Centers |
| 2/3/11 | CAFP |
| 2/14/11 | Sutter |
| 2/16/11 | CMA |

TABLE 19: UPCOMING PRESENTATIONS

| DATE | ORGANIZATION |
|---------|-------------------------|
| 3/7/11 | Planned Parenthood |
| 3/16/11 | CPCA - HIT Summit |
| TBD | UC Davis Medical Center |
| TBD | Adventist Health |
| TBD | Hill Physicians Group |

In addition to the efforts described in the table above, OHIT published an article to the REC sites and the Medical Board of California Newsletter, January 2011, which reaches all licensed medical doctors. This article can be viewed in **Appendix 12**. A Medi-Cal provider bulletin was issued in February 2011 to inform all Medi-Cal providers regarding the EHR Incentive Program.

During the planning process for the Medi-Cal EHR Incentive Program, OHIT staff provided regular updates on program development during the monthly e-Health

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Stakeholder Conference Call sponsored by the California Health and Human Services Agency.

PHASE II: BUILD-UP CAMPAIGN

TIMEFRAME: FEBRUARY 22, 2011 – MARCH 31, 2011

The goal of this phase is to continue to increase interest and direct providers to the Provider Outreach Page www.medi-cal.ehr.ca.gov where they can learn more about the Medi-Cal EHR Incentive Program. The objective is that those providers can use the workbook on the site to prepare their information so that upon the launch of the SLR, those providers will be able to immediately register successfully. Key campaign elements planned include:

- Placing online banner ads on the top 20 sites, including RECs, professional organizations, health care associations and managed care plans (see **Appendix 13**).
- Releasing of 2-3 timely articles that each highlights a different positive aspect of the Medi-Cal EHR Incentive Program.
- Creating subject-specific, downloadable one-sheets/pamphlets. These will be placed on the Provider Outreach Page www.medi-cal.ehr.ca.gov, as well as sent to the top 20 sites (RECs, professional organizations, health care associations and managed care plans) for placement on their sites as a reference tool to their providers. These will focus on individual topics within the Medi-Cal EHR Incentive Program, so that a provider can self-select which topic they need most or first, and learn about each related topic in smaller, more digestible sections. Sample one-sheet topics include:
 - What is the Medi-Cal EHR Incentive Program?
 - What is the difference between Adopt, Implement, or Upgrade (AIU)?
 - How do I qualify (for the Medi-Cal EHR Incentive Program)?

PHASE III: LAUNCH CAMPAIGN

TIMEFRAME: APRIL 1, 2011 – APRIL 30, 2011

The goal of this phase is to announce the launch of the Medi-Cal EHR Incentive Program and to drive providers to register in the SLR on the Provider Outreach Page www.medi-cal.ehr.ca.gov. Key campaign plan elements for Phase III include:

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- Placing large online banner ads on the top 20 sites, including RECs, professional organizations, and health care associations and managed care plans (see **Appendix 13**).
- Placing the subject-specific, downloadable one-sheets/pamphlets on the Provider Outreach Page www.medi-cal.ehr.ca.gov, as well as disseminating them to the top 20 sites, including RECs, professional organizations, health care associations and managed care plans.
- Continuing articles and news releases, and especially focus these on positive stories.
- Highlighting the numbers of providers who have already registered, and dollar amounts that have been paid out in incentive payments.
- Endeavor to engage the first provider and hospital incentive payment recipients to participate in campaign outreach.

PHASE IV: MAINTENANCE CAMPAIGN

TIMEFRAME: MAY 1, 2011 – JUNE 1, 2012

The goal of this phase will be to continue to drive awareness of the Medi-Cal EHR Incentive Program, and begin to specifically focus on the late adopters. These providers will most likely need messaging that is tailored to their unique needs. DHCS is currently gathering qualitative data to help understand what these unique hurdles may be. We will use this information to create messages that resonate with this particular audience.

- Continue to place online banner ads placed on the top 20 sites, including RECs, professional organizations, and health care associations and managed care plans (see **Appendix 13**) to:
 - Drive late adopters to register in the SLR on the Provider Outreach Page www.medi-cal.ehr.ca.gov by employing messages that resonate with them
 - Begin to address next phase of program: meaningful use

PHASE V: BENEFICIARY CAMPAIGN

TIMEFRAME: SEPTEMBER 1, 2011 – JUNE 1, 2012

The goal of this phase will be to build awareness and highlight the benefits of EHRs.

At the hospital level, DHCS believes that the most efficient way to get this message across is to use a variety of very targeted media within the hospital environment and is considering the following key elements:

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- Distribution of beneficiary messaging to hospitals across the state:
 - TV Infomercial – that will loop on the hospital’s internal television station. This will be a simple, easy-to-understand explanation that will effectively communicate the benefits of using an EHR, as well as reassure beneficiaries on privacy and security protections.
 - Radio – that will loop on internal audio systems. Similar to the TV infomercial above in content, but broken up into smaller segments so as to make the information easier to absorb and understand in this auditory format.
 - Posters – that will highlight benefits of EHRs to beneficiaries, as well as providing reassurance on privacy protections.
 - Print ads for hospital-to-patient publications – that will highlight benefits of EHRs to beneficiaries, as well as providing reassurance on privacy protections.
 - All media channels will direct beneficiaries to additional resources available on a user-friendly website.
 - County eligibility offices (State Medi-Cal Enrollment Broker)

At the provider level, DHCS will take a multi-pronged approach, which includes:

- Distribution of beneficiary collateral to providers across the state, so that they can, in turn, share it with the beneficiary:
 - Downloadable pamphlets/one-sheets
 - Posters – that will highlight benefits of EHRs to beneficiaries, as well as providing reassurance on privacy protections.
 - Talking-Point cards – that will aid physicians and staff in explaining the benefits and privacy reassurances regarding EHRs.
 - Print ads for physician group publications – that will highlight benefits of EHRs to beneficiaries, as well as providing reassurance on privacy protections.
- Distribution of beneficiary collateral to the state’s Medi-Cal managed care plan enrollment contractor Maximus. They can share collateral with new members as they go through the enrollment process:
 - Downloadable pamphlets/one-sheets
 - Posters – that will highlight benefits of EHRs to beneficiaries, as well as providing reassurance on privacy protections.
 - Talking-Point cards – that will aid staff in explaining the benefits and privacy reassurances regarding EHRs.

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- DHCS will explore the development and distribution of beneficiary messaging via mass media channels, such as out-of-home (OOH), television, radio, print advertisements, and direct mail. Where and when possible, DHCS will partner with the California HIE Operational Plan's efforts to achieve economies of scale, and consistent messaging :
 - Bus shelter advertising – in geographic areas that target our core beneficiary demographics
 - TV spots – that clearly and effectively communicate the benefits of EHRs and reassure beneficiaries on privacy protections
 - Radio spots – that clearly and effectively communicate the benefits of EHRs and reassure beneficiaries on privacy protections
 - Direct Mail Pieces – that clearly and effectively communicate the benefits of EHRs and reassure beneficiaries on privacy protections
 - Pharmacies
 - Posters – that will aid physicians and staff in explaining the benefits and privacy reassurances regarding EHRs.
 - Pamphlets – that will aid physicians and staff in explaining the benefits and privacy reassurances regarding EHRs.
 - TV Infomercial – that will loop on the pharmacy's television. This will be a simple, easy-to-understand explanation that will effectively communicate the benefits of using an EHR, as well as reassure beneficiaries on privacy protections.
 - Radio – that will loop on the pharmacy's audio system. Similar to the TV infomercial above in content, but most likely broken up into smaller segments so as to make the information easier to absorb and understand in this auditory format.
 - All media channels will direct beneficiaries to additional resources available on a user-friendly website.

TABLE 20: OVERARCHING CAMPAIGN PHASE DATES

| CAMPAIGN PHASE | DATES | 2011 | | | | | | | | | | | | |
|--------------------------|------------|-------------|----------|-------------|-------------|----------|----------|----------|----------|----------|----------|----------|----------|--|
| | | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV | DEC | | |
| PHASE I: Foundation Work | Completed | [Completed] | | | | | | | | | | | | |
| PHASE II: Build Up | 2/22-3/31 | [Active] | | [Completed] | | | | | | | | | | |
| PHASE III: Launch | 4/1-4/30 | [Active] | [Active] | [Completed] | | | | | | | | | | |
| PHASE IV: Maintenance | 5/1-6/1/12 | [Active] | [Active] | [Active] | [Completed] | | | | | | | | [Active] | |
| PHASE V: Beneficiary | 9/1-6/1/12 | [Active] | [Active] | [Active] | [Active] | [Active] | [Active] | [Active] | [Active] | [Active] | [Active] | [Active] | [Active] | |

Please see **Appendix 14** for full, detailed timeline of all phases of the Outreach Campaign.

RESULTS

DHCS is currently conducting a more detailed landscape assessment to gather data on EHR adoption by Medi-Cal providers throughout the state. This data will serve to create the benchmarks against which we will measure the following:

- Has the campaign created clarity about incentive funding and eligibility among ambulatory clinics and hospitals?
- Has the campaign encouraged EHR adoption among providers?
- Has the campaign increased knowledge of resources to support providers during EHR planning and implementation?

DHCS will conduct periodic surveys to assess progress on these criteria against the benchmarks we establish.

DHCS is also working with ACS for development of additional provider outreach to help educate providers and encourage the adoption of certified EHR technology.

DHCS is working collaboratively with the State Designated Entity, Cal eConnect, and the RECs in order to establish a common message.

3 ADMINISTRATION & OVERSIGHT OF THE PROGRAM

The following information documents California’s administration and oversight of the Medi-Cal EHR Incentive Program as it applies to the questions outlined in the SMHP Template. California will implement a very robust program to ensure eligibility of the maximum number of providers in accordance with the Final Rule, while ensuring that incentive payments are timely, proper and without fraud or abuse.

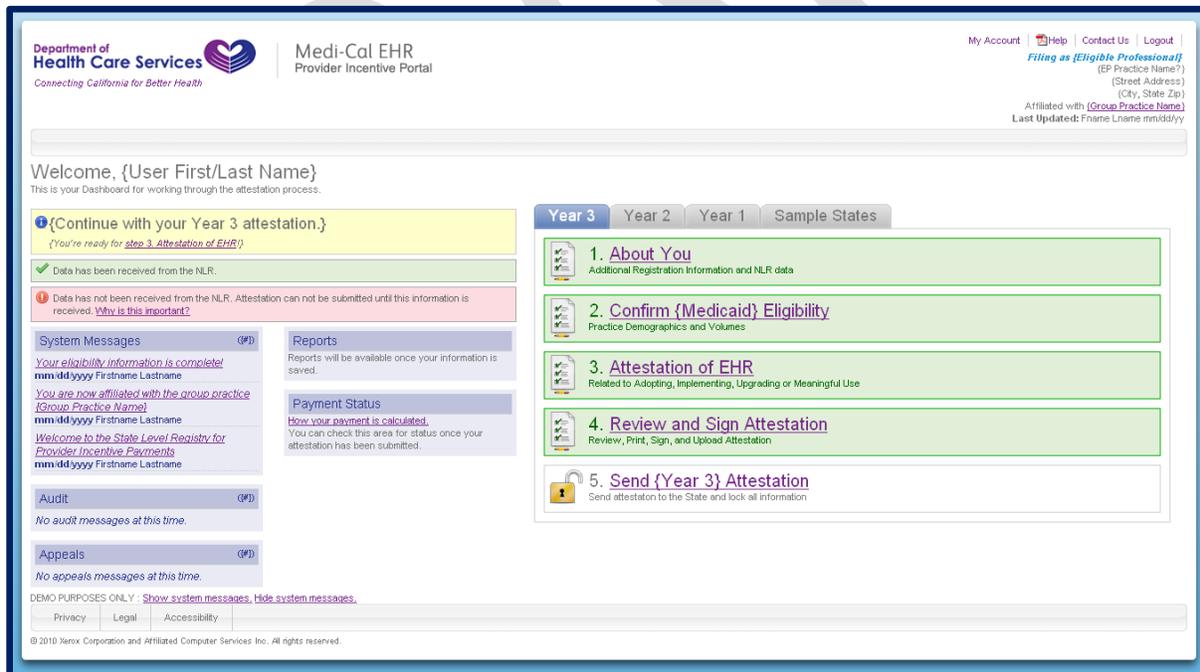
3.1 STATE LEVEL REGISTRY (SLR)

3.1.1 OVERVIEW

The State Level Registry, found on the Medi-Cal EHR Provider Incentive Portal, is a web-based solution utilizing a Software-as-a-Service (SaaS) type of solution with configurable components to meet all of the requirements of the Medi-Cal EHR Incentive Program.

With a focus on delivering a user-friendly application, the home page of the SLR has a series of status fields organized in a single view.

FIGURE 12: SLR WELCOME SCREEN



The SLR accommodates a wide range of users and is a web-based portal that allows providers access to a complete set of tools required not only for state-level registration

and attestation, but also for the centralized user management of their SLR account, viewing payment information, and submitting and monitoring appeals.

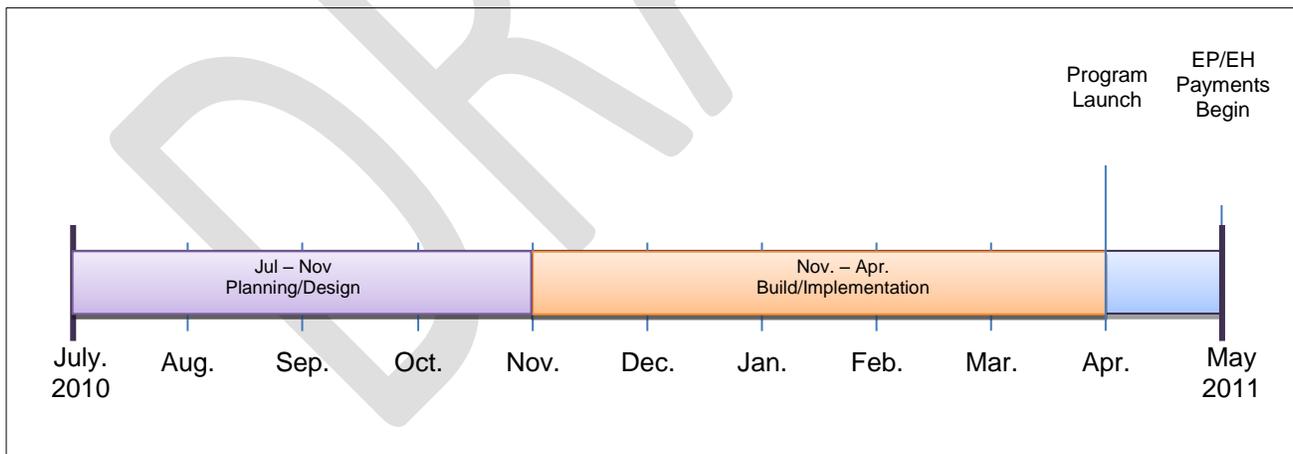
The core functions of the SLR application can be categorized into the following:

- Registration and viewing of NLR data
- Medi-Cal Eligibility
- Attestation for Adopt, Implement, or Upgrade (AIU) or Meaningful Use (MU)
- Payments, Audits, and Reporting

The SLR serves as the gateway to the provider attestation process and manages all aspects of the process, including the interfaces with NLR, data exchanges with the MMIS and payment systems, automated validation of CMS and state rules for the program and provides for a provider appeals process. The system uses business rules and workflow routing to assist the user with the completion of their attestation. This routing is demonstrated graphically below in a high-level view of the business process flow for AIU attestation.

The SLR has been developed over the course of 9 months through collaborative work between OHIT and ACS staff. OHIT staff consulted extensively with stakeholders in the development of business needs and ACS staff has conducted numerous demonstrations relevant to potential users.

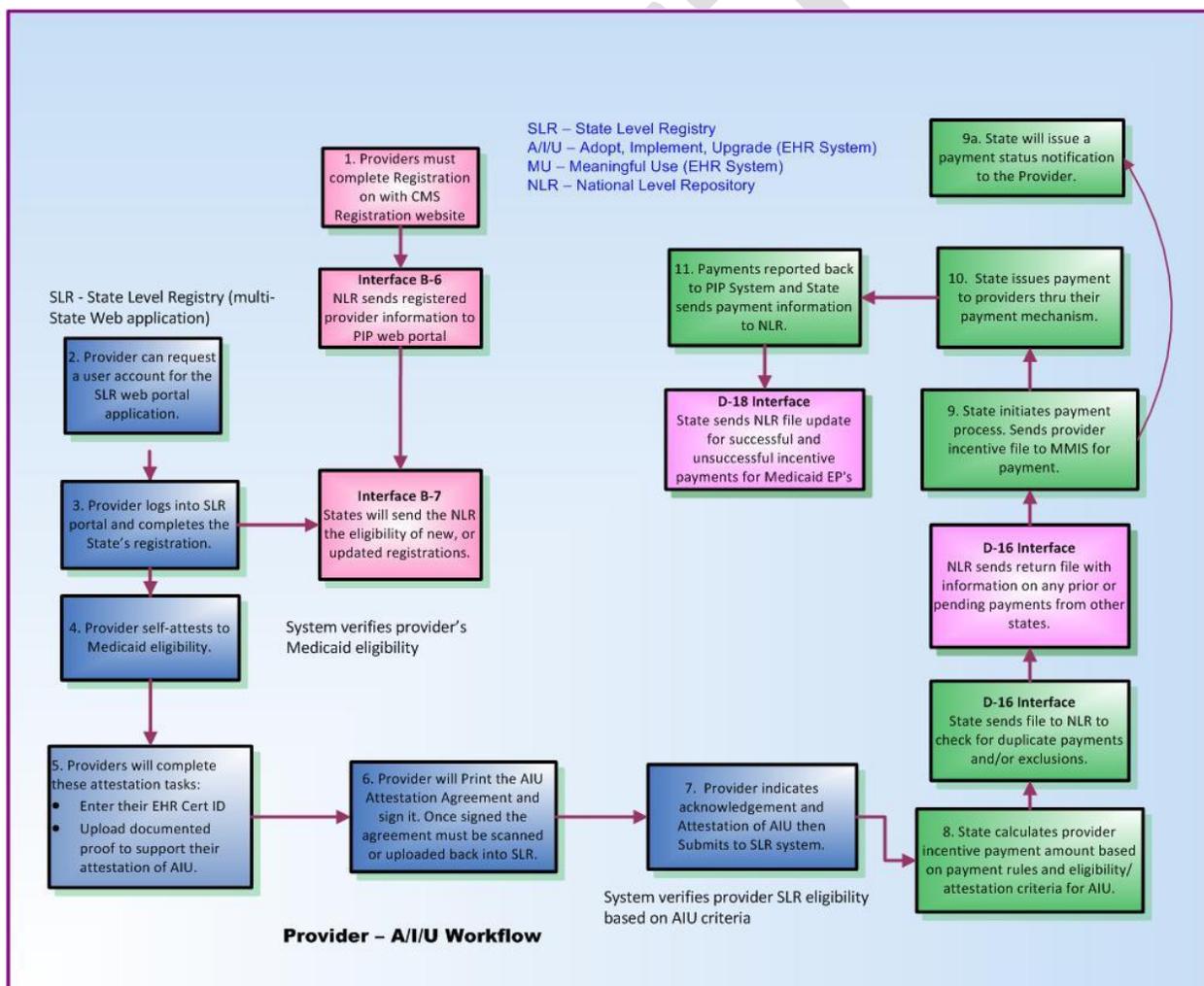
FIGURE 13: MEDI-CAL EHR PROVIDER INCENTIVE PORTAL DEVELOPMENT TIMELINE



Participation in the Medi-Cal EHR Incentive Program first requires the provider to register through the SLR. The information captured in the SLR includes the detail required for verification against state’s Provider Master File (PMF) and other data sources to confirm the provider’s legitimacy as a Medi-Cal provider. Upon authentication of the provider’s credentials, providers further self-attest to their Medi-Cal eligibility. This final eligibility determination is subsequently sent to the NLR.

Once eligibility is confirmed, the provider then moves through the process of attestation. As required by CMS guidelines, the SLR allows the provider to complete attestation tasks including the documentation of adoption, implementation, or upgrading (AIU) of certified EHR technology. Providers attest to AIU in the first year of participation with the attestation for MU able to be completed the second year of participation. If the provider fails to enter required information on a screen, the provider is delivered onscreen notification that the field is required. If an eligible professional starts an application and does not complete it within a certain timeframe, the SLR has business logic that sends an email notification to the eligible professional.

FIGURE 14: PROVIDER AIU WORKFLOW



Various tools are available to users as “help” functions. “Tool Tips” are visible on screens throughout the registration process as help text to guide providers through the fields. In addition, a “Help” link is included on all SLR web pages and connects users to

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an online user guide. To email a Help Desk associate directly, a “Contact Us” link is also available. The Medi-Cal EHR Incentive Program rules and regulations are complex and can be confusing to providers and the healthcare community. It is imperative to minimize the level of frustration and maximize the provider experience for a successful program. The state understands providers need to use technology efficiently in order to limit their administrative time and maximize time for patient care.

The online help feature within the SLR for the Medi-Cal EHR Incentive Program solution not only lists the toll free number to our Provider Help Desk (see Section 3.8), but also has a “Contact Us” link that contains the following:

- Ability to send secure messages directly to Help Desk staff
- A toll free number to contact the Help Desk

The most efficient and effective support is through the Tool Tip feature that shows a user an immediate description, definition, or direction for a specific area being completed. The online help services are intended to decrease the administrative burden for the providers in completing the SLR processes.

The SLR has a comprehensive online help system to assist providers who need a more detailed description of system functionality. This service is integrated into the portal and available at any point in the application. In addition, a User Manual is available for providers who require a single document on the SLR application. This manual is available to providers as an Adobe PDF document and can be downloaded from the SLR. The user manual can be found in **Appendix 15**.

The SLR will include the capability to send e-mail notifications to providers at various points in the registration and/or validation process, as determined by the state. Each provider will be required to provide an e-mail address as part of their state specific registration data to ensure that messages can be received. DHCS intends to work with ACS to develop the appropriate messaging to inform providers of key events and updates, including eligibility, denials, audits, appeals and approval of payments.

3.1.2 SLR/NLR INTERFACES

The SLR will interact with the National Level Repository (NLR) through the interfaces described in the following tables:

TABLE 21: SLR/NLR INTERFACES

| Interface Number | Description | Purpose |
|------------------|--|---|
| B-6 | Incoming: NLR to the SLR, Provider Registration Data | To inform the SLR of new, updated, and cancelled Medicaid registrations. The NLR will send the SLR batch feeds of new Eligible Professionals (EPs) and hospitals that signed up for HITECH and selected or switched to Medicaid. Also included in the data are any updates or changes to the EP or hospital entries and any registration cancellations. |
| B-7 | Outgoing: The SLR to NLR, Registration Confirmation Data | To update the NLR regarding the final eligibility of EPs and hospitals that opt-in to the Medicaid incentive program. The SLR will send the NLR the eligibility of new, changed, or updated registrations. The SLR will also confirm cancellations. |
| D-16 | Outgoing and Incoming: The SLR to NLR, NLR to the SLR, Duplicate Payment/ Exclusion Check | To prevent duplicate payments for providers between Medicare and Medicaid. Also prevents duplicate payments between states. |
| D-18 | Outgoing: The SLR to NLR, Incentive Payment Data | To update NLR records indicating successful and unsuccessful incentive payments for Medicaid EPs and dually eligible hospitals. The data includes all registered EPs and dually eligible hospitals including those that did not meet the CA's SLR qualifications for payment. |

The interfaces in **TABLE 22** will be implemented as CMS makes them available.

TABLE 22: FUTURE SLR/NLR INTERFACES

| Interface Number | Description | Purpose |
|------------------|--|--|
| C-5 | Incoming: NLR to the SLR, Dually Eligible Hospital Attestation Data | To send the SLR attestation information submitted by dually eligible hospitals via the CMS Attestation Module. |
| D-17 | Incoming: NLR to the SLR, Dually Eligible Hospital Cost Report Data | To send the SLR the cost report data elements utilized by CMS to determine Medicare hospital payments for dually eligible hospitals deemed eligible for the Medicare HITECH incentive payment. |

NLR batch files import into database tables by a data driven ETL (extract, transform, and load). Gentran is a point-to-point file transfer software that manages file transfer workloads with an extensive audit trail of data movement through statistic logs. The SQL Server Integration Services (SSIS) package imports job runs daily. It calls the import stored procedure for each incoming file individually. The stored procedure loads

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Extensible Markup Language (XML) files by a Structured Query Language (SQL) bulk load function and parses them using XML Path Language (XPath) while saving the data to the table. Outgoing data is prepared in the database table to await transmission. An SSIS package export job schedules daily queries in the database for such outgoing batches. When found, the queries process one-by-one, generating XML for each batch and saving it to a file in an outgoing folder. As part of the back-end validation process, an error generates when imports of file content contains a file type code that is unexpected. All errors track and save along with the final import status to the service table for audit.

A series of algorithms are utilized in the SLR based upon the various data sources integrated into the SLR data base. These data sources, such as the PMF and the State Licensing Board, can all be incorporated into the solution.

Once eligibility is confirmed, the provider then moves through the process of attestation. As required by CMS guidelines, the SLR enables the provider to complete attestation tasks including the documentation of the AIU of EHR technology. More specifically, the AIU component consists of the following tasks

- Include the EHR technology's certification identification number
- Upload documents supporting the provider's attestation of AIU

The state does not intend to allow MU attestation in 2011, but for subsequent years, providers must identify from a list of CMS-defined selections the following features of the EHR technology to which they are attesting:

- Core Objectives – Providers must meet all core objectives unless the provider qualifies for an exclusion
- Menu Set Objectives – Providers must meet five of the menu set objectives
- Clinical Quality Criteria Objectives – Eligible professionals must report on six Clinical Quality Metrics (CQM) and eligible hospitals must meet all fifteen metrics

At the end of both the AIU and MU workflows, the provider is required to print out an Attestation Agreement, sign, scan and upload the document into the SLR, and submit their acknowledgement of the attestation within the SLR application.

EPs and EHs are not allowed to submit their attestation until they have successfully completed their federal registration with the NLR and have been approved.

The information collected provides the basis from which OHIT can perform further validations and upon which the SLR will calculate the provider's incentive payment.

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Communication of the payment cycle is achieved through the following transactions and information exchanges:

- A D-16 interface transmits the calculated payment file from the SLR to the NLR to check for duplicate payments, etc.
- A responsive D-16 interface from the NLR identifies for the SLR any processed or pending payments and exclusions from other states.
- SLR transmits the provider incentive payment file to CA-MMIS for payment as well as issues a payment status notification to the provider.
- Payment information such as the date, amount of the payment, and check number are sent to the SLR from CA-MMIS.
- Following receipt of the payment file from CA-MMIS, the SLR transmits an update to the NLR utilizing the D-18 file specification.

The NLR provides a nightly file containing information on newly registered professionals and hospitals, updated registrations, and cancelled registrations. The NLR captures the email address of each eligible provider and passes that value in a nightly file along with other registration information. As this file is received from NLR, the SLR sends email notifications to EPs and EHs to advise them to review their NLR information in the SLR.

For providers who have not yet established an SLR account, the e-mail contains the URL to the provider outreach page to enable the provider to create their SLR account. The message includes instructions for creating an account and for reviewing their NLR information.

Emails to EPs and EHs that have created a user account in the SLR notify providers to log into their SLR account and asks them to review the NLR data details for accuracy. After logging into the SLR, providers may select a sub-menu option for “NLR Data” to open a screen where their NLR information is displayed in a read-only format. In addition to the registration details, the NLR Data screen contains a statement similar to:

“The data on this screen was provided by the National Level Repository (NLR) and contains the information that you provided to the NLR. If any of the information is incorrect, please update your registration information in the NLR. Updates to the NLR data may take two to three days before they can be viewed here.”

If the provider fails to enter required information on a screen, the provider will get onscreen notification that the field is required. If an EP starts an application and does not complete it within 14 days, the SLR has business logic that sends an email notification to the professional suggesting that they may wish to continue their enrollment process. However, this notification does not impact the provider’s ability to continue with their enrollment at any time.

3.2 PROVIDER ELIGIBILITY

The SLR will provide a number of validation steps to ensure that providers are eligible to participate in the program prior to any payment being issued.

The SLR will contain a Provider Master File (PMF), which will be populated from the Medi-Cal PMF. As providers register for user accounts in the SLR, their national provider identifier (NPI) and tax identification number (TIN) are verified against the PMF to determine if the provider is enrolled in Medi-Cal before the user account is created. Because California does not require all providers to enroll with Medi-Cal (such as providers in managed care), OHIT staff will verify eligibility for providers who do not appear in the PMF by checking other data sources, such as lists of providers from managed care plans. Once verified, such providers will be entered into the PMF. If a provider is permanently sanctioned in the PMF for California, the provider will not be allowed to create a user account for the SLR, or to put in any information. Providers who have a temporary sanction, or other status that requires further review, will be allowed to create an account and provide their information for the program, but will be flagged for an in-depth review to determine their specific eligibility. In cases where the provider has created an account in the SLR and matching data from the NLR has not been received within 10 working days, the SLR will initiate a message for DHCS to follow up in order to determine if the provider was eliminated based on Federal exclusions.

The SLR will also contain information on provider licensing from all the licensing entities within California for eligible providers. Providers will be required to enter their license information as part of the state-specific registration data. This license data will be verified against the provider license master data from the California licensing entities. Recognizing that some providers that practice in Indian Health Clinics or other federal clinics may be eligible for the incentive program but not licensed in California, the SLR will provide the ability for providers to indicate whether they fall into this category, and to provide the license number and state in which they are licensed for manual verification by DHCS with the licensing state prior to payment being issued. In addition, providers will be asked to attest to the fact that they do not practice 90% or more of the time in a hospital inpatient or emergency room setting as part of their registration for the state.

The B-7 Eligibility interface will be sent to the NLR confirming provider eligibility once the automated eligibility checks described above, as well as the other verification processes are completed. Essentially, DHCS considers that a provider is eligible to participate in the incentive program once they have been determined to be free of sanctions, properly licensed and credentialed, a valid provider type under the HITECH act, not be hospital based, and have provided the minimum percentage of Medi-Cal encounters required by law within the prescribed period.

3.2.1 ELIGIBLE PROFESSIONAL TYPES

In addition to the EP provider types designated in the Final Rule for all state Medicaid EHR Incentive Programs, DHCS is considering designating optometrists as eligible providers since California's State Plan contains the proper language for this designation as specified on page 44490 of the Final Rule (see **Appendix 4**). DHCS is aware of a recently issued frequently asked question from CMS on the eligibility of optometrists. This stated that "CMS is providing guidance to states that currently cover adult optometry services in order to possibly make optometrists eligible for the Medicaid EHR Incentive Program." California is in the process of arranging a conference call with the CMS Regional Office on this issue. DHCS has changed all public communications to reflect that optometrist eligibility is pending review.

Physician assistants (PAs) must practice in a PA-led FQHC or RHC In order to be eligible for the Medi-Cal EHR Incentive Program. According to the Final Rule "PA-led" can be established in three ways:

1. When a PA is the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider)
2. When a PA is a clinical or medical director at a clinical site of practice
3. When a PA is an owner of an RHC

The eligibility of every PA applicant will be verified by OHIT staff. To fulfill the first criteria that a PA is the primary clinic provider, the applicant will be requested to furnish timesheets, statements of billable hours, or other similar proof. To fulfill the second criteria DHCS will require a copy of a contract or duty statement delineating the PA's responsibilities and evidence of being the medical or clinical director of the FQHC or RHC. In California PAs are not permitted by law to have majority ownership in a clinic. Thus, California does not anticipate applicants from PAs under the third criteria.

Pediatricians are eligible to receive incentive payments at the 20% Medi-Cal encounter level. In a frequently asked question CMS has directed states to: "define pediatrician in a manner consistent with how they define the term for other purposes of their Medicaid programs." For this reason DHCS will use the criteria for a pediatrician established by its Child Health and Disability Prevention Program (CHDP): board certification or board eligibility with the American Board of Pediatrics. For verification purposes the SLR will direct pediatricians qualifying at the 20% encounter volume level to upload documentation supporting their eligibility, such a board certificate or a diploma specifying completion of a residency in pediatrics. All applications for pediatricians qualifying at the 20% encounter volume level will be subject to a "soft stop" by the SLR and referred to OHIT staff for verification.

3.2.2 ELIGIBILITY FORMULAS FOR PROFESSIONALS

As California has both fee-for-service and managed care programs under Medi-Cal, DHCS is giving eligible professionals the option to choose the eligibility formula that is most advantageous for achieving the minimum threshold for participation in the program.

- **Formula 1:**

$$\frac{\text{Total Medi-Cal Encounters}^*}{\text{Total All Patient Encounters}}$$

* Note: Medi-Cal encounters may only be counted once for services received from the same provider on the same day. Medi-Cal encounters must be paid for in part or whole by Medi-Cal or a Medi-Cal demonstration project, including payment in part or whole of an individual's premiums, co-payments, and cost sharing. For this reason Medi-Cal encounters without federal financial participation may not be counted for services in the 13 Medi-Cal aid codes that do not include federal financial participation—OR, OT, 2V, 4V, 53, 65, 7M, 7N, 7P, 7R, 71, 73, 81. (see **Appendix 16** for a detailed description of these aid codes)

- **Formula 2:**

$$\frac{\text{Total Patients Assigned to a Medi-Cal Panel}^* + \text{Total Medi-Cal Encounters}}{\text{Total Patients Assigned to a Panel}^* + \text{Total Patient Encounters}}$$

* Note: In order to be counted in either the numerator or denominator, panel patients must participate in managed care, a medical or health home program, or similar provider structure with capitation and/or case assignment. Panel members must have had at least one encounter in the 12 months preceding the 90-day representative period.

Providers practicing 50% time or more in an FQHC or RHC can add other needy individual encounters (Healthy Families--the state's CHIP program, uncompensated care, or no cost or reduced cost care based on a sliding scale determined by the individual's ability to pay) to the numerator of either formula in order establish the 30% (or 20% for pediatricians) patient volume. Please note that the Final Rule defines needy individuals as including Medi-Cal patients. In the SLR, for clarity, we have separated Medi-Cal patients from other needy individuals. However, this does not affect the eligibility calculations.

Groups will be able to enter the entire group's encounter data (including for non-EP providers) for the numerator or denominator of both formulas into the SLR to establish group eligibility for their providers. Each EP is required to attest to the program eligibility criteria individually. The group user is authorized to enter data on behalf of providers. The group user can enter Medicaid volume numbers, and the group functionality allows for the group user to aggregate group practice volumes, but they cannot actually submit the attestation, this must be done by each individual provider. To qualify as a group the entity must have an NPI and be present in DHCS' Provider Master File as a Medi-Cal Provider. In compliance with recent CMS guidance in a frequently asked question, if a

clinic or group chooses to qualify its providers with group data, then the encounter data for all providers (not just EPs) must be used in the calculation. EPs can choose to establish eligibility through any group in which they treat Medi-Cal patients (no lower minimum of patients but not zero). If a provider chooses to establish eligibility through one group, the providers in the other group(s) are not penalized by being unable to use group data to establish their eligibility. If a provider in one group chooses to establish eligibility using his/her individual encounter data in the group, then the other providers in that group are prohibited from using group data to establish their eligibility. If a provider opts out of establishing eligibility with a group (Group A) and chooses to qualify under another group’s encounter volumes (Group B) or individually using private practice data the ability of other providers in the group (Group A) to qualify using group data is not affected.

3.2.3 SLR WORKBOOK FOR DETERMINING EP ELIGIBILITY

The SLR contains a workbook that providers can use to compile required information and determine their eligibility in preparation for data entry into the SLR. The pages of this workbook are displayed below.

FIGURE 15: EP WORKBOOK INSTRUCTIONS

| Eligible Professional (EP) Worksheet for Eligibility for the Medi-Cal EHR Incentive Program | |
|---|--|
| <p>Overview: This workbook is designed to help you collect information needed to complete the Eligibility components of the SLR. It is designed to gather detailed information regarding your practice and create summarized data for entry into the SLR. You can also use this workbook to estimate your Medi-Cal eligibility based on your patient volumes.</p> | |
| <p><u>General instructions for completing this workbook:</u></p> | |
| 1 | <p>The information entered on the About You worksheet is entered on the About You page in the SLR. The information entered on the Encounters, Panel Members, and Needy Individuals worksheets are entered on the Confirm Medi-Cal Eligibility page in the SLR.</p> |
| 2 | <p>This workbook is designed for the individual eligible professional that is not associated with a group practice. Group practices have a separate workbook that should be used to gather the specific data for the group entry in the SLR.</p> |

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The Workbook begins by collecting general demographic information.

FIGURE 16: DEMOGRAPHIC INFORMATION

| | | |
|--|--|---|
| <p>You will have information that you must provide to the SLR, which is in addition to the information you provide when you register with the NLR. This additional information is used by the state to help determine your eligibility to participate in the Medi-Cal Incentive Program.</p> | | |
| <p>Professional License Number Your Professional License Number is required to determine that you are properly licensed and credentialed.</p> | <input type="text"/> | <p>The Professional License Number is entered on the About You page in the SLR.</p> |
| <p>Licensing Board Name The Licensing Board Name is used to confirm that your professional license is active and in good standing.</p> | <input type="text"/> | <p>The Licensing Board Name is entered on the About You page in the SLR.</p> |
| <p>State in which your license was issued If you practice in a certain setting, such as an Indian Health Services clinic or VA clinic, you must have a valid license from ANY state. This information is used to confirm that your license from a different state is active and in good standing.</p> | <input type="text"/> | <p>The Licensing State is entered on the About You page in the SLR.</p> |
| <p>Medi-Cal Managed Care Organizations you participate in This information is used to confirm if you participate in any Medicaid Managed Care Organizations.</p> | <input type="text"/> <input type="text"/> <input type="text"/> | <p>Medi-Cal Managed Care Organizations are selected on the About You page in the SLR.</p> |
| <p>REC Name This information is used to document any REC you may be working with.</p> | <input type="text"/> | |
| <p>Contact Person Name</p> | <input type="text"/> | <p>The Contact Person Name is entered on the About You page in the SLR.</p> |
| <p>Contact Person Phone Number</p> | <input type="text"/> | <p>The Contact Person Phone Number is entered on the About You page in the SLR.</p> |
| <p>Contact Person Email Address</p> | <input type="text"/> | <p>The Contact Person Email Address is entered on the About You page in the SLR.</p> |

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The Workbook then steps the professional through the process of calculating encounter information.

FIGURE 17: EP ENCOUNTER DATA

| | | | | | | | |
|---|---------------------|-------------------------|------------------|------------------------------|----------------------------------|---|--|
| 90 Day Representative Period | | Start: 2/15/2011 | End: 5/16/2011 | | | | The Start date is entered on the Confirm Medi-Cal Eligibility page in the SLR. |
| You can choose any 90-day period within the prior calendar year to use to determine your Medi-Cal eligibility to participate in the program. | | | | | | | |
| | | Total Encounters | | | Medi-Cal Encounters | | |
| Encounter Totals | | 0 | | | 0 | Total Encounters and Total Medi-Cal Encounters are entered on the Confirm Medi-Cal Eligibility page in the SLR. | |
| The Encounter Totals are the sum of all EP encounters across all states. This information is calculated from the fields listed for each state below. | | | | | | | |
| Encounters by State | | | | | | | |
| | Total EP Encounters | Total Non-EP Encounters | Total Encounters | Total EP Medi-Cal Encounters | Total Non-EP Medi-Cal Encounters | Total Medi-Cal Encounters | Total Encounters for each State and Total Medi-Cal Encounters for each state are entered on the Confirm Medi-Cal Eligibility page in the SLR |
| Homestate: | | | 0 | | | 0 | |
| If you only practice in your home state, enter that information in these fields. | | | | | | | |
| Additional States: | | | | | | | |
| If you practice in multiple states and would like your volumes for all states to count toward determining your Medi-Cal eligibility, enter the additional State information below. You must complete both the Total Encounters and Medi-Cal Encounters for that state's volumes to be included in your totals to determine eligibility. | | | | | | | |
| State Name | Total EP Encounters | Total Non-EP Encounters | Total Encounters | Total EP Medi-Cal Encounters | Total Non-EP Medi-Cal Encounters | Total Medi-Cal Encounters | |
| | | | 0 | | | 0 | |
| | | | 0 | | | 0 | |
| | | | 0 | | | 0 | |

Note that as these are individual worksheets within the Workbook, the professional has the option of collecting and collating the data in any order that is preferred. There is no concern about saving and coming back at a later date or that the system may somehow timeout.

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The next screen allows users to collect data regarding panel patients if this is appropriate for the provider.

FIGURE 18: EP PANEL DATA

| | | | |
|--|--|-------------------------------------|--|
| <p>If you have panel patients, defined as those for whom you are receiving capitation and/or case assignment through medical or home health programs, you can use those patients to help achieve Medi-Cal eligibility.</p> | | | |
| | | Total Assigned Panel Members | Total Assigned Medi-Cal Panel Members |
| Panel Member Totals | | 0 | 0 |
| <p>Total Assigned Panel Members and Total Assigned Medi-Cal Panel Members are entered on the Confirm Medi-Cal Eligibility page in the SLR.</p> | | | |
| <p>The Assigned Panel Members Totals are the sum of all panel members across all states. This information is calculated from the fields listed for each state below.</p> | | | |
| Panel Members by State | | | |
| Homestate: | | Total Assigned Panel Members | Total Assigned Medi-Cal Panel Members |
| | | | |
| <p>Note: For panel members to be counted, they must have been seen at least once in the year prior to the 90 day period.</p> | | | |
| <p>If you only practice in your home state, enter that information in these fields.</p> | | | |
| Additional States: | | | |
| <p>If you practice in multiple states and would like your volumes for all states to count toward determining your Medi-Cal eligibility, enter the additional State information below. You must complete both the Total Assigned Panel Members and Total Assigned Medi-Cal Panel Members for that state's volumes to be included in your totals to determine eligibility.</p> | | | |
| State Name | | Total Assigned Panel Members | Total Assigned Medi-Cal Panel Members |
| | | | |
| | | | |

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As seen in the next screen, the Workbook allows for eligible professionals practicing in primarily in FQHCs or RHCs to include patient volumes for other needy individuals.

FIGURE 19: EP ENCOUNTERS IN FQHCs AND RHCs

| | | | | | |
|---|--|---|--|--|---|
| Eligible practitioners who practice predominately in an FQHC or RHC can use Other Needy Individual encounters to help achieve Medi-Cal eligibility. CMS defines "practice predominately" as greater than 50% of the time. | | | | | |
| | Total Other Needy Individual Encounters | | | | Total Other Needy Individual Encounters is entered on the Confirm Medi-Cal Eligibility page in the SLR. |
| Encounter Totals | 0 | | | | |
| The Total Other Needy Individual Encounters are the sum of all encounters across all states. This information is calculated from the fields listed for each state below. | | | | | |
| Encounters by State | | | | | |
| Homestate: | CHIP Enrollees | Patients furnished services on sliding scale | Patients furnished uncompensated care | Total Other Needy Individual Encounters | |
| | | | | 0 | |
| If you only practice in your home state, enter that information in these fields. | | | | | |
| Additional States: | | | | | |
| If you practice in multiple states and would like your volumes for all states to count toward determining your Medi-Cal eligibility, enter the additional State information below. | | | | | |
| State Name | CHIP Enrollees | Patients furnished services on sliding scale | Patients furnished uncompensated care | Total Other Needy Individual Encounters | |
| | | | | 0 | |
| | | | | 0 | |
| | | | | 0 | |

The final page of the Workbook actually calculates the likelihood of eligibility based on the information provided. The calculations include both Formula #1 and Formula #2 for professionals that do practice primarily in FQHCs and RHCs and for those who do not.

FIGURE 20: CALCULATION OF EP ENCOUNTERS

| Medi-Cal Eligibility Formula #1 | | | | | |
|--|---|------------------------------|------------------------------|---|-------------|
| Calculation for EP's that don't practice predominately in an FQHC or RHC | Total Medi-Cal Encounters | | Total Encounters | | |
| | 0 | / | 0 | * | 100 = 0.00% |
| Calculation for EP's that practice predominately in an FQHC or RHC | Total Medi-Cal Encounters | | | | |
| | 0 | | | | |
| | + | | | | |
| | Total Other Needy Individual Encounters | | | | |
| | 0 | | | | |
| | = | | | | |
| Total Qualifying Encounters | | | Total Encounters | | |
| 0 | / | | 0 | * | 100 = 0.00% |
| Medi-Cal Eligibility Formula #2 | | | | | |
| Calculation for EP's that don't practice predominately in an FQHC or RHC | Total Medi-Cal Encounters | | Total Encounters | | |
| | 0 | | 0 | | |
| | + | | + | | |
| | Total Medi-Cal Panel Members | | Total Assigned Panel Members | | |
| | 0 | | 0 | | |
| | = | | = | | |
| Total Qualifying Medi-Cal Encounters | | | Total Qualifying Encounters | | |
| 0 | / | | 0 | * | 100 = 0.00% |
| Calculation for EP's that practice predominately in an FQHC or RHC | Total Medi-Cal Encounters | | | | |
| | 0 | | | | |
| | + | | | | |
| | Total Medi-Cal Panel Members | | Total Encounters | | |
| | 0 | | 0 | | |
| | + | | + | | |
| Total Other Needy Individual Encounters | | Total Assigned Panel Members | | | |
| | 0 | | 0 | | |
| | = | | = | | |
| Total Qualifying Medi-Cal Encounters | | | Total Qualifying Encounters | | |
| 0 | / | | 0 | * | 100 = 0.00% |

3.2.4 ELIGIBLE HOSPITALS

The SLR will require hospitals, other than Children’s Hospitals, to enter information on Medi-Cal discharges, total discharges and average length of stay for the prior fiscal year. This data will be verified for all hospitals by OHIT staff using the hospital’s most recently filed Medicare Cost Report. All hospitals will be required to upload relevant pages of this cost report into the SLR so that it can be accessed by OHIT staff.

Hospitals with significant disparities between data reported in the SLR and data in the cost report will be referred to the Audits and Investigations division for further investigation.

3.3 ATTESTATION FOR INCENTIVE PAYMENTS

In order to provide a robust verification and validation process, as well as a functional audit mechanism, DHCS has determined the appropriate level of documentation required to be filed with attestations. As a component of attestation for AIU the provider or hospital must attest that the documentation provided is for AIU of a certified EHR.

The user may provide a copy or their entire contract for a certified EHR or those portions of the contract (in the event of a lengthy document) that provide sufficient detail to verify the service, such as cover page, product/service listing and signature page.

However, the user is not limited to submission of a contract and may submit other forms of documentation for attestation such as a receipt, software license agreement, purchase order, service order, lease agreement or a services contract in the case of a remotely hosted certified EHR solution.

The SLR provides an easy mechanism with complete explanations and pop-up menu help to facilitate the user with the attestation process.

Contained within the **Appendix 17** are the attestation forms for eligible professionals and eligible hospitals that will be required as part of the attestation process. The forms are pre-populated with data from the SLR such that the user may review all content provided prior to signing and attaching to the form to their submission.

3.4 PAYMENTS

3.4.1 FOR ELIGIBLE PROFESSIONALS

The SLR designates the appropriate payment amount for the provider based upon the year for which they are receiving payment less any additional funding that is above the allowable threshold. The SLR is able to accommodate the two-thirds incentive payment for pediatricians meeting the 20% Medi-Cal eligibility threshold. The SLR also assures that only one payment per provider is issued per year, and does not calculate a payment for a provider that is ineligible (e.g. does not meet the 30% requirement). The SLR will also have functionality to limit the number of years of payments to any EP to six.

3.4.2 FOR ELIGIBLE HOSPITALS

The system will calculate the amount of the hospital incentive using the formula provided by CMS. As part of the registration and eligibility processes for hospitals, the system will gather all of the information required to complete the calculation. The SLR will display the calculation on a screen so that hospitals will be able to determine exactly how their incentive payments are calculated.

Calculation of the Overall EHR Amount is a one-time calculation based on the following steps:

- Calculate the average annual growth rate over three years using the Medicare/Medicaid Cost Reports prior to the most current Cost Report. Note that if a hospital's average annual rate of growth is negative over the three year period, it will be applied as such. Transition factors are applied to years one through four in the following amounts; Year One – 1; Year Two – 75; Year Three – 5, and Year Four –.25.
- Calculate the total Medicaid discharges using the Medicaid discharges in the Medicare/Medicare Cost Reports plus the discharges where Medicaid is the secondary payer. Only discharges between 1149 and 23,000 per CCN will be allowable discharges.
- Calculate each of the next four year's total discharges by multiplying the previous year's discharges times the average computed growth rate.
- Calculate the Aggregate EHR Amount for each year by multiplying (total discharges times \$200) plus the \$2,000,000 base.
- Apply the appropriate transition factor to each year's Aggregate EHR Amount. (Year One – 100%, Year Two – 75%, Year Three – 50%, Year Four – 25%).
- Calculate the total Overall EHR Amount by adding the total of each year with the transition factor applied.
- Apply the Medicaid Share percentage to the Overall EHR Amount. (See Medicaid Share calculation below). This is the hospital's Medicaid Aggregate EHR Incentive amount.

Calculation of the Medicaid Share percentage:

- Total Medicaid days includes both the total Medicaid Days and total Medicaid HMO days from the Medicare/Medicaid Cost Report.
- Calculate the non-charity percentage. Divide the (total hospital charges less uncompensated care) by the total hospital charges.

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- Calculate the non-charity days by multiplying the non- charity percentage times the total hospital days.
- Calculate the Medicare Share percentage by dividing the Medicaid days by the non-charity days.

DHCS has created a calculation worksheet for EHs that mirrors the calculation in the SLR application.

FIGURE 21: HOSPITAL CALCULATION WORKSHEET

| Calculation of Medicaid Electronic Health Record (EHR) Incentive Payment | | | | | | |
|--|----------------------|--------------------------------|-----------------------|----------------------|--------------|--|
| Green areas are for data input from your cost reports. | | | | | | |
| The overall "EHR" amount is the sum over 4 years of (a) the base amount of \$2,000,000 plus (b) the discharge related amount defined as \$200 for the 1,150 through 23,000 | | | | | | |
| For years 2 - 4, the rate of growth is assumed to be the previous 3 years' average. | | | | | | |
| Step 1 Calculate the average annual growth rate for the last 3 years of available data using previous hospital cost reports | | | | | | |
| | | Prior Year | Current Year | Increase/Decrease | Growth Rate | Data Source (CMS 2552-96 Version) |
| Fiscal Year 2007 | | 16,000 | 16,500 | 500 | 3.13% | Worksheet S-3, part I, col 14, sum of lines 1 + lines 6-10 |
| Fiscal Year 2008 | | 16,500 | 17,000 | 500 | 3.03% | Worksheet S-3, part I, col 14, sum of lines 1 + lines 6-10 |
| Fiscal Year 2009 | | 17,000 | 17,500 | 500 | 2.94% | Worksheet S-3, part I, col 14, sum of lines 1 + lines 6-10 |
| | | Total Increase/(Decrease) | | | 9.10% | |
| | | Average 3 year Growth Rate | | | 3.03% | |
| Step 2 Calculate the discharge related amount using the annual growth rate to adjust discharges for years 2 - 4 | | | | | | |
| Total Medicaid Discharges | | | | | 22,000 | Data Source (CMS 2552-10 Version) Worksheet S-3 part I, col. 14, sum of lines 1,8,9,10,11,12,16,17 (Excludes nursery and swing beds) |
| | Per Discharge Amount | Total Discharges | Disallowed Discharges | Allowable Discharges | Amount | |
| Year 1 | \$ 200 | 22,000 | 1,149 | 20,851 | \$4,170,200 | |
| Year 2 | \$ 200 | 22,667 | 1,149 | 21,518 | \$4,303,615 | |
| Year 3 | \$ 200 | 23,354 | 1,149 | 21,851 | \$4,370,200 | |
| Year 4 | \$ 200 | 24,063 | 1,149 | 21,851 | \$4,370,200 | |
| | | Total Discharge Related Amount | | | \$17,214,215 | |
| Step 3 Calculate the Initial Amount for 4 Years | | | | | | |
| | | Year 1 | Year 2 | Year 3 | Year 4 | |
| Base Amount | | \$2,000,000 | \$2,000,000 | \$2,000,000 | \$2,000,000 | |
| Discharge Related Amount | | \$4,170,200 | \$4,303,615 | \$4,370,200 | \$4,370,200 | |
| | Aggregate EHR Amount | \$6,170,200 | \$6,303,615 | \$6,370,200 | \$6,370,200 | |
| Step 4 Apply Transition Factor | | | | | | |
| | | Year 1 | Year 2 | Year 3 | Year 4 | |
| Transition Factor | | 1.00 | 0.75 | 0.50 | 0.25 | |
| | Transition Factor | \$6,170,200 | \$4,727,711 | \$3,185,100 | \$1,592,550 | |

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| | | | | | |
|---------------|--|-------------------|-----------------------|-----------------------|---|
| Step 5 | Calculate Overall EHR Amount for 4 Years | | | \$15,675,561 | |
| Step 6 | Calculate Medicaid Share from Hospital Cost Report data | | | | |
| | (estimated Medicaid inpatient-bed-days + estimated Medicaid HMO inpatient-bed-days) / (est. Medicaid IP-bed-days x ((est. total charges - est. charity care charges) / est. total charges)) | | | | |
| | | | | | Data Source (CMS 2552-10 Version) |
| | Total Medicaid Inpatient Bed Days | 1,750 | | | Worksheet S-3 part I, col. 7, sum of lines 1,8,9,10,11,12,16,17 |
| | Total Medicaid Managed Care Inpatient Bed Days | 135 | | | Worksheet S-3 part I, col. 7, Sum of lines 2 - 4 |
| | Total Medicaid and Managed Care Inpatient Bed Days | | 1885 | | |
| | Total Inpatient Hospital Charges | 5,000,000 | | | Worksheet C part I, col. 6, line 200 |
| | Total Charity/uncompensated care charges (non-Medicare) | (1,000,000) | | | Worksheet S-10, line 23, col. 3 (Excludes bad debt) |
| | Total Hospital Charges - Charity charges | 4,000,000 | | | |
| | Divided by Total Hospital Charges | 5,000,000 | | | |
| | Non-charity percentage | 80.00% | | | |
| | Total Hospital Inpatient Bed Days | 5,000 | | | Worksheet S-3 part I, col. 8, sum of lines 1,8,9,10,11,12,16,17 |
| | Total Hospital Inpatient Bed Days excluding charity | | 4,000 | | |
| | Medicaid Share | | | 47.13% | |
| Step 7 | Calculate Medicaid Aggregate EHR Incentive Amount | | | | |
| | Overall Amount for 4 years | | | \$15,675,561 | |
| | Medicaid Share | | | 47.13% | |
| | Medicaid Aggregate EHR Incentive Amount | | | \$7,387,108.25 | |
| Step 8 | Calculate Annual Incentive Payment Amount | | | | |
| | | Percentage | Payment | | |
| | Year 1 Payment | 50% | \$3,693,554.13 | | |
| | Year 2 Payment | 30% | \$2,216,132.48 | | |
| | Year 3 Payment | 10% | \$738,710.83 | | |
| | Year 4 Payment | 10% | \$738,710.83 | | |

Data sources from the Medicare hospital cost report are designated on the worksheet for each required data element. However, DHCS is determining if additional data sources may be required to verify Medi-Cal HMO days, charity care and to eliminate “swing beds” as the Medicare/Medicaid cost reports may be unreliable in these areas. Hospital finance reports and daily census reports are being evaluated in regards to being potentially more reliable than the cost reports. If charity care charges are not available, DHCS proposes that the data for uncompensated care be used instead of charity care charges. If neither charity care data nor uncompensated care cost data are available, DHCS will set the charity care ratio to one. Hospitals submitting cost reports after May 1, 2010 use cost report version form CMS 2552-10. Any Medicare Cost Report prior to that date will have used version form CMS 2552-96. CMS has made charity care reporting mandatory after February 2010, and therefore 2010 Medicare Cost Report data on charity care may be more reliable than previous cost reports.

For the purpose of calculating the Medicaid discharges, DHCS will allow hospitals to count discharges when Medicaid is the primary or secondary payer. This method is in accordance with the instructions from the CMS Facts, Answers and Questions section published on the CMS website.

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“Medicaid Share,” which is applied against the aggregate EHR incentive amount, is essentially the percentage of a hospital’s inpatient non-charity care days that are attributable to Medicaid inpatients. DHCS will only allow the hospital to count the Medicaid primary days for the purpose of calculating the Medicaid patient volume. This method is in accordance with the instructions from the CMS Facts, Answers and Questions section published on the CMS website.

The estimated amounts for total charges and charity care charges used in the formula must represent inpatient hospital services only and exclude any professional charges associated with the inpatient stay.

DHCS plans to pay the aggregate hospital incentive payment amount in four annual payments, contingent on the hospital’s annual attestations and demonstrations of meaningful use. In the first year, if all conditions for payment are met, 50% of the aggregate amount will be paid to the EH. In the second year, if all conditions for payment are met, 30% of the aggregate amount will be paid to the EH. In the third year and fourth year, if all conditions for payment are met, 10% of the aggregate amount will be paid to the EH for each year. Payments are extended over four years in order to increase the number of EHs incentivized to achieve Stage 2 meaningful use. No Medi-Cal EHs may begin receiving payments after 2016 and payments will not be made after the calendar year 2021. Prior to 2015, payments can be made to an eligible hospital on a non-consecutive annual basis.

3.4.3 PAYMENT PROCESSING

DHCS has determined that the most efficient intervals for delivery of incentive payments to recipients are twice monthly. This will take advantage of the existing payments processes currently in place for the state and also ensure that incentive payments are made within the timeframes required by the Final Rule and subsequent CMS findings.

The payment processing begins in the State Level Registry (SLR). The system captures the payment request, request status, appeals, final disposition, and previous payment information. The system includes sufficient storage capacity in preparation of capturing and tracking transactions between 2011 and 2021.

The role of the SLR is to send the payment information to the state’s payment system based upon the MMIS Interface Standards. The MMIS system will be able to process provider payments or EFT, and the annual 1099 required by the IRS for reporting income.

The system delivers the following:

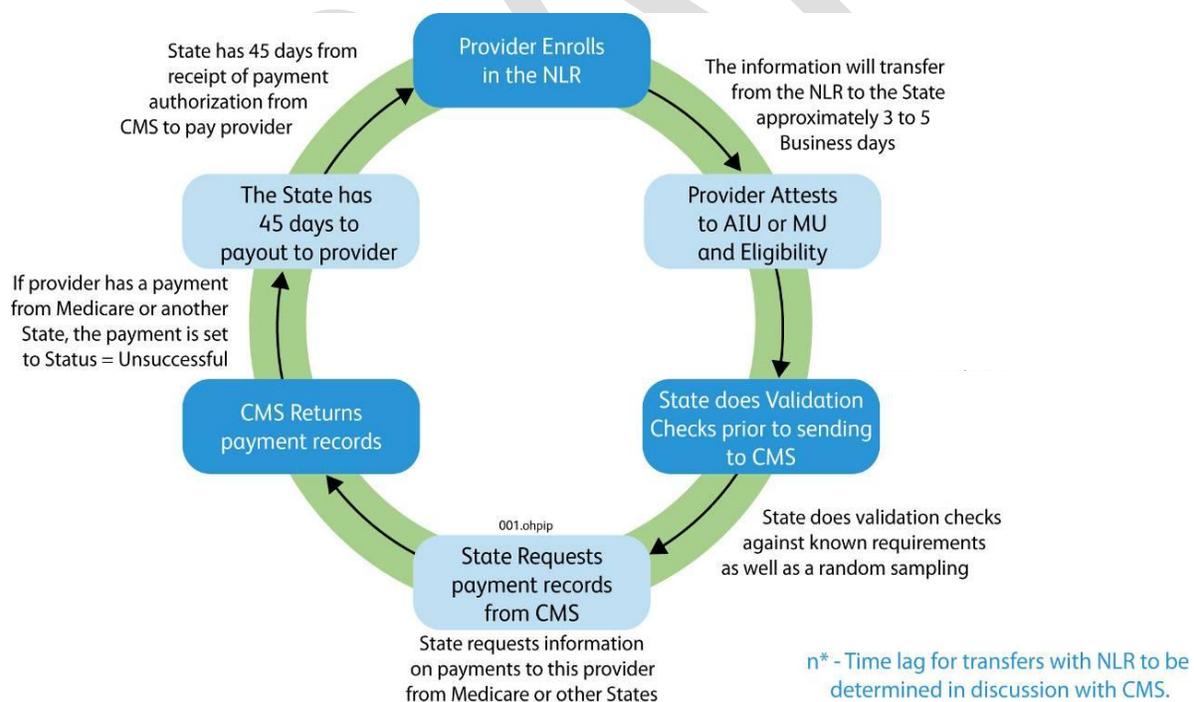
- Maintains a complete repository of incentive payment-related information
- Follows correct payment methodology based on CMS payment rules

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- Accurately exchanges payment information with the MMIS payment system
- Avoids inappropriate payments
- Does not issue payments to providers when there are state or federal exclusions, sanctions, and/or other state incentive payments pending or paid
- Provides the functionality to pay assigned payees as designated by the provider

The SLR system calculates incentive payment amounts, executes a validation process with the National Level Repository (NLR), and sends a file to the MMIS for payment. This feed can also be configured to be directed to other systems as required by the state. The MMIS issues incentive payments and notifications to eligible professionals through normal payment channels and returns confirmation to the SLR system. The SLR system then updates the repository with payment details. The SLR system sends a file with the payment details to the NLR to update the NLR records for those eligible parties receiving payments.

FIGURE 22: PAYMENT CYCLE

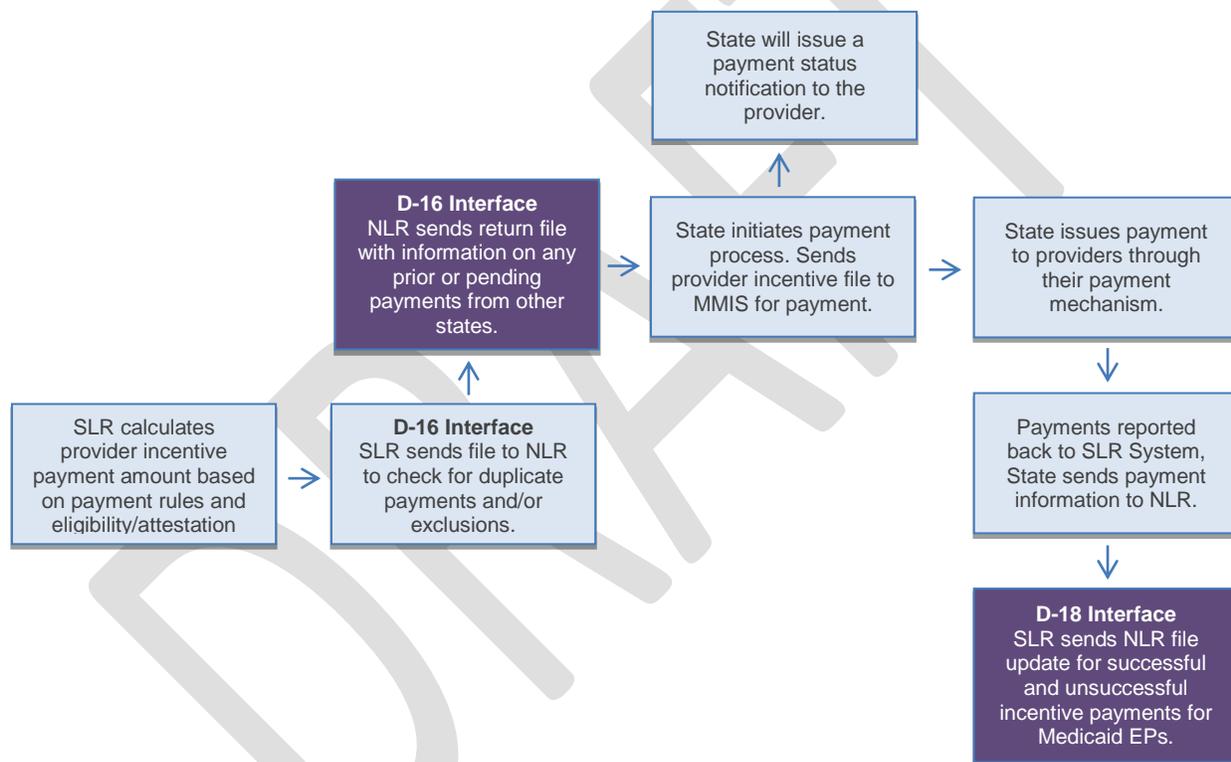


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The SLR system uses the correct payment methodology for incentive payments to all eligible entities, including EPs and EHs. The DHCS Fiscal Intermediary (FI), ACS, has worked directly with CMS to define the details for correct computation of incentive payments under the EHR Incentive Program.

The Medi-Cal payment methodologies are similar to those prescribed for Medicare incentive payments. Using validation checks with the NLR, the SLR prevents making payments when actual or pending Medicare payments and payments from other states are identified. However, there is an exception allowing both Medicare and Medicaid incentive payments to dually-eligible hospitals.

FIGURE 23: NLR PAYMENT APPROVAL PROCESS



When the payment has been calculated, the SLR requests information on duplicate or pending payments and any updated exclusions from the NLR. If the NLR returns information that there is another payment for this provider, the payment status is set to “Unsuccessful.” The payment file is sent to the MMIS for payment. When the MMIS reports the payment back to the SLR, the payment record is forwarded to the NLR to keep that repository accurate.

DHCS is currently defining the most appropriate way to provide the approved incentive amounts to the payment system given its current Medi-Cal payment methodologies.

Figure 24 illustrates the standard flow for the generation of provider incentive payments. The transfer of payment information may be through an interface to the MMIS, an interface to a state's accounting system at the Department of Finance, the creation of an Excel file in an appropriate format to upload to another system, and/or generation of paper invoices that the state enters manually, depending upon the number of providers and provider payments.

To avoid inappropriate payments, the SLR payment process validates user-entered information against NLR payment data. The SLR sends a request for information for each EP or EH to the NLR. The NLR returns information on whether there are other payments and/or exclusions for the provider. A payment from another state or from Medicare disqualifies the provider from receiving a Medi-Cal incentive payment.

When an inappropriate payment is identified through the SLR audit and investigations process, it is reported to the state. CMS allows each state to determine methods for recovery of inappropriate payments. The state will utilize its existing Medi-Cal recovery methodologies to recover inappropriate incentive payments.

The payment processing within the SLR includes stops to prevent issuing automatic payments if the eligible entity is flagged for exclusions or sanctions by the state. The system also executes a validation check with the NLR to determine whether there are prior or pending Medicare payments to the entity, or payments and/or exclusions from other states. The SLR avoids making payments to providers when they are receiving other payments or when there are state or federal exclusions.

EPs receiving incentive payments under the incentive program may assign their incentive payments to certain other entities. For example, an EP is allowed to specify that his or her group practice receive his or her incentive payments. The EP designates the TIN of the practice (payee) to which he or she wishes to assign his or her incentive payments on the NLR, and that information is received and stored in the SLR. The state will validate that the NPI/TIN reassignment combination is allowed. The payments for that EP are then made to the payee TIN. Although the state has not yet designated any adoption entity, the Final Rule specifically allows making such payments to "entities promoting the adoption of certified EHR technology..." The adoption entity payee TIN may also be used for this type of assignment.

The state's payment process requires that a warrant number is included for tracking and audit purposes. The State Controller's Office (SCO) issues the final payments and is the source of the warrant information. The system will employ the current Medi-Cal check write system.

The proposed solution for payment processing includes the following steps:

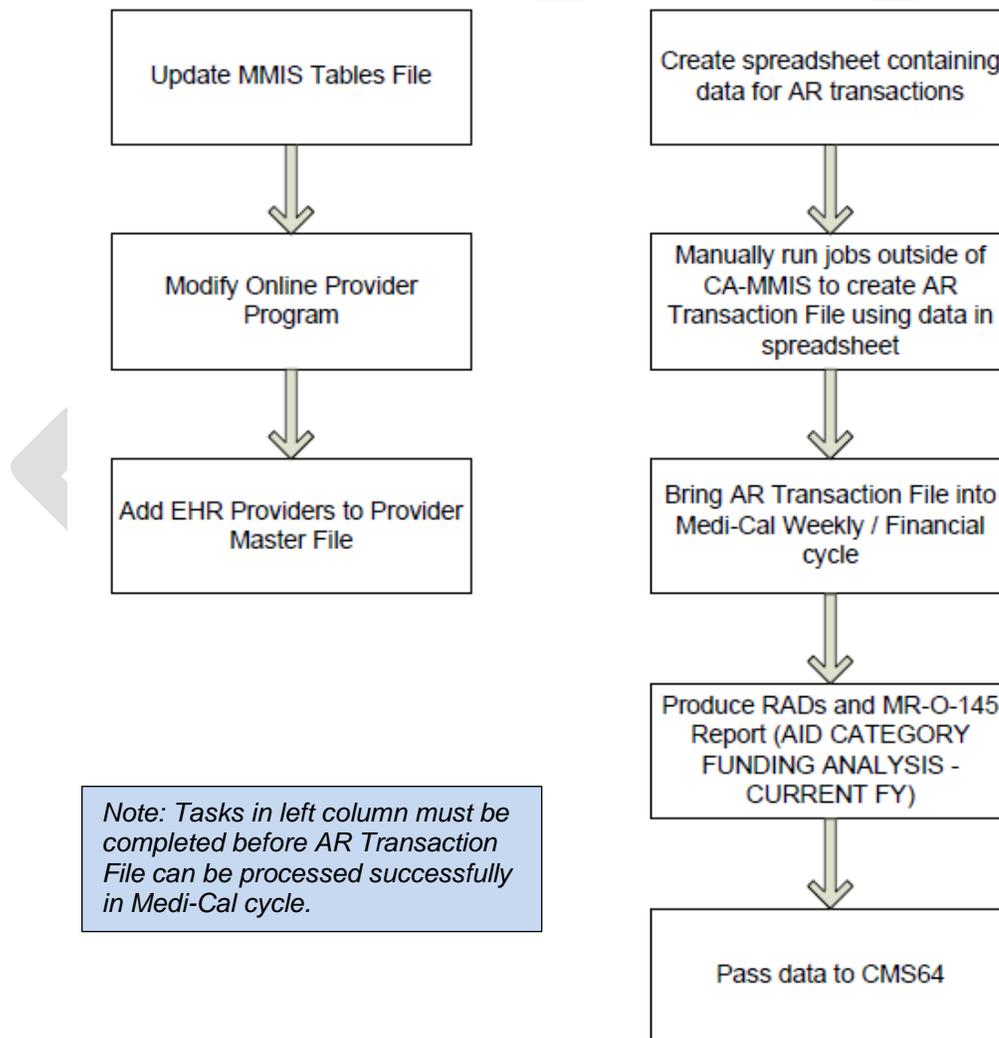
- 1) Upon acceptance of the verification and validation processes within the SLR, and notification from NLR that payment may be released, the Fiscal

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Intermediary (FI) will receive an Action Notice from the SLR to pay the appropriate provider incentive payments.

- a) The payment is made with the warrant number from SCO and a uniquely identifiable transaction number.
 - b) The transaction number will have an EHR Incentive Program descriptive message in the provider manual.
- 2) The system reporting will be updated to identify the payments separately within existing service categories based on the transaction number identified above.
 - 3) The CMS64 database will calculate FFP for EHR Incentive Payments and retain the information for reporting purposes.

FIGURE 24: PAYMENT PROCESS DATA FLOW



3.5 VERIFICATION AND VALIDATION

DHCS has developed an administrative review process that is designed for two explicit objectives:

- Address issues with providers and hospitals proactively to avoid appeals whenever possible
- Work with providers and hospitals proactively in order to ensure that all possible providers and hospitals meet the eligibility requirements within the constraints of the Final Rule

3.5.1 PREPAYMENT ELIGIBILITY VERIFICATION FOR EPS

Prepayment verification of eligibility will be carried out on all EP applications. The number of Medi-Cal encounters reported in the numerator of Formula 1 or Formula 2 will be verified by comparing against encounter data maintained in the DHCS MIS/DSS system. If the number reported in the application is more than a small percentage above the number documented in encounter data for the EP in the specified time period, the application will be referred for further review by DHCS staff. This review will require the submission of further documentation by the provider and may include an on-site audit (see Audit Strategies in Section 4). DHCS plans to be able load encounter data into the SLR so that all EP applications can be verified automatically. The size and complexity of the Medi-Cal program, including both fee-for-service and managed care components, make deployment of 100% automated verification challenging in both manual and automated verification.

FQHC or RHC providers, using aggregate clinic level data to establish eligibility, will have their verification carried out by OHIT staff using the Office of Statewide Health Planning's Annual Utilization Report of Primary Care Clinics. This report documents clinic encounters broken out by payer source. Applications with reported numbers greater than a small percentage above documented numbers will be referred to Audits & Investigations for further examination. Because the Annual Utilization Report of Primary Care Clinics uses annual data, OHIT staff will determine whether the annual data is not representative of the reporting period (for example, the clinic was not operational during part of the year) before referral to Audits & Investigations staff. All providers claiming to practice predominantly (50% or more services) in an FQHC or RHC will have this verified pre-payment against provider type data contained in the MIS/DSS.

All EP applications will be screened pre-payment to identify providers with practice locations of 90% or greater in ER (POS 21) or hospital settings (POS 23) by OHIT staff using place of service data stored in MIS/DSS. Providers whose documented practices are found to be 90% or greater in ERs or hospitals will be further investigated by DHCS to confirm ineligibility.

To verify total patients assigned to a Medi-Cal panel in the numerator of Formula 2, OHIT staff will use patient panel information derived from encounter data stored in the MIS/DSS system. DHCS plans to load patient panel data into the SLR so that all applications containing patient panel data can be automatically verified. Applications with reported numbers exceeding a small percentage above documented numbers will be reviewed by DHCS staff.

Because DHCS does not have access to an all-payer database, it will not be possible for OHIT staff to verify the numbers reported in the denominators of either Formula 1 or Formula 2. However, Audits & Investigations Division staff will investigate denominator information by requiring further documentation or through onsite audit visits. DHCS also does not have data regarding most non-EP visits. When applications including non-EP encounters are selected for verification, the review will be passed immediately by OHIT staff to Audits & Investigations which can audit a variety of data sources, such as clinic visit calendars or encounter logs.

3.5.2 SLR VALIDATION STOPS

The SLR will utilize a number of “soft stops” which will trigger reviews by state staff before an incentive payment is issued or denied. These will prompt verifications by state staff and interactions with providers to clear up any issues. Soft stops will not prevent providers from submitting information, but will prevent progression to final approval. A few “hard stops” will be employed in the SLR, such as lack of a valid and current professional license that will prevent the provider from progressing with the application.

TABLE 23: STATE LEVEL REGISTRY VALIDATION ITEMS

| VALIDATIONS | AUTOMATED (A), MANUAL (M) | EXCEPTION RESULT |
|--|--------------------------------------|---|
| PROVIDER CREATE ACCOUNT | | |
| Validate that the provider’s TIN and ID (NPI or CCN) matches PMF | A | SOFT STOP |
| If not found on PMF then validate using the NLR record | A | HARD STOP |
| Standard check to validate that a “group” status is noted on the PMF for users selecting Group Representative role | A | N/A – State will be sent exception notice, but user can proceed |
| STEP 1: ABOUT YOU | | |
| Standard check provider license number is on the PMF and is active | A | SOFT STOP |
| Standard check PMF Provider Status 4 is noted as deceased | A | HARD STOP |

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| VALIDATIONS | AUTOMATED (A), MANUAL (M) | EXCEPTION RESULT |
|--|---|---------------------|
| Standard check PMF Provider Status 6 is noted as permanently suspended | A | HARD STOP |
| ACS standard check PMF Provider Status 3 is noted as pending a transition | A | *HOLD |
| Standard check PMF Provider Status 2 is noted as inactive | A | SOFT STOP |
| Standard check PMF Provider Status 5 is noted as rejected | A | SOFT STOP |
| Standard check PMF Provider Status 9 is noted as temporarily suspended | A | SOFT STOP |
| STEP 2: ELIGIBILITY | | |
| For EP - Validate that the outcome of Formula 1 or Formula 2 meets eligibility when result is as follows: <ul style="list-style-type: none"> • ≥ 20% for pediatricians OR • ≥ 30% for all other provider types | A = Confirmation that data entered meets minimum eligibility requirements M = OHIT staff to verify. | SOFT STOP |
| For EH- Validate that the outcome of the eligibility entries meets eligibility when the result is as follows: <ul style="list-style-type: none"> • The hospital is a children's hospital OR • If Medicaid volume > 10% AND LOS (Avg. Length of Stay) <=25 days AND the last 4 digits of CCN = 0001 – 0879 or 1300 – 1399 | A = Confirmation that data entered meets minimum eligibility requirements; M = Confirmation that data entered matches Hospital Cost Report | SOFT STOP |
| Validates if the provider has been paid a Medicaid claim within the last year | A | HARD STOP |
| If provider is a pediatrician with less than 30% volume, validate board eligibility/certification | A | SOFT STOP |
| STEP 3: ATTESTATION OF EHR AIU/MU | | |
| Criteria Method (AIU or MU) - Check to validate that a document is attached. In the case of a modular approach the provider will be able to attach up to 10 documents per page within the system. Since there is document management functionality in several places in the SLR, the provider could attach more documents in other locations in the application. | A = Confirmation that document is attached; M = Confirmation that document includes required information | SOFT STOP |
| EHR Certified Technology – CMS EHR Certification ID is listed on ONC as a Certified EHR system. In the case in which a provider presents a modular solution DHCS staff will verify the CMS EHR Certification ID for the specific combination of modules on the ONC website. | A | SOFT STOP |

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| VALIDATIONS | AUTOMATED (A), MANUAL (M) | EXCEPTION RESULT |
|--|--|--|
| EHR Certified Technology – Validate that a document is attached | A = Confirmation that document is attached; M = Confirmation that document includes required information. | N/A – User cannot proceed without attaching document |
| STEP 4: REVIEW, SIGN AND ATTACH ATTESTATION | | |
| Validate that there is a document attached | A = Confirmation that document is attached; M = Confirmation that document includes required information. | HARD STOP |
| STEP 5: SEND (YEAR X) SUBMISSION | | |
| Standard check to validate the NLR record is on file | A | HARD STOP |
| Standard check provider license number is on the PMF and is active | A | SOFT STOP |
| Standard check PMF Provider Status 4 is noted as deceased | A | HARD STOP |
| Standard check PMF Provider Status 6 is noted as permanently suspended | A | HARD STOP |
| Standard check PMF Provider Status 3 is noted as pending a transition | A | *HOLD |
| Standard check PMF Provider Status 2 is noted as inactive | A | SOFT STOP |
| Standard check PMF Provider Status 5 is noted as rejected | A | SOFT STOP |
| Standard check PMF Provider Status 9 is noted as temporarily suspended | A | SOFT STOP |
| Validate that the outcome the eligibility formulas meets eligibility criteria | A | SOFT STOP |
| ADDITIONAL VALIDATIONS | | |
| B-6 interface with other state exclusion NOTE: From NLR to states; informs states of new, updated and cancelled Medicaid registrations. The NLR will send the states batch feeds of new EPs and Hospitals that signed up for HITECH and selected, or switched to, Medicaid. | A | SOFT STOP (in place until B-6 received from NLR) |
| D-16 response interface with other state exclusion NOTE: From state to NLR, with NLR Response; to prevent duplicate EHR incentive payments, to notify NLR of state exclusions, to be notified of any Federal exclusions by NLR. | A | SOFT STOP (in place until D-16 received from NLR) |
| D-16 response interface with a Federal exclusion NOTE: From state to NLR, with NLR Response; to prevent duplicate EHR incentive payments, to notify NLR of state exclusions, to be notified of any Federal exclusions by NLR. | A | HARD STOP |
| * HOLD – Will occur only if PMF Provider Status is noted as 3: <i>Pending Transition</i> . HOLD will occur for 3 days, after which will change to SOFT STOP if <i>Pending Transition</i> status has not changed. | | |

The SLR includes the capability to send email notifications to providers and OHIT staff at various points in the registration and/or validation process. In the event that one of these events (hard stop or soft stop) occurs, the user is notified of the outstanding issue. However, OHIT administrative personnel are also apprised of the occurrence. An OHIT analyst will be assigned to contact the user through various channels in order to apprise the affected party of the options available to overcome/resolve the issue.

The SLR contains a Message Center that includes a subsection specific to messages regarding Appeals. The user will be able to access the entire string of messages related to any appeal issue.

Aside from automated system notifications to OHIT staff regarding these occurrences, OHIT staff will be trained to run specific reports within the system to glean information regarding the “aging” issues that have previously been addressed with the user but remain in the system.

OHIT will monitor and review exceptions as needed to reduce the number of unnecessary appeals. Follow up discussions will occur to ascertain whether the user is still working on the issue, requires additional assistance or has received information or concluded the issue cannot be overcome.

There are generally two global issues that could precipitate an appeal: eligibility and incentive payment calculation. Although eligibility is generally determined through the automated application verification and validation process, there are components of the eligibility process that can and will be addressed by the OHIT administrative staff.

The most common eligibility issue is expected to be that of Medi-Cal patient volumes. Where the eligibility issue may be CCN number for a hospital or perhaps current participation in the Medicare incentive program by a professional - there is little that can be accomplished administratively. However, determination of patient volumes for both professionals and hospitals can be a complex task. OHIT administrative staff will be well versed in the requirements of the Final Rule and direction from CMS as it relates to patient volumes.

Not only will the system generate notifications of failures to reach patient volumes, OHIT staff will also be able to run reports to determine which professionals and hospitals may be within reach of meeting the volume requirements, and be able to provide guidance in these efforts. These efforts may include validation that the data entered matches the hospital cost report; alternately, there may be another 90-day period available within which the professional may meet the Medi-Cal patient volume.

In order to ascertain the effectiveness of the administrative processing of issues, OHIT is incorporating an issue tracking database. OHIT expects to produce a reporting template to track the number of issues, pending issues, resolved issues, nature of

resolutions, and the nature of appeals for those that result in appeal. OHIT will analyze report findings to identify areas of concern and possible solutions.

Based on the findings from this reporting information, OHIT will adjust its processes, tactics and resources in an effort to resolve issues better and in a timely manner. All avenues will be addressed by the OHIT administrative staff to ensure that professionals and hospitals are provided every opportunity to complete eligibility and procure the incentive payment to which they are entitled according to the Final Rule and CMS regulations.

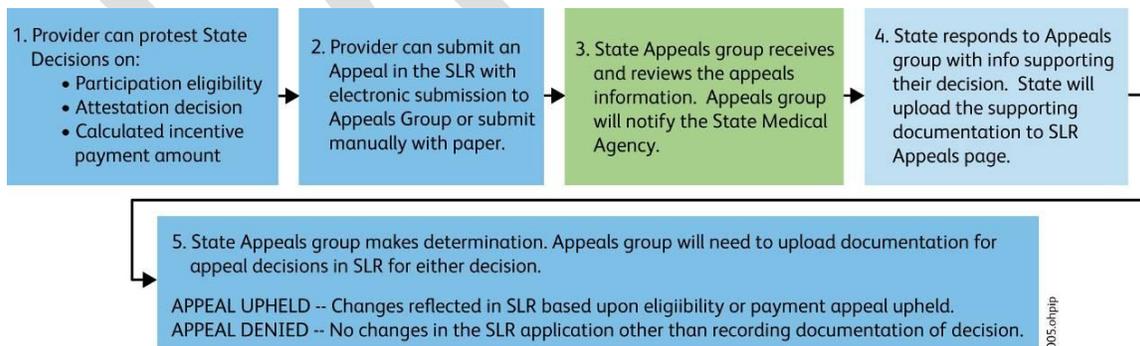
3.6 APPEALS

DHCS will implement an appeal process mirroring that under the Welfare & Institutions Code Section 14043.65. This code designates a written appeal process to the director’s designee. No formal administrative hearing is required. The provider has 60 days from the date of the department’s action to file their written appeal with all of the supporting materials. The director/designee has 90 days from receipt of the appeal to issue a decision. The decision may uphold, continue or reverse the department’s action in whole or in part. Any further appeal shall be via § 1085 of the Code of Civil Procedure (a writ to the Superior Court).

Eligible professionals and hospitals have the right to appeal OHIT’s decision on participation eligibility, attestations, and incentive payment amounts. The SLR appeals module maintains all appeal documentation.

As the process flow in **Figure 25** below illustrates, the SLR allows providers to submit their appeal using either electronic or manual means. As required, the Appeals module of the SLR application retains all documentation associated with the appeal.

FIGURE 25: APPEAL PROCESS



Once a provider files an appeal within the system, the SLR sends the state’s appeals group an automatic notification. In response, DHCS uploads its supporting documentation and explanation for why the provider believes an appeal is warranted.

Based upon the information provided, the appeals group either confirms or reverses the ruling and uploads their decision documentation. If necessary, for decision reversals, the SLR reflects the appropriate updated changes.

3.7 REPORTING

The SLR provides DHCS with a highly actionable reporting package to manage effectively the Medi-Cal EHR Incentive Program. Key SLR reporting features include:

- Active eligible professional attestation applications currently being completed
- Active eligible professional attestation applications currently being adjudicated by CMS
- Active eligible professional attestation applications currently awaiting payment, include the dollar value of the payments
- Inactive eligible professional attestation applications currently pending
- Completed eligible professional attestation applications
- Email traffic received, summarized by the messages unassigned, the messages assigned/being worked, the messages resolved, the messages pending more information from the sender, and the messages pending (other)
- Active appeal notifications currently being managed
- Active audit functions currently being executed

3.8 HELP DESK

The purpose of the SLR Help Desk is to handle and manage **Tier I** user calls. Tier I calls are those that will provide assistance with the following:

- Initial access to the SLR
- Navigating each of the SLR screens that include each task to complete the Provider Registration, Eligibility, Attestation, and Submission within the SLR
- Uploading documents
- What to generally expect in terms of next steps (approval, payment, etc.)
- Any Information Technology issue that would be considered an application performance issue as experienced by the end user
- A user needing access to a locked record
- A user with questions about Information Technology related functionality

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- A user needing administrative assistance

Tier II calls will be referred to the appropriate state resource within OHIT. **Tier II** calls are calls related to:

- Policy
- Payment
- Audit
- Appeals

There will be questions regarding the NLR, as well as calls regarding other forms of support services. Types of questions to be referred to CMS/ONC or RECs (**Tier III**) include the following:

- Initial access to the NLR
- Navigating each of the NLR screens that include each task to complete the Provider Registration, Eligibility, Attestation, and Submission within the NLR
- What to expect in terms of next steps after NLR enrollment (timelines, approval, payment)
- Caller demographics will assist in routing callers to the appropriate RECs (CalHIPSO, CalOptima, HITEC LA, CRIHB) with questions about eligibility, practice support, certified EHR technology, AIU/MU or any other questions that may pertain to the participation by the caller in the Medi-Cal EHR Incentive Program. Callers will also be prompted to access the resource links on the outreach site (www.medi-cal.ehr.ca.gov) that have links to CMS, REC and other resources.

HELP DESK ISSUE ROUTING

To support the SLR, the state's Fiscal Intermediary has staffed and begun a Help Desk in Henderson, North Carolina to provide technical assistance to providers relative to the Medi-Cal EHR Incentive Program enrollment portal.

The hours of operation are from 8 am to 5 pm PST/11-8 EST Monday through Friday, and includes a 24x7 Voice Response System. Calls will be broken down into three tiers.

The following table examines the types of calls that the Help Desk is expected to receive, which will be handled by Help Desk personnel.

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| TABLE 24: TIER I CALLS | |
|--|--|
| The purpose of the SLR Help Desk is to handle and manage Tier I user calls. Tier I calls are calls that will provide assistance with the following: | |
| Initial access to the SLR | |
| Create, Activate, Deactivate or Unlock Account | |
| Password Reset | |
| Remove from Group | |
| Retrieve User ID | |
| Assisting callers with navigating the SLR solution | |
| Assisting providers in completing the attestation process | |
| Navigating each of the SLR screens that include each task to complete the Provider Registration, Eligibility, Attestation, and Submission within the SLR | |
| Uploading documents | |
| What to generally expect in terms of next steps (approval, payment) | |
| Application performance issue | |
| A user needing access to a locked record | |
| A user with questions about Information Technology related functionality | |
| A user needing administrative assistance | |
| Issues resulting from a staff member failing to follow rules and policies | |

For issues and questions beyond the scope of Tier I, the Help Desk staff will refer providers to appropriate resources including DHCS, RECs and CMS.

| TABLE 25: TIER II ISSUE ROUTING | | |
|---|--|--|
| DHCS | | |
| <i>Questions related to; Policy, Payment, Audit and Appeals will be referred to DHCS</i> | | |
| DHCS Provider Outreach | www.medi-cal.ehr.ca.gov | medi-cal.ehr@dhcs.ca.gov |
| Regional Extension Centers (RECs) | | |
| <i>Questions related to: AUI/MU, Eligibility, Practice Support, Attestation, EHR vendors, Certified EHR Technology, How to maximize reimbursement and general questions pertaining to participation in the Medi-Cal EHR Incentive Program will be referred to the following RECs and other state affiliated entities.</i> | | |
| CalOptima | www.caloptima.org | |
| Karynsue Frank | | 714-246-8673 |
| CalHIPSO | www.calhipso.org | 888-589-4897 |
| Speranza Avram | speranza@calhipso.org | 510-285-5723 |
| Reena Samantaray | reena@calhipso.org | 510-285-5726 |
| HITEC-LA | www.hitecla.org | |
| Mary Franz | mfranz@lacare.org | 562-810-2335 |
| Mary Mitchell | mmitchell@lacare.org | 213-694-1250 |

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| | | |
|---|--|------------------------|
| California Rural Indian Health Board (CRIHB) | www.crihb.org | |
| Rosario Arreola | rosario.arreolapro@crihb.net | 916-929-9761 ext. 1300 |

| TABLE 26:TIER III ISSUE ROUTING |
|--|
| CMS or the NLR Support Help Desk |
| www.cms.gov |
| Initial access to the NLR |
| Navigating each of the NLR screens that include each task to complete the Provider Registration, Eligibility, Attestation, and Submission within the NLR |
| What to expect in terms of next steps after NLR enrollment (timelines, approval, payment) |

REPORTING

Help Desk statistical reporting will be performed on a monthly basis and include reports on the following areas of support:

- Priority level of calls: volume and category (high, medium, low)
- Notification, Assignment, and Resolution: volume and timeframes
- First Contact Resolution: volume and timeframes
- Call Hold Time: average and volume
- Abandonment Rate: volume
- Volume of incoming calls
- Volume of calls answered
- Number of calls answered in 30 seconds or less
- Number of calls answered over 30 seconds
- Average answer time
- Average hold time
- Number of calls transferred
- Category and type of calls

Help Desk staff will capture each call using the following categories and subjects:

Provider Identification

- Payer ID
- Entity ID (NPI)

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- Entity selection
- Last name
- EIN

Categories

- SLR Password/ID/Log in
- SLR Navigation/Enrollment/Registration
- SLR Policy
- SLR Payment

Type of Assistance

- Referred to CalHIPSO (Northern CA or Southern CA)
- Referred to HITEC-LA (for LA County)
- Referred to CalOptima (for Orange County)
- Referred to CRIHB (for CA)
- Referred to DHCS (for CA)
- Reset password/ID/Log in
- Assisted with navigation within the system

BUSINESS PROCESS: ADDRESSING PROVIDER QUESTIONS

The most Frequently Asked Questions (FAQs) by users of the enrollment application will be incorporated into the Help Desk scripting. The following are some of the initial questions which are expected with the attendant responses:

What can I do with the SLR web application?

The Help Desk will be prepared to discuss the following:

- Create your SLR User Account
- Login and Access to the SLR
- Applying for the incentive as an Eligible Professional (EP)
- Applying for the incentive as an Eligible Hospital (EH)
- Completing Group-Level Data Entry on behalf of Associated Providers
- Viewing Messages
- Viewing Reports
- Viewing Payment Status / Payment Calculations

What do I need in order to be able to use the SLR web application?

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The Help Desk will discuss the functional requirements and walk the provider through, such as:

- Computer with access to a web browser
- Software – Adobe Acrobat Reader – installed on your computer to view PDF files
- Pop-up blocker browser feature should be turned off in order to receive the pop-up window features
- Manuals and FAQs that are available for download

They will also note that the application is compatible with Microsoft Internet Explorer V7.0 and above.

Who does CMS consider an eligible professional?

The Help Desk will be prepared to discuss the Medi-Cal EHR Incentive Program, the SLR application documentation, and eligible professional (EP) as defined by the following:

- Physicians (primarily doctors of medicine and doctors of osteopathy)
- Nurse practitioner
- Certified nurse-midwife
- Dentist
- Optometrist
- Physician assistant who furnishes services in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) that is led by a physician assistant

To qualify for an incentive payment under the Medi-Cal EHR Incentive Program, an EP must meet one of the following criteria:

- Have a minimum 30% Medi-Cal patient volume
- Have a minimum 20% Medi-Cal patient volume, and is a pediatrician
- Practice predominantly in a FQHC or RHC and have a minimum 30% patient volume attributable to Medi-Cal and other needy individuals

What does CMS consider an Eligible Hospital?

The Help Desk will be prepared to discuss the following:

For the purposes of the Medi-Cal EHR Incentive Program and SLR applications documentation, an Eligible Hospital (EH) is defined as the following:

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- Acute care hospitals (including critical access hospitals and cancer hospitals) are eligible if all of the following requirements are met:
 - The CMS certification number’s last four digits are within the range 0001-0879 or 1300-1399
 - The average length of stay is 25 days or less
 - 10% or more of discharges are attributable to Medi-Cal patients

Note: Children’s hospitals are eligible regardless of the percentage of Medi-Cal discharges or the average length of stay.

How do I log into the SLR Web application?

The Help Desk will discuss the functional requirements and walk the provider through the process.

The SLR is a web-based application.



From here, you will reach the SLR web application login page. You’ll have three chances to enter in the correct login information before the system locks your account. If that happens, you can call the Help Desk for assistance. Throughout the SLR application, red asterisks (*) display on various fields. This symbol indicates that this field is required and must be completed in order to continue through the application.

ADDITIONAL AREAS OF SUPPORT

- The Help Desk anticipates a variety of questions from providers and hospitals, and is prepared to offer assistance for the following areas of concern:

| | |
|---|---|
| My User ID/Password does not work | How do I create an account? |
| What are the requirements for AIU? | How do I manage data for my Group? |
| How do I enter data for my Group? | What about Attestation for my Group? |
| How do I print, scan and upload? | How do I access my Messages? |
| What are these System Messages? | How to I access Reports? |
| What is the Payment Calculation for a Professional? | What is the Payment Calculation for a Hospital? |

ADDITIONAL SUPPORT IN USER GUIDES

In addition to the Help Desk support, users of the system are able to review and download a User Guide specific to a Professional, Hospital or Group. One of these guides can be found in **Appendix 15**.

The User Guides provide comprehensive information for each component of the application specific to Groups, Hospitals or Professionals. There are step-by-step directions and screen shots for ease of use. The User Guides delineate all aspects of the application including an overview of the application and its features, navigation of the system, accessing help, reviewing and sending messages, reports from the system, and methods for reporting issues with the system.

The User Guides are generally organized in a manner conducive to ease of navigation within the system:

- Creation of an account in the system begins with informational pages and the ability to select access to the system via log in. Users may review new documentation/information available prior accessing the system.
- Account creation and maintenance include all of the requisite functions such as access, password resets, user type identification, account changes, end user license agreement and application features.
- The User Guide conducts the participant through the demographic information requirements, practice information requirements and a discussion of system messaging pertaining to various aspects of the application.
- The registration description for the Incentive Program describes an intuitive online workflow process segmenting the documentation requirements by payment year of the program.
- “Tool Tips” are provided on screen and in the User Guides in order to address questions regarding specific fields for entry of eligibility criteria. Screen shots are employed as visual aids and key instruction techniques.
- The User Guide describes the attestation process and the requirements for certified EHR technology and provides the user with both narrative and graphical instructions for accessing the CMS/ONC site for CMS EHR Certification ID.
- Final attestation documentation and processing is described in detail along with descriptions of the type of documents required in addition to the file formats required and accepted for each.
- For users in need of additional one-on-one help, the User Guide offers options that will meet the need of all users. Numbers are listed for the Call

Center which is available during normal business hours. External website resources are identified such as the CMS Frequently Asked Questions and references to the Regional Extension Centers for assistance. An email address is also provided for users that prefer this method of communication.

The figure that follows is a list of the contents for one of the User Guides:

FIGURE 26: SLR USER GUIDE TABLE OF CONTENTS

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COMMON ERROR MESSAGES AND RESOLUTIONS

The following table examines the common error messages that a user may encounter along with the best method for resolving the issue.

TABLE 27: COMMON ERROR MESSAGES AND RESOLUTIONS

| What is the error message? | On what page(s) could this error appear? | How can you fix it? |
|--|--|--|
| Your login attempt was not successful. Please try again. | Login | Re-enter your Login ID and password. You have four total attempts to enter the correct information. |
| Your account is currently locked out. Please contact your site administrator or Help Desk at (866) 879-0109. | Login | Contact the site administrator or Help Desk at (866) 879-0109 to unlock your account. |
| Please select the agreement checkbox to continue. | EULA | Click the checkbox. |
| The User ID entered is not recognized in the system. Please try again. | Forgot Password | Re-enter your User ID. You have four total attempts to enter the correct information. |
| Your attempt to retrieve your User ID was not successful. Please contact the Help Desk at (866) 879-0109. | Forgot Password | Contact the site administrator or Help Desk at (866) 879-0109. |
| Your answer could not be verified. Please try again. | Forgot Password | Re-enter your answer to the Challenge Question. You have four total attempts to enter the correct information. |
| Your attempt to retrieve your password was not successful. Please contact the Help Desk at (866) 879-0109. | Forgot Password | Contact the site administrator or Help Desk at (866) 879-0109. |
| Password must have a minimum of 8 characters and a maximum of 20. Your password must include at least one upper case and one lower case letter, one number, one special character (the “at” symbol “@”; pound “#”; exclamation “!”). Do not use an old login name or password. | <ul style="list-style-type: none"> • Reset Password • Create Login • My Account • Create Account | Re-enter your password. You have four total attempts to enter the correct information. |

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| What is the error message? | On what page(s) could this error appear? | How can you fix it? |
|--|---|--|
| The Confirm New Password must match the New Password entry. | <ul style="list-style-type: none"> • Reset Password • Create Login • My Account • Create Account | Re-enter the new password. |
| NPI is 10 digits. | <ul style="list-style-type: none"> • Forgot User ID • Create Account • Manage Providers in Your Group | Re-enter your 10 digit NPI. |
| CCN is 6 digits. | <ul style="list-style-type: none"> • Forgot User ID • Create Account | Re-enter your 6 digit CCN. |
| TIN is 9 digits. | <ul style="list-style-type: none"> • Forgot User ID • Create Account • Manage Providers in Your Group | Re-enter your 9 digit TIN. |
| IDs entered are not in our system. If you need assistance, please contact the Help Desk at (866) 879-0109. | Forgot User ID | Re-enter any numbers that are incorrect. |
| The TIN and ID entered does not match a provider on file. Please contact the Help Desk at (866) 879-0109 for assistance. | Create Account | Contact the Help Desk at (866) 879-0109. |
| The characters you entered didn't match the image verification. Please try again. | Create Account | Re-enter the CAPTCHA image. |
| The User ID must be between 8 – 10 characters. No spaces or special characters are allowed. Please try again. | Create Login Create Account | Enter a User ID that is between 8 to 10 characters without spaces or special characters. |
| User ID is not available. Please try again. | <ul style="list-style-type: none"> • Create Login • Create Account | Enter a new User ID. |
| Please enter a valid Email address. | <ul style="list-style-type: none"> • Create Login • My Account • Create Account • About You for EP and EH • About Your Group | Re-enter your email address. |

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| What is the error message? | On what page(s) could this error appear? | How can you fix it? |
|--|--|---|
| Medicaid number is 9 digits. | About You for EP and EH | Re-enter your 9 digit Medicaid number. |
| License number is 9 digits. | About You for EP and EH | Re-enter your 9 digit license number. |
| To proceed, please select the checkbox to agree with the statement. Providers that do not meet these minimum criteria are not eligible to participate in the program. | About You for EP and EH | Click the checkbox. |
| Representative Period must be in the previous calendar year. | Confirm Medicaid Eligibility for EP, EH, and Group | Re-enter dates in the previous calendar year. |
| Your Total Encounters does not match the sum of your Total State Encounters. | Confirm Medicaid Eligibility for EP and Group | Re-enter your total encounters amount to equal the sum of the total state encounters. |
| Your Total Medicaid Encounters does not match the sum of your Total State Encounters. | Confirm Medicaid Eligibility for EP and Group | Re-enter your total Medicaid encounters amount to equal the sum of the total State encounters. |
| You have entered the same state twice. Please remove the state or change it to a unique state for indicating patient volumes. Duplicate states are not allowed. | Confirm Medicaid Eligibility for EP, EH, and Group | Review the states you have entered and remove duplicates or change the entry to a unique state. |
| Numerical data must be entered in the Total Discharges for Representative Period and Medicaid Discharges for Representative Period fields for the calculation to be run. | Confirm Medicaid Eligibility for EH | Re-enter the appropriate data in the required fields. |
| Please attach your supporting document. | Attestation of EHR – Criteria for EP Attestation of EHR – Expenses for EP Review, Sign, and Attach Attestation for EP and EH | Attach a document. |

| What is the error message? | On what page(s) could this error appear? | How can you fix it? |
|--|--|--|
| Duplicate expense types cannot be saved. Please select another expense type. | Attestation of EHR – Expenses for EP and Group | Review the expense types you have entered and remove duplicates or change the entry to a unique expense type. |
| Please select a funding source to remove. | Attestation of EHR – Other Funding for EP and Group | Click a checkbox for a funding source. |
| Your CMS EHR Certification ID is not found. | Attestation of EHR – Certified EHR Technology for EP, EH, and Group | Re-enter the certification ID of your EHR. |
| Attestation of EHR – Criteria for EH | A brief description of how you meet the selected Criteria is required to continue. | Enter a brief description of how you meet the selected criteria. |
| The provider you have selected is not currently eligible to be associated with your Group. The provider selected has been flagged with an “Opt Out” status from another Group’s request. If you believe this is in error, please contact the Help Desk at (866) 879-0109 for assistance. | Manage Providers in Your Group | Re-select another provider (if the original provider selected was incorrect) or call the Help Desk at (866) 879-0109 for assistance. |
| This provider must create a user account before you can send this notification to submit their attestation agreement. | Enter Data on Behalf of Provider Page | Try again once the provider has created his/her user account. |

3.9 ASSUMPTIONS

In providing a strategic and tactical plan for successfully implementing the Medi-Cal EHR Incentive Program, DHCS identifies the following assumptions and dependencies related to the program:

- Role of CMS:** The role of CMS is critical to the success of the state’s plan and requires the ongoing and close interaction of CMS with ONC and the state. The state is relying on CMS to develop global provider outreach materials which the state may employ in its campaign. The state will also refer providers and hospitals to CMS for help desk support related to NLR questions and issues. DHCS encourages CMS to work closely with ONC in furthering the availability of certified EHR technology as one of the

significant perceptions and barriers to adoption has been identified as cost.

- **Role of HIT Coordinator (CHHS):** CHHS is the recipient of the HIE Cooperative Agreement in California and the Deputy Secretary for HIT serves as the HIT Coordinator under the grant agreement. The HIT Coordinator plays a critical role in California as the coordination point for all of the HITECH activities occurring within the state. DHCS is partnering with the HIT Coordinator on many activities to identify opportunities to maximize funding streams and impact across the different HITECH programs. While DHCS has responsibility for the Medi-Cal EHR Incentive Program to reach providers and hospitals that are eligible for Medi-Cal incentive funding, the HIT Coordinator has the responsibility to ensure all of the HITECH programs are coordinating to maximize the effect of each. CHHS has designated the non-profit, Cal eConnect as the state designated entity and thus provides significant grant dollars to Cal eConnect to establish core HIE capacity within the state.
- **Collaboration with RECs:** DHCS will continue to work collaboratively with the three RECs in California, as well as the Indian Health Service REC serving California, to ensure adequate coverage of all providers in the state; and in particular those providers in rural and remote locations. DHCS understands the RECs and their associated Local Extension Centers are in the field and at provider locations, offering significant access for campaign, outreach, education, training and technical assistance. The RECs provide significant value to small groups and solo providers in the areas of group purchasing, vendor selection, and workflow redesign and implementation management. These are efforts which directly and positively affect DHCS' efforts to promote EHR adoption and meaningful use.
- **Collaboration with SDE:** OHIT will continue its collaboration with the state-designated entity, Cal eConnect, to facilitate the creation of a statewide technical infrastructure that supports HIE. Cal eConnect is employing a market-based strategy, dividing the state into three general targets of concern including rural communities, urban communities and unaffiliated providers such as solo and small group practices. Across each of these, Cal eConnect staff is identifying the market features, requirements, opportunities and partners that will be leveraged for implementation. Urban and rural markets without HIE or with limited HIE will benefit from Cal eConnect planning and operations. Cal eConnect is facilitating larger HIE operations in their expansion efforts into outlying areas, and promoting the piloting of more sophisticated technologies and services. This is being accomplished through a market strategy framework to further refine the setting, features, requirements and opportunities available in each of the three target areas. In addition to facilitating a

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“network-of-networks” approach maximizing HIE opportunities for these three markets, providers may be supported in achieving meaningful use through additional value-added business services provided by Cal eConnect: These services would be developed and offered on an as-needed basis over time. The services being considered may include:

- Translation services that facilitate translating structured lab results into standard format(s)
- A clearinghouse as a single delivery point for lab systems that facilitates routing of lab results to appropriate provider systems and/or public health departments
- A clearinghouse as a single access point for EHRs and practice management systems for insurance eligibility information via EDI transactions across various health plans
- A secure messaging system to enable patients and providers to communicate electronically
- Translation services that facilitate translating and transforming among standardized summary clinical formats
- A clearinghouse as a single delivery point for EHRs for routing clinical summary documents among providers and patient-designated entities
- A clearinghouse as a delivery point that can accept immunization messages from EHRs and forward them to the intended immunization registry
- A utility service to manage pseudonym-ization and re-identification when required for public health reporting and surveillance

OHIT and Cal eConnect understand that the ability for providers to meet meaningful use of EHRs that exchange of data is critical to success. The services described above are intended to both facilitate exchange and provide an ongoing resource for continued HIE expansion efforts by Cal eConnect. Additionally, efforts are underway to integrate HIE across the various state departments including Medi-Cal, Public Health (Immunization Registry, Public Health Lab Reporting, clinical preventive services), Social Services (which is in the process of procuring a new Statewide Automated Child Welfare Information System), and Mental Health (working with County Mental Health Agencies to implement electronic medical records for mental health services), among others public health implementations. OHIT and Cal eConnect are facilitating and supporting these efforts and continue to become involved where necessary. For example, OHIT and Cal eConnect will need to coordinate directly with Public Health and CAIR to strategize around cross-registry data exchange as well as on the CalREDIE efforts.

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- **Provider Technical Assistance:** The state is examining the development of a Request for Proposals to provide technical assistance and field support for providers, and expects significant responses from RECs and provider organizations among others.
- **NLR Readiness:** Launching of the incentive program for California is dependent on NLR readiness. The ability to accept attestation is dependent on the ONC web service availability as specified in the State Medicaid Directors Letter.
- **SMHP and I-APD Approvals:** CMS reviews and approves the SMHP and I-APD in a timely manner
- **Status/Availability of Certified EHR Technology:** Certified EHR applications continue to be approved and updated on the ONC web service in order to facilitate a market approach for providers examining functionality and cost
- **State-Specific Readiness Factors:** The state offers the following assumptions and dependencies specific to state operations:
 - SLR is on schedule for implementation in April 2011
 - SLR payment functionality is on schedule for implementation in May 2011
 - NLR interface testing for payments is on schedule

4 CALIFORNIA'S AUDIT STRATEGIES

4.1 INTRODUCTION

The mission of Audits and Investigations (A&I) is to ensure the financial and programmatic integrity of the health care programs administered by DHCS. The overall goal of A&I is to improve the efficiency, economy, and the effectiveness of DHCS and the programs it administers. As part of its mission A&I promotes sound management of public funds, performs specific audits of DHCS operations and medical and financial audits of Medi-Cal and public health providers, conducts investigations of suspected violations of Medi-Cal laws and regulations, aggressively identifies public funds spent inefficiently or illegally for recovery, and has the lead responsibility for DHCS' Medi-Cal anti-fraud program.

The Deputy Director of A&I reports to the Chief Deputy Director and has direct access to the Director of DHCS which enables A&I to operate independently with no organizational impairments in order to fulfill its oversight and fiduciary responsibilities with regard to DHCS programs and operations. A&I is comprised of four audit functions: the Medical Review Branch, Financial Audits Branch, Investigations Branch (IB), and the Internal Audits Office. The primary two branches with EHR program responsibilities are the Medical Review Branch (MRB) and the Financial Audits Branch (FAB). MRB audits the non-institutional providers (e.g. laboratories, pharmacists, durable medical equipment providers, and various individual providers and practitioners). FAB audits the institutional providers (e.g. acute care hospitals, nursing home facilities, federally qualified health care centers, and rural health clinics). A&I conducts its audit work in accordance with Generally Accepted Governmental Auditing Standards (GAGAS). A&I has full access and authority to DHCS program operational data, Medi-Cal claims data, provider master file data base, and other relevant data and information needed to carry out its oversight activities of Medi-Cal providers. A&I oversight and audit activities provide assurance that payments made to Medi-Cal providers are valid, reasonable, and in accordance with federal and state laws, regulations, and program intent.

EP and EH audit responsibilities will be divided between MRB and FAB for structural and efficiency reasons. The EP and EH audit population is naturally divided between the two branches; EPs are reviewed by MRB and EHs by FAB. By assigning EHR EP/EH oversight to the branches by specialty, the audits can be incorporated into existing production and will be conducted by the auditors who are familiar with the history, operations, and program documentation of the practitioners. Because of these divided responsibilities, the activities of MRB will be presented in Section 4.2, and the activities of FAB will be presented in Section 4.3. However, the processes of both branches are similar.

Although the IB will not be primarily involved in EP and EH oversight, MRB and FAB will refer providers who are involved in EHR activities that misuse, abuse, or are fraudulent

activities. MRB and FAB will consult with IB when a multi-disciplined effort is needed to conduct unannounced reviews of high risk providers where fraudulent activity has been detected. IB monitors the Medi-Cal Fraud Hotline, and facilitates referrals to the California State Department of Justice (DOJ) Bureau of Medi-Cal Fraud and Elder Abuse (BFMEA). In addition, IB is involved with various federal and state Program Integrity and Fraud Task Force activities to coordinate A&I's investigative and oversight activities with the Office of Inspector General, U.S. Attorney's Office, and other law enforcement agencies.

4.2 MEDICAL REVIEW BRANCH: AUDITS OF EPS

4.2.1 MRB EP AUDIT LANDSCAPE AND PROCESS

MRB has seven field office sections located throughout the state. MRBs field audit sections are responsible for conducting audits and reviews of non-institutional providers within their regional territory. MRBs primary audit and review activities are focused on antifraud intuitive related to provider fraud which is a dynamic process which requires constant oversight and attention. MRB is composed of multi discipline staff (e.g. health program auditors, research analysts and medical staff). In addition to the on-site reviews of providers that are performed by the medical and audit staff, research and data mining has become an important component of the antifraud strategies by the branch.

DHCS expects to have a large universe of eligible professionals participating in the Medi-Cal EHR Incentive Program, MRB will have a five-tier audit approach to EHR Program audits. In each of the tier levels, desk or field audits will be utilized dependent on assessed audit risk. The five tiers are as follows:

- Pre-Payment Audits (Pre-payment) - requested/referred to MRB by OHIT
- Conjunction Audits (Post-payment) - An audit done in conjunction with regular Medi-Cal Field Audit Reviews for EPs who have received EHR program funds
- Focused Audits (Post-payment) - Development of audit cases for problem fraud areas discovered in prior audit cases or searching for emerging trends of fraud and abuse
- Random Audits (Post-payment) - A randomly selected approach between 1 to 10% per year of enrolled EP's dependent on available universe
- Audit for Recovery (AFR) Audits (Post-payment) - Audits to determine the financial extent of recoupment of EHR Program Funds that were inappropriately received by EPs

To leverage existing department resources risk profiles will be developed from a combination of existing analytical tools and experience developed in first year audits. Two primary data tools which MRB expects to utilize extensively (see **Table 29**) are the Gatekeeper list and Case Tracking System. By using historical data on known practitioners the department can pre-screen applications referred by OHIT based on past activity.

To supplement the historical profiles when developing risk profiles MRB will have access the SLR to review how the practitioners registered. The SLR tracks the hard and soft stops during the attestation process, all of which do not carry the same risk. An inverted number in a license number would not carry the same risk as multiple failed patient volume submissions. Comparing the severity of the registration stops with historical data will allow MRB to develop risk profile. As the process is refined after the first year risk profiles can be assigned to audit category.

4.2.2 PRE-PAYMENT AUDITS

ACS will has installed flags in the SLR that are known as “soft stops” and “hard stops” in pre-determined areas that will alert ACS program administrators and OHIT of potential problems (see **Table 23**). The hard stops will stop the registration process. The soft stops will allow the provider to continue their enrollment process and flag their file for further review.

The EP applications with a soft stop will be referred to OHIT. If OHIT determines that an investigation type audit is warranted, OHIT will alert MRB EHR Program Administrators. OHIT’s referral will contain a completed form template that will indicate the concerns about the application and any relevant information. These referrals may include EPs who have been reviewed in OHIT’s random sampling universe (see the random sampling section).

Once the MRB receives a pre-payment audit request, EHR Program Administrators will research the applicable databases available to MRB for case resolution or further development of the audit case.

4.2.3 CONJUNCTION AUDITS (POST-PAYMENT)

The MRB is continuously developing and performing Field Audit Reviews (FARs) of Medi-Cal providers to verify their compliance with the Medi-Cal program or to seek out suspected fraud and abuse by Medi-Cal providers. In the development phase of the FAR audits, staff will review the provider to determine if they have received Medi-Cal EHR Incentive Program funds and if they have been previously reviewed for EHR Program compliance. If the provider has received EHR Program funds and either 1) has not been previously reviewed or 2) there were previous adverse/suspect findings, an

EHR audit will be performed in conjunction with the FAR. This will minimize the provider's impact as well as increase MRB's oversight of EPs.

4.2.4 FOCUSED AUDITS (POST-PAYMENT)

MRB constantly seeks to be kept informed on emerging trends regarding fraud and abuse in the Medi-Cal program. The branch is constantly testing potential trends of fraud and abuse by developing audit cases on provider's where the identified trend is suspected.

Once MRB's auditing program is underway, audit findings will be collected by EHR Program Administrators who will assess adverse findings to determine if common threads of suspected fraudulent and abusive practices are emerging. Data will be analyzed and EHR trained auditors will be alerted to these suspected practices. Audit cases will be developed on discovered problem areas.

4.2.5 RANDOM AUDITS (PRE & POST-PAYMENT)

During the enrollment phase, the SLR will employ a random soft stop process where 10% of EP applications will be randomly selected for further review of their qualifying encounter and panel percentages. OHIT will conduct a comparison review of the EP's reported encounter and panel numbers to Medi-Cal claims and other data. If, during this review any of these applications fall outside of OHIT's pre-determined variance threshold, those EPs will be referred to MRB for a further, more in-depth review of the numerator and denominator before payment will be issued. In the latter half of 2011, DHCS plans to implement an automatic review of all applications in the SLR which will also result in referrals to MRB for applications falling outside of the variance.

Depending on the universe of EPs that participate in California's EHR program and the utilization of the above type audits, MRB also will randomly select between 5 to 20% of the EPs who have received EHR program funds and have not been previously reviewed by MRB for post-payment review.

4.2.6 AUDIT FOR RECOVERY (AFR) AUDITS

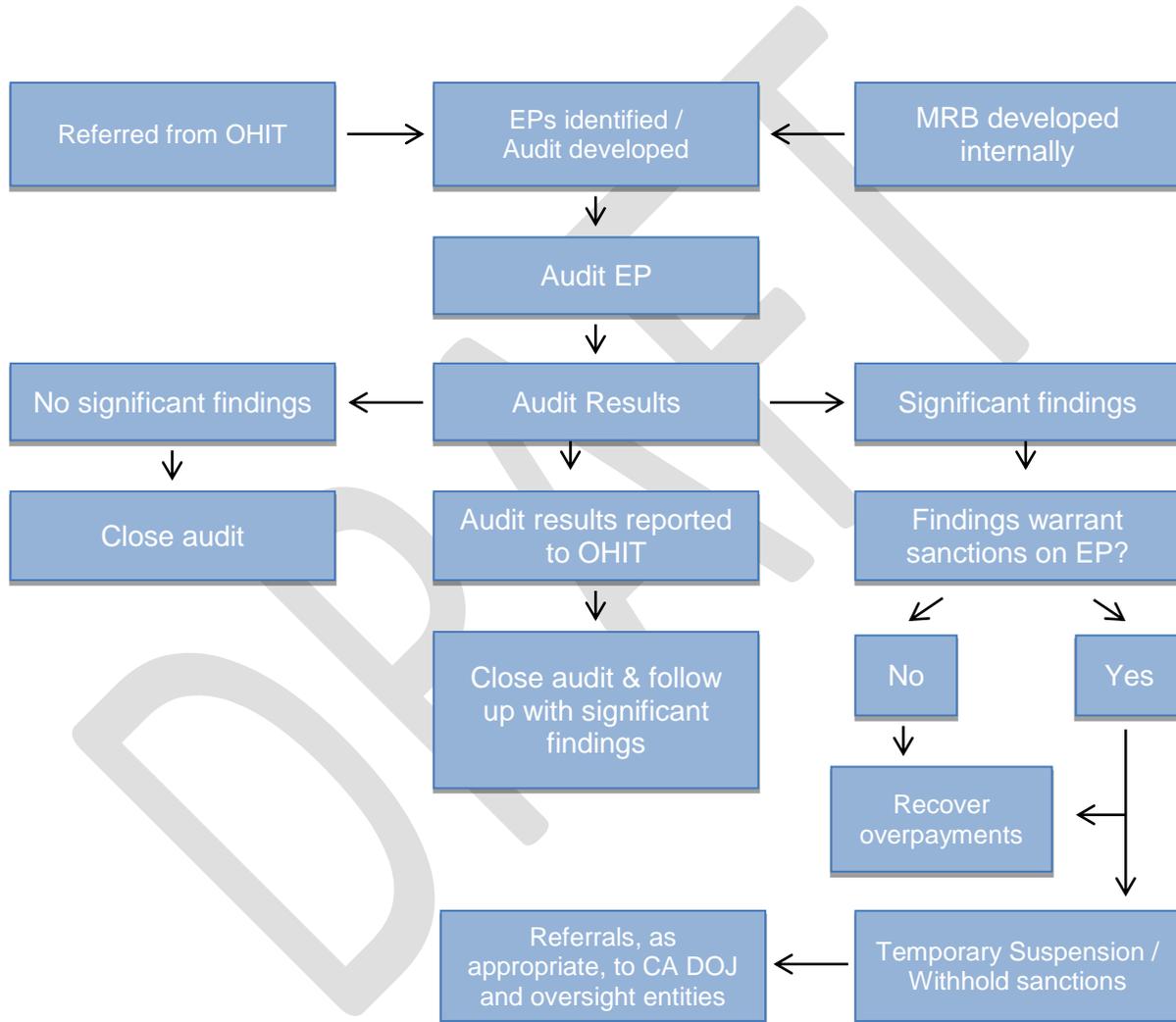
When overpayment of EHR Program Funds to EPs is suspected and/or confirmed, the MRB will conduct an AFR audit to determine the extent of overpayment the EP has received. Once the overpayment amount is determined, MRB will initiate actions for DHCS to recover overpaid EHR program funds. MRB is experienced in performing these types of audits.

The MRB has staff capable of performing the EHR audits list above, is experienced in the five tiers of audits, and has offices throughout the state. Therefore, A&I does not anticipate using contractors for EHR auditing functions for EPs.

4.2.7 MRB AUDIT PROCESS

The MRB EP Audit Process diagram summarizes the MRB planned audit process. The process to be instituted for EHR is nearly identical to MRB’s audit process of our Medi-Cal program with the exception of OHIT. All audit results, regardless of type of audit, will be reported to OHIT.

FIGURE 27: MRB EP AUDIT PROCESS DIAGRAM



4.2.8 FRAUD AND ABUSE

When A&I receives reliable evidence of fraud and abuse perpetrated by the provider for the Medi-Cal EHR Incentive Program, DHCS will withhold or deny EHR Incentive Program funds to the provider. For funds the provider previously received through participation in the EHR Program in the state of California, MRB will determine the

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overpayment received by the EP when the EP was non-compliant with the EHR Incentive Program and when there is reliable evidence of fraud and abuse. All findings will be reported to OHIT.

In these instances, MRB will conduct a more in depth audit program review of the Medi-Cal provider and may institute temporary suspension and withhold of all Medi-Cal (and EHR) program funds. When MRB has obtained sufficient documentation and evidence of fraudulent activities, the EP will be referred to the State Department of Justice (DOJ) Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA).

4.2.9 MRB AUDITING TOOLS

MRB's audit program includes audit processes and tools developed to audit EPs. The tools developed list all the criteria associated with EP, AIU, and MU Objectives. Each of the tools lists the applicable regulation(s) for each requirement so auditors may quickly review the federal regulation to verify compliance. The design and application of the EHR audit program tools developed emulate program audit tools already in use by MRB. Additionally, enrollment tools and guides developed by CMS and ACS have been downloaded for audit staff to use as necessary, especially when the same tools have been utilized by the enrolling EP. The MRB Audit Tool Table lists primary EHR criteria addressed on the developed audit program and audit tools.

TABLE 28: MRB AUDIT TOOL CRITERIA

| Eligible Professional (EP) | AIU | MU Objectives* |
|---|--|---|
| EP Type | Adoption of Certified EHR Technology | Reporting periods as applicable to payment years |
| Provider type | Computer equipment | At least 50% of encounters took place with EHR technology |
| Board licensure | | Core Set Objectives |
| Medicaid program status | Reassigned payments | Menu Set Objectives |
| Federal suspended and ineligibility list | Utilization of EHR technology | Clinical Quality Measures (6) |
| NPI | Meaningful use | 3 core or alternate core |
| Tax identification number | Upgrade of certified EHR technology | 3 of 38 from additional menu set |
| Pediatrician verification | Entity approved to receive EHR incentive funds | |
| EP Medicaid percentage | Computer equip as applicable | |
| Reporting periods as applicable to Payment Year | Entity's retention of no more than 5% of EHR | |
| 30% / 20% Pediatrician | | |

| Eligible Professional (EP) | AIU | MU Objectives* |
|--|-----|----------------|
| Practices predominantly in clinics 50% | | |
| Non-hospital based 90% | | |

* DHCS recognizes that MU is not available in 2011, or required for the 1st payment year and therefore, auditing will not occur for MU in 2011.

4.2.10 AUDITING TECHNIQUES AND STRATEGIES

MRB's audit program includes the verification of ownership and controlling interest as a standard audit procedure which is an EHR oversight requirement. The intent of this procedure is to ensure any individual receiving payment, or entity with an ownership or controlling interest in the provider, does not appear on the Office of the Inspector General's exclusion list.

MRB audit staff has knowledge of reviewing business documents, agreements, contracts, and like documents in the normal course of auditing Medi-Cal providers. These same techniques and expertise will be utilized to verify EPs' and Adoption Entities' acquisition of certified EHR technology. Since the audit staff has previous experience requesting and reviewing a vast variety of business documents, the impact on EPs should be minimized.

Audit staff will use the CMS approved calculation methods for EPs as stated in 42 CFR 495.306. Audit staff will validate EP SLR attestations to their Medi-Cal percentage by utilizing Medi-Cal claim data, provider data, and other applicable and reliable audit sources for patient encounters and patient panels. Audit staff will be able to run Medi-Cal claim reports for the reporting periods specified by the EPs and compare to the EP's Medicaid/Medi-Cal encounter data. EHR Program Administrators will be able to access Medi-Cal Managed Care data to retrieve managed care data as it relates to encounters and patient panels to verify the EP's attestations.

MRB DATA RESOURCES

The resources listed in the MRB Data Resources Table are the primary resources that will be utilized on a consistent basis. In addition to the SLR/NLR, the Provider Enrollment Tracking System (PETS) system, Surveillance and Utilization Review Subsystems (SURS), Provider Master File, Gatekeeper List, and our Case Tracking System will be the key data resources for MRB in maintaining the fiscal integrity of the EHR Program for EPs. MRB will utilize additional resources when available and appropriate to each audit. These resources will lessen EP's audit burden and make MRB's audit processes more efficient.

TABLE 29: MRB DATA RESOURCES

| Data Resource | Resource Function | Resource Benefit |
|---|--|---|
| SLR (State Level Registry) | Provider Registration | Review provider statements and submissions and compare to other data sources and audit findings |
| SURS (Surveillance and Utilization Review Subsystems) | Extensive report system of claim data for all Medi-Cal providers and beneficiaries | Claim detail reports will be run on EPs to help verify the professional's Medicaid/Medi-Cal eligibility percentages and participation |
| PETS (Provider Enrollment Tracking System) | Reviewing provider CA Medi-Cal enrollment applications | Compare SLR registration information for EPs to their PETS file to verify accuracy of information provided on the SLR. |
| Provider Master File (EDSNET) | Master file on all Medi-Cal providers from information submitted by the provider to the Provider Enrollment Division | Will be used to compare locations, businesses, practices, owners, tax identification numbers, NPI numbers, provider names, payment and location addresses, review Medi-Cal status, Medi-Cal payment histories, etc. |
| CA Dept of Consumer Affairs | Licensure of medical professionals | Verify licensure status and professional licensure sanctions |
| American Board of Medical Specialties website | Tracking of physician certification of 24 medical specialties | To assist in the verification of an eligible professional's pediatrician designation |
| Gatekeeper List | Data list of providers, businesses, locations, individuals, etc. in which previous significant adverse audit findings were found | Compare SLR data to Gatekeeper list to verify providers, locations, assigned payees, etc. to see if provider may be listed on the Gatekeeper in which MRB will exercise increased audit awareness |
| Case Tracking System | Tracks audit cases and their results, amounts, sanctions, findings, etc. | Review the Case Tracking System for previous audit findings on providers |
| Management Information System/Decision Support System (MIS/DSS) | Database of eligibility, provider, and claims information for Medi-Cal | Review provider statements and submissions and compare to other data sources and audit findings |

SLR (STATE LEVEL REGISTRY)

MRB will have access to the SLR maintained by ACS. MRB EHR audit staff will be able to run reports, view EP profiles and uploaded documents in order to access audit risk, level of review needed, and develop audit cases. Additionally, EHR audit staff will be

given SLR data, as needed, in order to analyze their assigned audits of the EP and efficiently plan and conduct their audits. This will minimize provider impact.

SURS (SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEMS)

The SURS system is a mainframe-based reporting system that captures all elements of submitted claims by Medi-Cal providers whether paid or not paid. The SURS system will be used extensively by EHR Program Administrators and auditors when verifying EHR Medi-Cal requirements, such as the 30%/20% EP eligibility, 30% Needy Individuals patient volume when practicing more than 50% of encounters over six months in the prior calendar year at FQHC/RHC's, and the 90% hospital-based measures. EHR Program Administrators will be running frequency distribution reports as well as claim detail reports during the case development scoping process.

PETS (PROVIDER ENROLLMENT TRACKING SYSTEM)

The PETS system will be utilized frequently by MRB to compare data attested by the provider in the SLR and NLR systems to application data the provider attested to in order to participate in California's Medicaid/Medi-Cal program. The PETS system is used extensively for ownership and control disclosures, practice locations, provider's affiliations with sub-contractors, medical specialties, etc. Review of the PETS system will be a standard audit case development tool used for both pre-payment audits and post-payment audits. When discrepancies are found between the provider's attestations in the SLR/NLR and their CA Medi-Cal enrollment data, the audit risk will increase which will increase audit steps.

PMF (PROVIDER MASTER FILE)

Once the Provider Enrollment Division (PED) accepts a provider's application, the information on the application is put into the Provider's Master File which tracks all providers and the payments received by each provider for the Medi-Cal program. The PMF is maintained by PED. The PMF is easily accessible by all audit staff in MRB. PMF lists addresses, including pay-to addresses, tax identification numbers, social security numbers, active statuses, declared profession type, payment history, etc.

GATEKEEPER LIST

The Gatekeeper list was developed by MRB to track individuals and sites (addresses, regional areas, etc.) where significant Medi-Cal fraud, waste, or abuse has occurred. The Gatekeeper list will be checked to determine if any of the EPs, locations, entities, owners, affiliated individuals, etc. are listed.

CASE TRACKING SYSTEM

A&I utilizes a case tracking system in which all audit cases of all providers are tracked. The tracking system assigns a specific case number for each audit and records the entire history of the case from beginning to end. Once a case is closed, the tracking system will return all data. Each audit file in the tracking system contains many elements that include, but are not limited to, audit periods, monetary amount subject to review,

monetary overpayments, and dates of all actions relating to the audit, case notes, and the auditors/staff and MRB office(s) assigned to the review/audit. MRB EHR Program Administrators and auditors have access to the tracking system and are able to search the system by provider number and retrieve any prior audit information and results that are available for a particular provider. Audit and overpayment information for each EHR will be included and available in MRB's case tracking program.

MIS/DSS

The MIS/DSS is a subsystem of the California Medicaid Management Information System (CA-MMIS) and serves as the California Department of Health Care Services (DHCS) Medi-Cal Data Warehouse. As a current and comprehensive database of eligibility, provider, and claims information for the Medi-Cal Program, the MIS/DSS is the largest Medicaid data warehouse in the nation. It is Teradata-based, a leading-edge, hardware and software technology platform that enables the MIS/DSS to store great volumes of data and allow large numbers of users to simultaneously access the data without any deterioration in system performance. As an integrated repository of data that offers the capability for robust queries and analyses, MIS/DSS will be used in a fashion similar to SURS.

4.2.11 MRB OVERPAYMENT TRACKING

The MRB utilizes a case tracking system in which audit elements of all audits are inputted into a branch wide database. These elements include audit periods and audit amounts along with other elements. Each audit case has a unique tracking number. MRB's senior auditor(s) are responsible for tracking overpayments identified by MRB. The overpayment amounts and data are maintained in MRB's database.

MRB has a separate unit that is responsible for preparing action notices to collect funds from the providers. The notices are routed to the DHCS Fiscal Intermediary (FI) and the DHCS Third Party Liability and Recovery Division (TPL). TPL established the accounts receivable and initiate actions to instruct the FI to collect/offset the amounts from the provider's claims. If the provider is suspended, TPL will initiate action to implement collection procedures against the provider. MRB will inform OHIT of the EHR audit results including the monetary amounts overpaid to an EP.

4.2.12 MRB CONTINUING DEVELOPMENT

MRB will monitor the implementation of the EHR audit program along with both the new and previously established audit processes and tools to measure their effectiveness and make modifications and refinements as needed. Audit programs and processes will be expanded and modified when requirements are added or revised, such as the meaningful use objectives once DHCS receives additional guidance from CMS.

4.3 FINANCIAL AUDITS BRANCH – AUDITS OF EHS AND CLINIC PROVIDERS

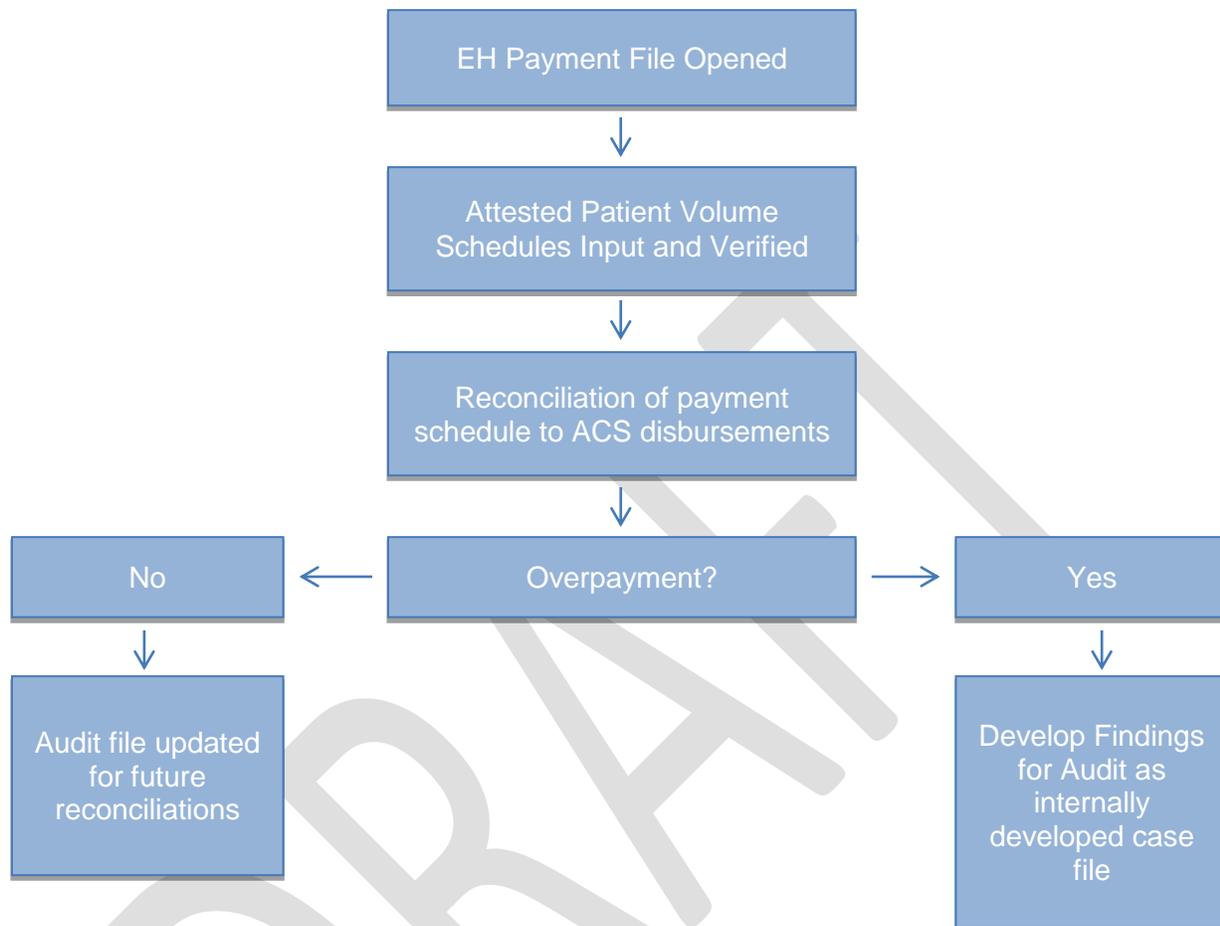
4.3.1 EH AUDIT LANDSCAPE AND PROCESS

FAB has eight field audit sections located throughout the state. Each field audit section is responsible for conducting audits and reviews of institutional providers within their regional territory. FAB performs desk or field audits of Medi-Cal institutional providers which include; acute inpatient hospitals, children's hospitals, critical access and rural hospitals, designated public hospitals), long term care facilities, FQHCs and RHCs. To minimize the burden on the provider community and for efficiency FAB plans to integrate reviews of EH's attestation verification in conjunction with desk or field audits whenever possible as a standard audit procedure. In certain cases, based on referrals from OHIT staff, FAB may be required to initiate a separate review due to the urgency of the issues.

At this time, FAB cannot forecast EHR participation level by EHs for year one. If the volume is greater than FAB's resources can cover then analytical tools and risk assessment will be utilized to prioritize the EHs to be reviewed/audited. FAB has audited the majority of the EH community and has historical claims and audited data to determine which EHs pose a higher risk and/or have the potential for problem areas. FAB has access to the SLR and will receive reports and can make queries to review EH submissions. This information and referrals from OHIT will provide FAB with the necessary background information to determine its audit population.

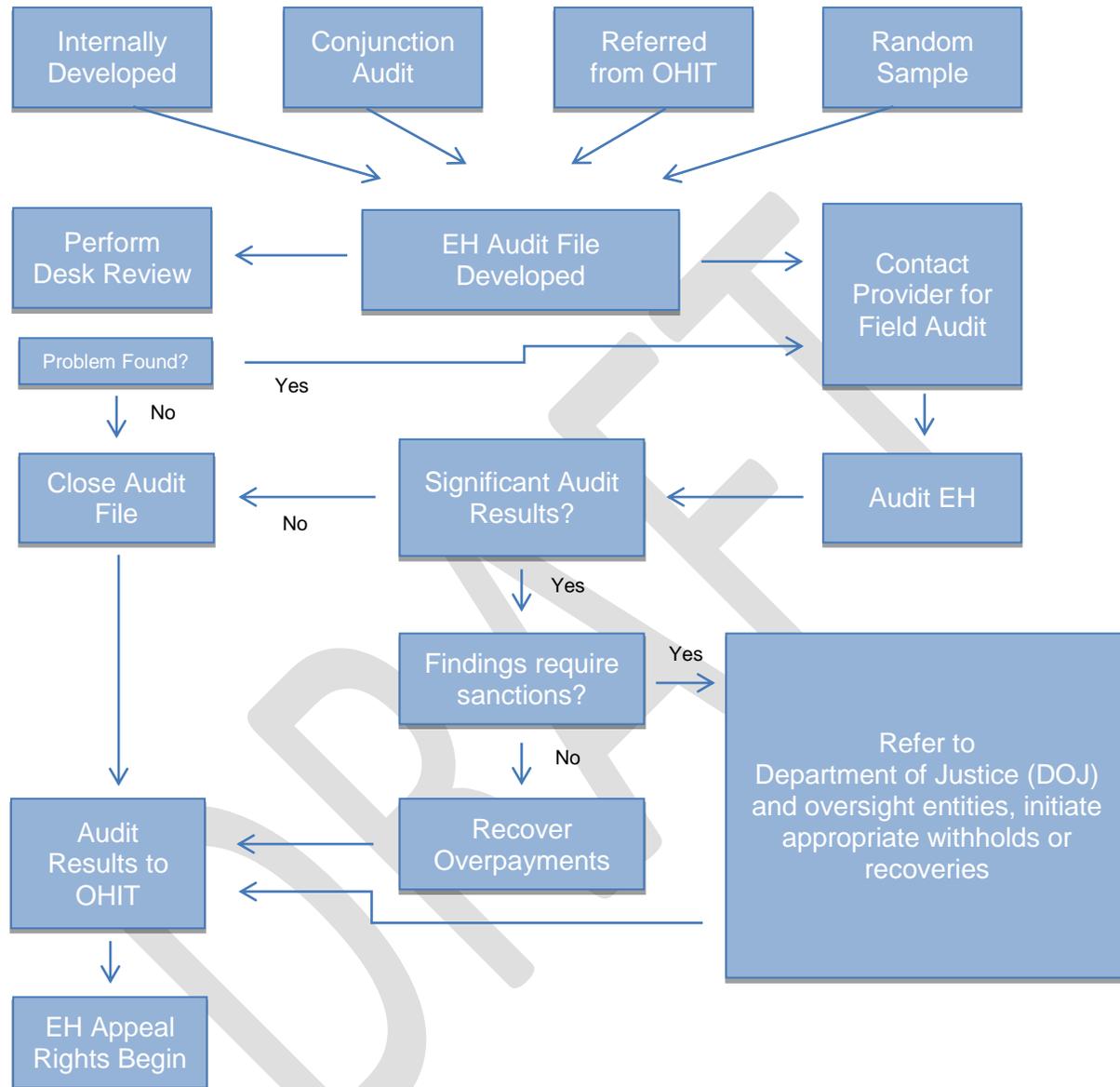
If the volume of EH providers is greater than the amount FAB can review through its regular audit coverage of EHs, it will employ a sampling method targeting certain providers based on historical and audited data and some randomly selected EHs. The risk profile development for EH will be similar to the EP's but leverage a different set data sources (see **Table 30**) and emphasize the findings in past financial reviews. FAB has a long history with many EH's, so when there is no or minimal historic contact the risk may be considered higher. The SLR submissions will be fully accessible by FAB and the primary source to define the audit universe. Analyzing payment size and patient volume will be the primary risk factors areas in addition to submission patterns. The scoping sheets will be developed from the submitted attestation data to determine abnormal data sets. FAB will conduct desk reviews of EHs for those with lesser audit risk, smaller EH incentive payments, or in cases where FAB is not scheduled to conduct a Medi-Cal field audit within a year. FAB's EH payment file reconciliation process is depicted in the following flow figure.

FIGURE 28: FAB’S EH FILE RECONCILIATION PROCESS



FAB will design audit programs and procedures to ensure that the EH has met the financial and programmatic requirements of the EHR Program. FAB will also develop training curriculum and conduct training sessions to ensure that the eight field audit section staff are properly trained to perform EH desk reviews and audits. FAB’s audit objectives include, but are not limited to: verifying the eligibility/patient volume based on CMS approved calculation methods for EHs (42 CFR 495.306) comparing it to Medi-Cal claims data, cost report patient days and/or audited patient days; confirming SLR attestations; reviewing documentation submitted by EHs; validating that proper incentive payments were made. FAB’s EH audit development process is depicted in the following flow figure:

FIGURE 29: FAB'S EH AUDIT DEVELOPMENT PROCESS



4.3.2 PRE-PAYMENT REVIEWS/AUDITS

ACS is responsible for developing and running the SLR. OHIT has the primary responsibility for the pre-payment registration screening activity. OHIT staff will manually review all EH eligibility and payment data against hospital cost reports uploaded to the SLR. OHIT has developed ranges of variance to compare to the self-reported attestation data. OHIT will refer EPs and EHs to MRB or FAB respectively based on the screening criteria to EH and EP designated email mailboxes. MRB and

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FAB will utilize the mailboxes and create file folders so there is a running history and audit trail of correspondence and information that is submitted by OHIT and other DHCS offices and associates who are involved in the Medi-Cal EHR Incentive Program.

When it has been identified that an audited EP has assigned incentive payments to an FQHC/RHC, MRB and FAB will coordinate review/audit activities. The review and audit procedures described in the audit activities sections will also be performed as applicable to the FQHC/RHC.

The SLR has soft and hard stops to flag and/or stop a EH progressing through the SLR registration process (see **Table 23**). OHIT will refer EH soft stops to FAB for further review and/or audit before the EH is cleared and allowed to move to the next step in the registration process. When FAB receives the referral, it will conduct the necessary procedures to follow-up and contact the EH to review additional data or validate the information submitted by the EH. If FAB determines that the EH has provided sufficient information to resolve the issue identified through the soft stop, it will notify OHIT and a notation will be made in the EH's file and SLR so that the EH can continue and be approved to register. If FAB determines that the EH has not provided sufficient information, FAB will notify OHIT. OHIT will notify the EH of the findings and of the administrative process to appeal the finding if necessary.

4.3.3 POST PAYMENT REVIEWS/AUDITS

In addition to pre-payment referrals from OHIT, FAB will conduct a post-payment audit of patient volume and payment data in conjunction with scheduled Medi-Cal EHR Incentive Program audits. The post payment audit scope will include, but not be limited to:

- Validating the patient volume numbers
- Reviewing the attestation and supporting documentation (contracts, leases, invoices, receipts, hardware and software certifications/serial numbers)
- Verifying that the incentive fund calculations and payments were correct and comparing the disbursement ratios by fiscal year and actual disbursements through the SLR payment database
- Reviewing and reconciling expenditures to determine that entities promoting the adoption of EHR technology do not retain more than 5% of EHR incentive payments for costs other than those related to the implementation and certification of a qualified EHR program (CFR 495.332) if such an option is available/utilized by an EH.
- Although meaningful use is not available in 2011 and not a requirement for year one release of funds, FAB in conjunction with MRB will develop procedures to

verify the attestation of self-certified meaningful use Stage 1 criteria starting with year two payments. As CMS releases additional guidance for Stage 2 and Stage 3 MU, A&I will work with OHIT to incorporate the core set measurements and requirements into audit programs and audit tools.

Once the review/audit is completed, FAB will notify OHIT and the EH of the results and findings. The EH will be given a two-week timeframe to provide additional information and documentation to resolve the findings. FAB will review the EH's additional information and documentation and determine whether the findings are resolved. FAB will notify OHIT and the EH whether the additional information will resolve some or all of the findings. FAB will issue an audit report identifying funds or payments that will be disallowed and recovered to the EH and will transmit a copy to OHIT. In addition, FAB will enter the results in the SLR. The EH is allowed appeal rights through an administrative hearing process under Welfare and Institutions Code (W&I Code) Section 14171. Upon completion of the administrative hearing process, if the judgment is rendered in favor of the EH and funding/payments were deemed allowable, FAB will initiate administrative action to remit the monies owed to the provider.

4.3.4 FRAUD AND ABUSE ACTIVITIES

A&I has lead responsibility for DHCS' Medi-Cal Anti-Fraud program. FAB utilizes various data sources outlined in the table below to develop its risk assessment and develop profiles to identify providers with indicators/red flags that should be prioritized for review and audit. Examples of the criteria that would normally identify a provider as a risk for fraud or abuse includes, but is not limited to:

- Unrelated investigations of a provider due to improper billing practices, data mining claims patterns irregularities, or whistleblower complaints.
- Manual reviews of uploaded AIU documentation identify evidence of improper modification, alterations, or fabrication of submitted documents.
- Verification of self-certified patient utilization, encounters, charity care charges, or discharges has significant variances to reported numbers with no explanation.
- Review of Medi-Cal claims volume identifies a sudden drop in claim submissions after payments are remitted to the provider.

If, upon completion of a referral, pre-payment, or post payment review, FAB identifies that the EH's submissions and representations exhibit misuse/abuse and/or fraudulent activities related to the EHR program, it will make a referral to the A&I Investigation Branch (IB). IB will log the case into the Case Tracking System and assign an Investigator. The Investigator will determine whether there is reliable evidence that fraudulent activity has occurred and then refer the case to the State Department of Justice (DOJ) Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA).

4.3.5 FAB DATA RESOURCES

The resources listed in the FAB Data Resources Table are the primary data resources for FAB in maintaining the fiscal integrity of the Medi-Cal EHR Incentive Program for EHs. FAB will utilize additional resources when available and appropriate to each audit. These resources will lessen EH's audit burden and make FAB's audit processes more efficient.

TABLE 30: FAB DATA RESOURCES

| Data Resource | Resource Function | Resource Benefit |
|---|--|---|
| SLR (State Level Registry) | Provider Registration | Review provider statements and submissions and compare to other data sources and audit findings |
| SURS (Surveillance and Utilization Review Subsystems) | Extensive report system of claim data for all Medi-Cal providers and beneficiaries | Claim detail reports will be run on EHs to help verify the professional's Medicaid/Medi-Cal eligibility percentages and participation |
| PETS(Provider Enrollment Tracking System) | Reviewing provider CA Medi-Cal enrollment applications | Compare SLR registration information for EHs to their PETS file to verify accuracy of information provided on the SLR (cross referenced with MRB for clinic ownership status) |
| Provider Master File (EDSNET) | Master file on all Medi-Cal providers from information submitted by the provider to the Provider Enrollment Division | Will be used to compare locations, businesses, practices, owners, tax identification numbers, NPI numbers, provider names, payment and location addresses, review Medi-Cal status, Medi-Cal payment histories, etc. |
| FATS (Financial Audits Tracking System) | Maintains the historical record of a provider's payment activity, Auditor assignments, and recoveries | Review FATS for historical payment background |
| ARAS Master File Room | Maintains complete audit files for all Hospital audits conducted in last 5 years and all filed cost reports | Full history of all previous audit findings for each EH |
| ARAS Master File Room | Maintains complete audit files for all Hospital audits conducted in last 5 years and all filed cost reports | Full history of all previous audit findings for each EH |

| Data Resource | Resource Function | Resource Benefit |
|---|--|--|
| Certified HIT Product List (CHPL) | Official database of certified EHR programs | Database of the criteria measures of EHR programs selected for certification measure. MU module audit procedures to be developed in future years |
| Office of Statewide Health Planning-- Annual Utilization Report | All licensed clinics in California submit an Annual Utilization Report | Review encounters by payer source |
| Management Information System/Decision Support System (MIS/DSS) | Database of eligibility, provider, and claims information for Medi-Cal | Review provider statements and submissions and compare to other data sources and audit findings |

SLR (STATE LEVEL REGISTRY)

FAB will have access to the SLR maintained by ACS. The SLR will be the primary access point for source data submitted for registration. EHR lead auditors and managers will utilize the SLR to develop internal reviews and perform desk reviews. The SLR will help minimize the impact of reviews on the providers as the initial evaluations can utilize registration documentation to build audit files and perform scoping before any provider contact.

SURS (SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEMS)

SURS is FABs primary source for verification of Medi-Cal payments and patient volume statistics within the program. The SURS system is critical for performing prepayment and post payment scoping and verification of attested data.

PETS (PROVIDER ENROLLMENT TRACKING SYSTEM)

The PETS system will be utilized in conjunction with MRB to determine the ownership status and structure to properly assign audits on referral. Within the clinical community, the organizations structure will determine if MRB or FAB is the lead audit agency. This ensures cases are developed through the proper audit agency.

PMF (PROVIDER MASTER FILE)

The PMF is maintained by PED. Information in which provider's attest on their enrollment application is entered into this system for claiming and payment tracking and can be utilized for FAB to identify address discrepancies, activity status, and payment tracking.

FATS (FINANCIAL AUDITS TRACKING SYSTEM)

FATS is a database developed by FAB to track the history of all audit types and capture relevant financial data for extraction and evaluation. Maintaining a data base system which can be accessed by all field offices centralizes the information.

ARAS MASTER FILE ROOM (MFR)

The MFR acts as the central keeper of records. The MFR maintains a complete history of issued audit report with supporting files and the corresponding filed cost report. The files can be utilized for scoping and verification of attested patient volume. As audit cases are developed, the file history will be maintained allowing for consistency between years.

CERTIFIED HIT PRODUCT LIST (CHPL)

The CHPL is the registry of data elements collected by certified EHR systems providers may elect to install. The database is a starting point to research the variety of systems available and may be used to develop MU attestation audit procedures in conjunction with CMS updates of Level 1-3 criteria.

OSHPD ANNUAL UTILIZATION REPORT

The OSHPD Annual Utilization Reports will be utilized in EH and FQHC/RHC audits. Information the database tracks includes encounters by payer source and procedure. All licensed clinics must file an Annual Utilization Report and the reports will supplement the claims data from the SURS system for patient volume verification.

MIS/DSS

The MIS/DSS is a subsystem of the California Medicaid Management Information System (CA-MMIS) and serves as the California Department of Health Care Services (DHCS)' Medi-Cal Data Warehouse. As a current and comprehensive database of eligibility, provider, and claims information for the Medi-Cal EHR Incentive Program, the MIS/DSS is the largest Medicaid data warehouse in the nation. It is Teradata-based, a leading-edge, hardware and software technology platform that enables the MIS/DSS to store great volumes of data and allow large numbers of users to simultaneously access the data without any deterioration in system performance. As an integrated repository of data that offers the capability for robust queries and analyses, MIS/DSS will be used in a fashion similar to SURS.

4.3.6 FAB CONTINUING DEVELOPMENT

FAB will monitor the implementation of the EHR audit program and take proactive steps to refine the audit programs and procedures. FAB audit staff will develop training materials and conduct training to ensure the auditors are aware of current changes to the EHR program. Audit programs and processes will be expanded and modified when requirements are added or revised, such as the meaningful use objectives once DHCS receives additional guidance from CMS.

5 CALIFORNIA'S HIT ROADMAP

The long term goals of the Medi-Cal EHR Incentive Program address improved quality and efficiency of health care for all Californians. The roadmap to these long term goals is discussed in the second half of this section. The 2011-2012 goals for the program are centered on the initial steps of increasing provider and hospital adoption, implementation or upgrade of certified EHR technology followed by meaningful use of this technology in practice. The activities supporting these 2011-2012 goals are understandably more clearly defined than those for the long term goals. These activities are discussed in the first half of this section.

5.1 2011-2012 ROADMAP

DHCS has identified activities in four major pathways that constitute the roadmap for the program over the next two years. These activities have been described earlier in the SMHP and are displayed here in a timeline table and summarized in the discussion that follows:

TABLE 31: 2011-2012 ROADMAP TIMELINE

| | Enrollment/ Verification/ Payment | Outreach/ Technical Assistance | Landscape Refinement/ Evaluation | HIE/Public Health |
|-------------|--|--|---|---|
| 2011 | <p>April SLR “go live;” 10% random verification</p> <p>May First payments. Appeals process active</p> <p>July Post-payment audits begin</p> <p>September Assumption of operations of MMIS by ACS</p> | <p>January Provider phase begins; ACS Help Desk active; Educational sessions by ACS begin</p> <p>February Medical Board Newsletter and Medi- Cal Provider Bulletin; Twitter account</p> <p>March Build-up campaign</p> <p>April Launch campaign</p> <p>May Adoption entity advisory group convenes; Ongoing maintenance campaign begins</p> | <p>Feb-July UCSF surveys of providers and hospitals conducted</p> <p>July-December UCSF survey of clinics and medical groups developed</p> <p>August Evaluation RFP released</p> <p>December Evaluation RFP awarded</p> | <p>January Cal eConnect technical architecture complete</p> <p>January-July RAND Toolset project with independent pharmacies</p> <p>March-May Cal eConnect awarding of expansion grants; Release RFP for core services and vendor selection</p> <p>March-September Laboratory exchange assessment</p> <p>May-June Immunization registry assessment completed</p> |

| | Enrollment/ Verification/ Payment | Outreach/ Technical Assistance | Landscape Refinement/ Evaluation | HIE/Public Health |
|-------------|---|---|---|---|
| | | <p>April-June Master campaign plan contract awarded</p> <p>July Technical Assistance RFP released</p> <p>September Technical Assistance contracts awarded; Ongoing beneficiary campaign begins</p> | | <p>July Foster children HIE project begins in Ventura County; Partners in e program begins; CONNECT Gateway e-prescribing project begins</p> |
| 2012 | <p>January MU attestation begin</p> <p>January-March 100% automated verification begin</p> <p>March Incorporation of SLR into MMIS</p> | | <p>January Evaluation contractor begins work</p> <p>February Clinic and medical group survey</p> <p>March-August UCSF provider and hospital surveys repeated</p> | <p>January-March Select behavioral health demonstration project</p> |

5.1.1 ENROLLMENT/VERIFICATION/PAYMENT

DHCS has worked with its new fiscal intermediary, ACS, to develop a state level registry to accept information from the NLR and from individual providers and hospitals. This SLR, which is described in detail in Section 3, not only accepts and stores information, but conducts analysis and notifies OHIT staff of applications lacking required information or containing information that requires verification. The SLR acts as the tracking system for all program activities and is capable of generating standardized and ad hoc reporting on a large number of issues. The SLR is designed to be the business engine of the program. Its deployment on April 1 2011 will be the cardinal event inaugurating the program with providers and the public.

The SLR can carry out verification on a number of data fields, but OHIT staff and staff in other parts of DHCS will be instrumental in carrying out pre-payment verification of provider and hospital eligibility and (beginning in 2012) attainment of meaningful use,

OHIT staff will initially assess all “soft stops” flagged by the SLR and work with providers and hospitals to correct any inadequacies or inaccuracies to avoid unnecessary denials and appeals. Given the volume of potentially eligible providers and hospitals in California, this will require considerable expansion of the OHIT analytic staff. All applications with data that cannot be confirmed by OHIT staff will be forwarded to DHCS’ Audits and Investigations Division for further and more detailed investigation. The SLR will generate a 10% random sample of EP applications for prepayment verification of patient and panel encounter volumes by OHIT staff referencing encounter data contained in DHCS’ MIS/DSS system. Any of these applications with patient or panel encounter volumes 20% or more above volumes documented in the MIS/DSS will be referred to Audits and Investigations. By the first quarter of 2012 this random verification will be replaced by a 100% automated verification carried out by the SLR with referrals to Audits and Investigations using the same 20% tolerance range. All applications from hospitals will undergo prepayment verification by OHIT staff to confirm patient discharge volumes and payment calculations.

Audits and Investigations will begin post-payment audits beginning immediately after the first payments occur in May 2011. This will be conducted on a random sample of 5-20% of EP applications, depending on application volume, work force capacity, and the frequency of irregularities identified in the applications. A larger number of irregularities will trigger the need for random samples of larger numbers of applications. All hospital applications will be audited as part of Audits and Investigation’s annual auditing and oversight of hospitals in California. Providers and hospitals, beginning in May, will be able to appeal all denials of eligibility or overpayment determinations through DHCS’ administrative appeals process.

Because the transition to ACS as DHCS’ fiscal intermediary is not scheduled to be completed until September 2011, the SLR has been built as a stand alone application separate from the MMIS. By March 2012 it is anticipated that the SLR will be fully integrated into the MMIS. Until then payment information generated by the SLR will be forwarded to DHCS’ Fiscal Intermediary Contracts Oversight Division for a partially manual payment process. After March 2012, this process will become fully integrated into the MMIS.

5.1.2 OUTREACH AND TECHNICAL ASSISTANCE

Outreach and education are integral components of the Medi-Cal EHR Incentive Program. DHCS began meeting with key stakeholders, professional and community organizations, the RECs, and Cal e-Connect early in 2010 to plan strategies and messages for outreach and education. The first phase of these activities have targeted the program’s initial key customers—providers, clinics and professional groups and hospitals. DHCS issued a provider bulletin to all Medi-Cal providers in February 2011 announcing the program and giving basic enrollment and payment information. All

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physicians in California received a similar notification in February 2011 through the Medical Board of California Newsletter.

DHCS' main conduit of information for the program has been through ACS. A "splash page" for the SLR went live in December 2010 and the ACS Helpdesk became operational in January 2010. ACS staff has presented in person or via webinar to over 30 provider groups or organizations over the last six months. The frequency of these presentations will intensify in the coming months as the SLR goes live and applications begin to be accepted. Recently ACS has established a Twitter Account for the program @EHRincentiveCA.

In the second half of 2011, the messaging for outreach and education will expand from emphasizing AIU for providers and hospitals to meaningful use and a focus on beneficiaries. Through the P-APD process, DHCS intends to create a joint contract with a public relations firm for the development of a master campaign plan strategy for education and outreach efforts focused on the achievement of MU, and to coordinate messages between Medi-Cal, the RECs, statewide HIE, various professional organizations and other national efforts. This consulting entity will be hired to conduct their efforts between April and June 2011.

Providers require assistance beyond simply purchasing an EHR. Assistance with installation, business process redesign, clinic workflow, and staff training is necessary. Providers in larger organizations tend to have better access to such assistance than those in smaller practices. For this reason the RECs have been funded to provide technical assistance to providers in practices with 10 or less providers. Unfortunately, their resources will not be sufficient to assist all Medi-Cal providers. For this reason in July 2011 DHCS will issue an RFP soliciting proposals from organizations to provide technical assistance to up to 5,000 eligible Medi-Cal providers over a two year period. DHCS expects to make awards to multiple organizations in September 2011. DHCS' intention is to model the best practices employed by the RECs for communication and technical assistance in the multiple contracts for technical assistance that will be awarded. Included in this effort will be an educational campaign component.

DHCS also recognizes that the designation of "adoption entities" may be another path for providing technical assistance to providers. However, there are several potential fiscal, ethical, and organization issues to be carefully considered before taking this step. For this reason DHCS will convene an advisory group in April 2011 which will be led by an external expert from an academic or business setting. DHCS hopes to conclude the work of this group by fall 2011.

The state will employ a coordinated campaign to accomplish outreach efforts, and will leverage the existing network of healthcare stakeholders such as the RECs, medical and trade associations, hospitals, clinics, managed care plans, FQHCs, IPAs, the CMS Regional Office, ONC, the state eHealth Coordinating Committee and Cal eConnect. These stakeholders will play a critical role in enabling adoption of EHRs. The campaign

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will convey a suite of messages to both providers and beneficiaries and will use a broad set of communication methods and tools.

The campaign and outreach plan will be conducted through a multi-phase approach. The overarching goals of each phase are outlined below, and detailed information on timing, messages, and vehicles to be employed can be found in the Provider and Beneficiary Outreach Campaign section, Section 2.4.

Phase I To Date used key encounters to lay a strong foundation for the next phases of the outreach campaign. This phase has employed direct face-to-face communication from OHIT and ACS to RECs, professional and hospital organizations and associations via webinars, and in person meetings and presentations. These presentations have been very successful in educating and gaining support from these groups.

Phase II Build-Up Campaign goal is to continue to increase interest and direct providers to the Provider Outreach Page www.medi-cal.ehr.ca.gov where they can learn more about the Medi-Cal EHR Incentive Program. The objective is that those providers can use the workbook on the site to prepare their information so that upon the launch of the SLR, those providers will be able to immediately register successfully.

Phase III Launch Campaign goal is to announce the launch of the Medi-Cal EHR Incentive Program and to drive providers to register in the SLR on the Provider Outreach Page www.medi-cal.ehr.ca.gov.

Phase IV Maintenance Campaign goal will be to continue to drive awareness of the Medi-Cal EHR Incentive Program, and begin to specifically focus on the late adopters.

Phase V Beneficiary Campaign goal of this phase will be to build awareness and highlight the benefits of EHRs to beneficiaries.

5.1.3 LANDSCAPE REFINEMENT AND EVALUATION

As described in Section 1, information about provider adoption and use of electronic health records in California is fragmented and some cases out-of-date. Recent information obtained on physicians from the National Ambulatory Care Survey and on hospitals from the American Hospital Association Survey has helped to fill in some of the gaps. In order to gain better baseline data and to establish scientifically valid tracking over time, DHCS will be partnering with researchers at UCSF on a number of research projects. DHCS will assess physician EHR use through a questionnaire (**Appendix 3**) attached to the Medical Board of California's application for physician license renewal to be first administered in February-March 2011. A modified version will also be developed by UCSF researchers to track EHR use by other types of practitioners. This randomized survey will provide a standardized, scientifically valid source of information that will be powerful enough to carry out sub-analysis of payer

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type (Medi-Cal vs. other payers), practice size, location (rural vs. urban) and other physician characteristics.

In a second survey, DHCS will also partner with researchers at UCSF to create and field a detailed study of hospitals in California. This survey will concentrate on systems of hospitals and will contain detail sufficient to break out Medi-Cal EHR Incentive Program eligible hospitals and attain a response rate above 50%. This will be administered between March and July 2011.

A third standardized survey of clinics and medical groups will be developed and fielded between July and December 2011. This will be developed in cooperation with clinic associations, major medical groups, IPAs, other organizations. The information about health systems contained in Section 1 has been derived from diverse surveys conducted by professional associations or trade groups. Such data is very difficult to compare across sources and there is no assurance that data will continue to be collected in the future by these sources without DHCS support. University of California researchers will convene a workgroup of representatives from hospitals, provider organizations, practice associations, and other groups to define the content, format, timing and other features of separate hospital and health system surveys to be carried out in 2011 and periodically over the next five years. Although the content of the instrument will be standardized, it is anticipated that the stakeholder organizations will be actively involved in promoting its use by their memberships.

In addition to tracking provider and hospital EHR use, it will be important to access program processes. For this purpose, an RFP for program evaluation will be released in August 2011. A contract will be awarded by December 2011. The contractor's duties will include:

- Satisfaction surveillance with the practitioners and hospitals enrolled in the program. Are payments received in a timely fashion? Are providers receiving the information and support that they need? Are providers finding the incentive payments sufficient? Are certain aspects of meaningful use more difficult in California? These are examples of some of the issues the evaluation contractor will address through surveying program participants and interacting with stakeholders
- Examination of administrative data to determine efficiency. How quickly are applications being processed and payments made? Are eligibility determinations being made correctly, or are too many being reversed on review or appeal? Are administrative 90-10 funds being spent optimally to aid in the effectiveness of the program?

The State HIT Coordinator has established an Evaluation Workgroup with representation from the designated HIE governance entity (Cal eConnect), RECs, and other stakeholders to identify a core set of metrics California must track for its multiple

HITECH-funded programs and affiliated efforts. DHCS is participating in this Workgroup, whose recommendations over the next several months will inform DHCS' approach to tracking the factors driving the adoption, meaningful use, and interoperability of EHRs and HIE.

5.1.4 HEALTH INFORMATION EXCHANGE AND PUBLIC HEALTH

DHCS' first activities in this area will target e-prescribing. As described in Section 1, many if not most of Medi-Cal beneficiaries are served by independent pharmacies that have the lowest rates of connectivity to e-prescribing networks. In January 2011, ten independent pharmacies were recruited to participate in a pilot project to assist them in deploying e-prescribing. The project will test a tool set for e-prescribing developed by RAND Corporation in a number of independent pharmacy sites in the Sacramento area. An assessment will be conducted to obtain feedback from sites after they attempt to use the RAND Toolset in the course of their own e-prescribing implementation efforts. A pharmacy specialty resident in e-health policy from DHCS will serve as the principal investigator of the pilot project and will work in collaboration with the RAND Corporation to provide performance results and feedback for modification of the RAND Toolset. The goal of the assessment is to evaluate the usability of the RAND Toolset as well as its usefulness in helping pharmacies to successfully implement e-prescribing for both new prescriptions and refill requests. This pilot will also serve to inform the development of content and process for the Health Information Technology for Pharmacists curriculum and outreach programs delivered through the California Schools of Pharmacy, Cal eRx, Cal eConnect and the RECs. Ideally, the RAND Toolset will be distributed to community pharmacies throughout California with additional support provided by e-prescribing and medication safety experts.

Beginning in March 2011 DHCS will partner with CHHS, Cal eConnect and CDPH to use P-APD funding to complete an assessment of lab reporting capacity within California. While in the past there has been exchange of electronic laboratory data, it has not been in a consistent format as required by the EHR Certification and meaningful use requirements. As part of the assessment, CDPH will be completing an implementation guide for public health laboratory result reporting. The assessment will result in a roadmap, identifying the operational and policy levers that the state should implement to increase lab data interoperability. Both DHCS and Cal eConnect have dedicated funds to implement the output of the assessment, including an implementation guide that will support providers and labs in submitting data to public health.

Beginning in March 2011, Cal eConnect will be awarding approximately \$3 million in grants to expand HIE capacity in local/regional communities. In the period of March-June 2011, Cal eConnect will release several RFPs addressing core services including legal, communication, IT support, and project management.

TABLE 32: CA HIE IMPLEMENTATION TIMELINE

| Define and Procure Core Service | |
|--|---|
| Complete Technical Architecture | January 2011 |
| Contract with entity for RFP development | February 2011 |
| Release RFP for Core Services | March 2011 |
| Select Vendor and Negotiate Contract | May 2011 |
| Phase Implementation | |
| Phase I: | Q3 2011 |
| <ul style="list-style-type: none"> • HIE-HIE (HIEs) Volume • NHIN Direct Volume <ul style="list-style-type: none"> ○ Providers • EHR-EHR (same Service) (eNT (entities)) • EHR-EHR via Connectivity Service (entities) | 2-4 2-4 (trials) <100 2-4 1-2 |
| Phase II: | Q4 2011 |
| <ul style="list-style-type: none"> • HIE-HIE (HIEs) • NHIN Direct <ul style="list-style-type: none"> ○ Providers • EHR-EHR (same Service) (entities) • EHR-EHR via Connectivity Service (entities) | 5-10 20-50 Live 300-500 20-50 5-10 |
| Phase III: | Q1 2012 |
| <ul style="list-style-type: none"> • HIE-HIE (HIEs) • NHIN Direct • Providers • EHR-EHR (same Service) (entities) • EHR-EHR via Connectivity Service (entities) | 11-20 100-500 Live 1,000-3,000 500-1500 100-300 |
| Sustainability Plan for Core Services | |
| Phase I: Implement, Operate, Maintain | FY 2011-12/TBD |
| Phase II: Develop Business Plan | Q4 2011/\$175,000 |
| Phase III: Finance Annual Operations | FY 2013/TBD |

DHCS will also leverage Cal eConnect’s core services and other targeted services to support the meaningful use criteria relevant to lab data exchange. In implementing the recommendations of its Lab Services Task Group, Cal eConnect will work with DHCS and other state agencies to promote the use of uniform standards such as LOINC and ELINCS and determine the strategy for providing lab routing and other services to enable safe and secure exchange of lab results.

DHCS plans to explore alternative network options to deliver formulary, eligibility, and medication histories in a secure fashion to the point of care through efforts including the Cal eConnect’s core HIE services reference implementations. In addition, and as a follow up to the Medi-Cal e-Prescribing Pilot, DHCS plans to support Phase 3 of the Second Generation e-Prescribing pilot program by delivering formulary file and

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medication histories through the National Health Information Network-based CONNECT Gateway. The Second Generation e-Prescribing pilot will provide a new platform that could potentially meet the needs of FQHC and community clinics throughout California who are participating in the 340(b) purchasing programs. The initial pilot will take place among providers in Sonoma County. DHCS will continue to participate and support the activities to promote e-prescribing through the Cal eRx and Cal eConnect. Such activities may include education and outreach activities, developing and/or modifying e-prescribing policy (e.g. electronic prescribing of controlled substances) and leveraging statewide prescription exchange volume for competitive pricing of transactions.

DHCS requested P-APD-U funding to support CDPH in developing an I-APD for a California Immunization Registry that would provide the functionality necessary to accept HL7 formatted data to support the Medi-Cal EHR Incentive Program business requirements. Due to delays in the California budget and unexpected cuts in funding this project recently commenced. DHCS has partnered with CDPH, CHHS and Cal eConnect to develop the I-APD and incorporate business requirements that have emerged as part of the HITECH Act. The anticipated completion of this project is now May-June 2011 pending approvals of both state and federal agencies of the I-APD and associated budget actions.

In July 2011 DHCS plans to begin the “Partners in e” program to educate e-prescribing and medication safety experts throughout California’s Schools of Pharmacy. Students will serve as subject matter experts in e-prescribing in advanced pharmacy practice electives in the community and as they perform in their fourth-year clinical pharmacy practice rotations. The program will include curriculum development in health informatics and medication safety, cross-training with other professional programs (e.g. medical and nursing programs) and outreach activities as part of a collaborative effort to meet the MU priorities in the Medi-Cal EHR Incentive Program.

PARTNERS IN E ACTIVITIES BEGINNING 2011

- Implement, refine, and evaluate pilot testing of RAND e-Prescribing Toolset
- Hire staff; set up infrastructure
- Select California Partners in e Board
- Structure required course, Health Information Technology (HIT) for Pharmacists, present Peer-to-Peer (P2P) sessions to School of Medicine and School of Nursing Interdisciplinary HIT course
- Develop Outreach Elective materials; conduct community outreach for e-prescribing education and training
- Develop Advanced Community Pharmacy Practice Experience (ACPPE) rotations

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- Develop community partnerships through RECs and Cal eConnect
- Choose and contract with PR firm

PARTNERS IN E ACTIVITIES BEGINNING 2012

- Implement, refine, and evaluate required Health Information Technology for Pharmacists course
- Train new student pharmacists in P2P; present P2P to SON (School of Nursing), SOM (School of Medicine), SOP (School of Pharmacy)
- Evaluate pharmacy staff and student experience with Outreach Elective
- Conduct Train-the-Trainer for 7 other CA SOPs on outreach elective
- Develop community partnerships through RECs and Cal eConnect
- UCSF students to begin community pharmacy outreach for e-prescribing via ACPPE
- All CA SOP conduct community pharmacy outreach for e-prescribing education and training
- Finalize PR plan, develop PR materials
- Conduct baseline data analysis of outcomes measures

Partners in e-activities are projected to continue until 2015 and will conclude with presentations of results at state and national meetings and publication of a manuscript in a professional journal.

In July 2011 DHCS will begin the foster children HIE project in Ventura County. Foster children have been identified in California as a special and vulnerable population that would benefit immensely from the use of EHRs and improved health information exchange capacity. In 2006, AB 2216 (Chapter 384, Statutes of 2006) established the California Child Welfare Council (CWC). The CWC is a state advisory body that considers recommendations to improve child and youth outcomes through increased collaboration and coordination among the programs, services and processes administered by the multiple agencies and courts that serve children and youth in California's child welfare system. The CWC has focused on four areas: Prevention/Early Intervention; Permanency; Child Development/Successful Youth Transitions and Data Linkage and Information Sharing. Now, as part of the Medi-Cal EHR Incentive Program and the HIE Cooperative Agreement, the focus on foster children continues as an area of key infrastructure that will impact multiple state and local agencies in order to leverage the advances that will be possible through the Medi-Cal EHR Incentive Program. Additionally, the CHHS HIE Policy Committee has identified care of foster children as one of three use cases that will be used to identify opportunities to leverage resources among the CHHS Offices and Departments based on the HITECH Act programs.

An initial demonstration project to implement an information exchange model within one county for foster children has been identified to better understand the components impacted, opportunities for improved care coordination, and potential cost savings or avoidance. Working in partnership, the California Department of Health Care Services, California Department of Social Services, California Health and Human Services Agency Deputy Secretary for HIT, the Directors of the Human Services Agency and the Health Care Agency in Ventura County, and The Children's Partnership have developed a demonstration project to implement an information exchange model for children in foster care. The Ventura County pilot system will provide real-time information to caseworkers and health providers to enhance care-related decision-making. This pilot is not only an opportunity to improve health outcomes for the over 600 children in foster care in Ventura County, but also is a critical step to improving outcomes for the approximately 62,000 children in foster care in California.

The policy, technology, and systems developed through this pilot will lay the groundwork for information-sharing between providers, as well as between state agencies and county and state level systems. This model will support meaningful use of EHR technology by allowing physicians in Ventura County to obtain important information – such as a list of medications, a list of known allergies, laboratory results, and smoking status – from prior and current members of the child's care team. It will also support secure messaging and facilitate the electronic exchange of key clinical information, which can be included in clinical summary care records for patients and other members of the care team for each office visit.

This model is synchronized with current plans for the state of California's HIE model and will be an important project for informing HIE policies. In developing a technology solution in Ventura County, it will be necessary to develop privacy and governance policies and procedures, a Record Locator Service, a Master Patient Index, interagency data-sharing agreements, and data and transactions standards, which will likely be available as models and reusable assets for other IT efforts in the state. Additionally, California's HIE effort will inform and support the pilot in Ventura County, as the policies, practices, and services of Cal eConnect and existing Health Information Organizations in California will be integrated in the development of the model. Specifically, the demonstration may use the Cal eConnect Core Services to accomplish some aspects of information exchange. Finally, this effort will be coordinated with the RECs in California to keep them informed as the model is developed, so that information can be incorporated during technical assistance with providers.

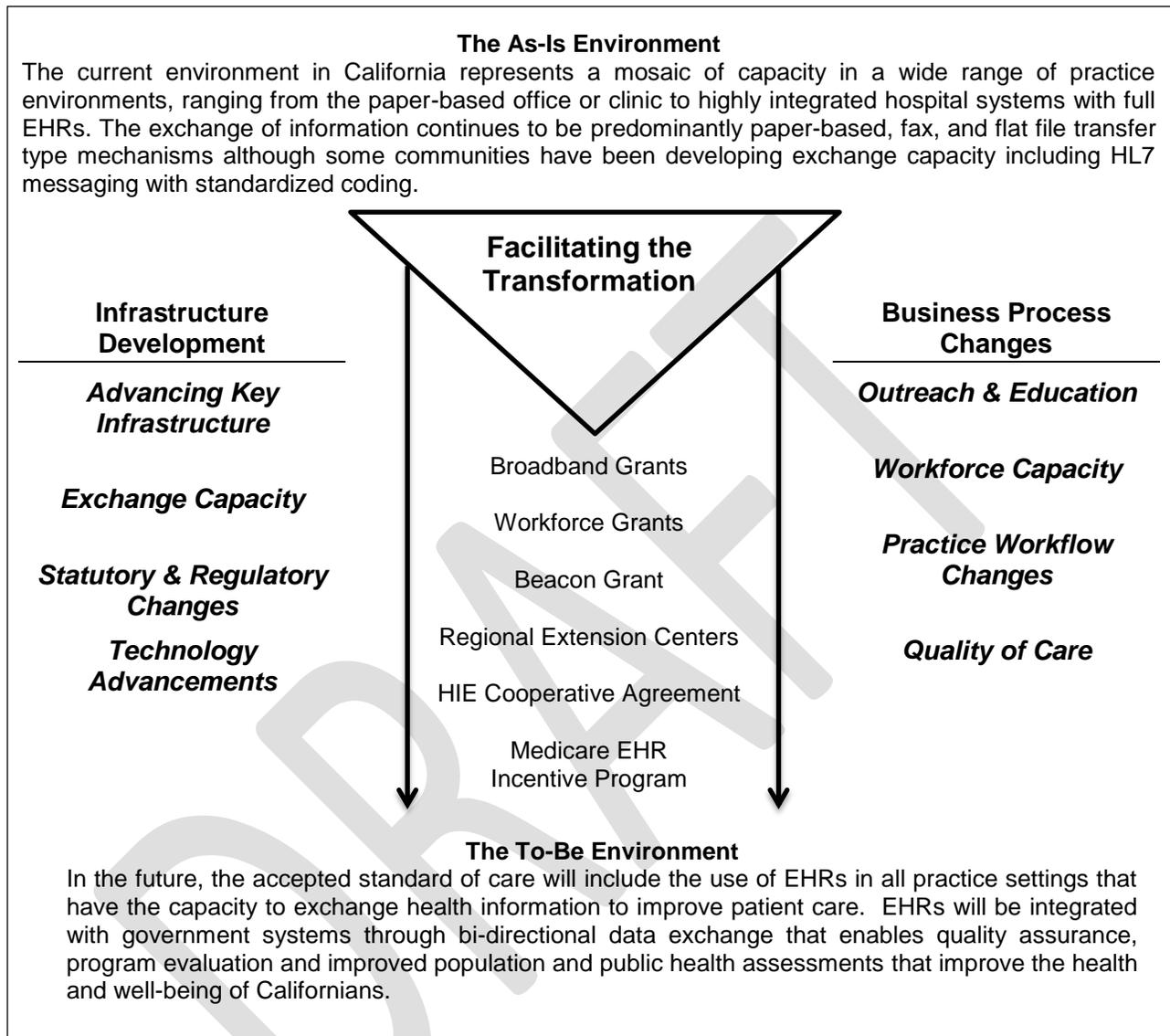
In the first quarter of 2012, DHCS will partner with the Department of Mental Health (DMH) in the selection of a pilot project to develop and test a joint medical and behavioral health electronic record. It is anticipated that this will be carried out by awarding a research grant through a competitive process.

5.2 LONG TERM ROADMAP

Over the coming years, California expects to leverage extensive relationships with stakeholders throughout the state to advance the use of EHRs, establish routine health information exchange practices and improve patient and population health. This is represented in **Figure 30**.

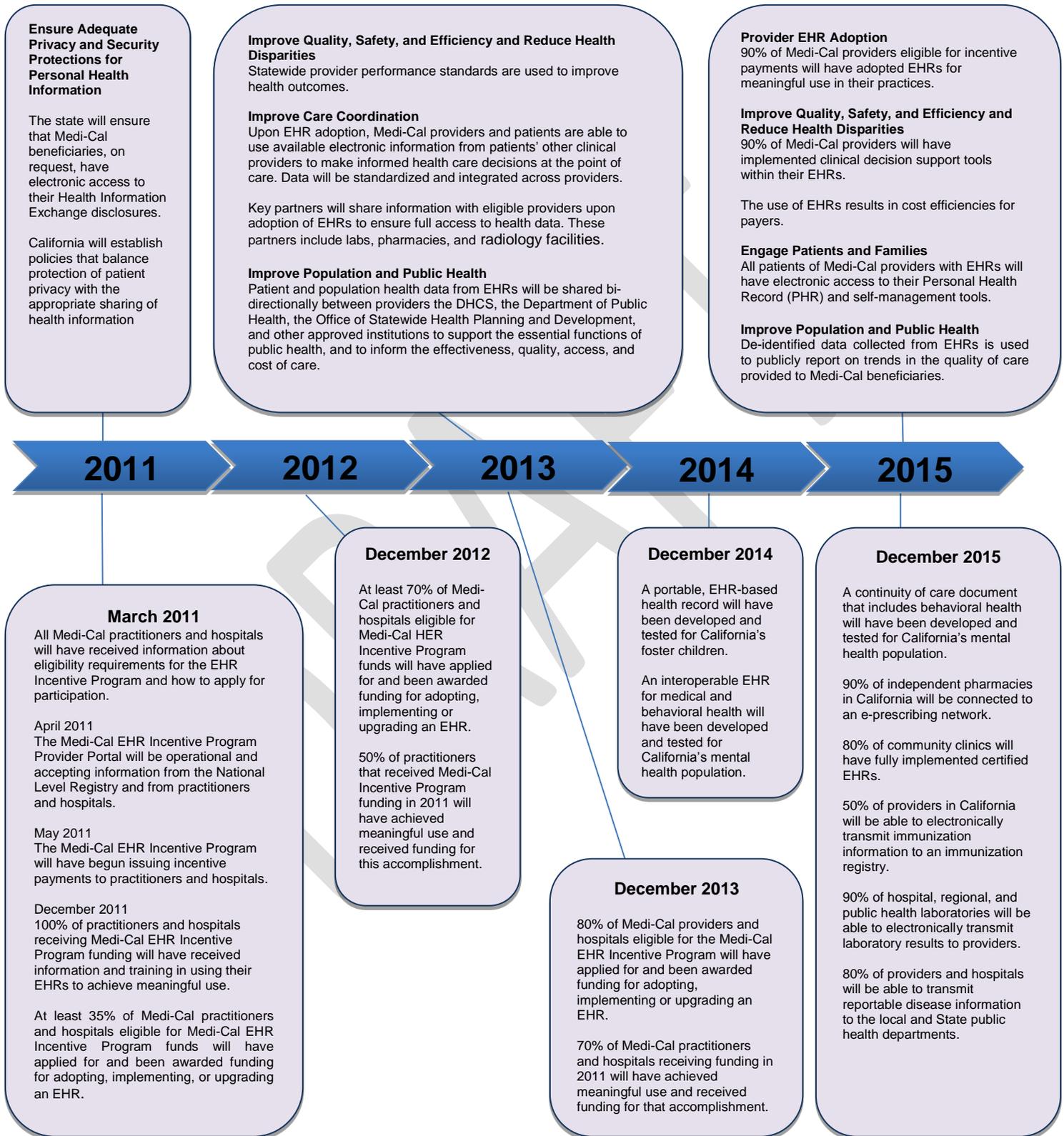
California recognizes that in the long term there are many components that need to be addressed to make the transformative changes that have been set out through the HITECH Act and the Medi-Cal EHR Incentive Program. We have separated these changes into two categories: infrastructure development and business process changes. Infrastructure development represents changes that need to be made structurally at local and state levels as well as in community capacity to enable the use of EHRs in meaningful ways. These changes will require capital investment to modify and create both technology solutions. We have also identified statutory and regulatory changes as part of the infrastructure development as these changes will be necessary to allow us to efficiently use technology to improve the services provided to our constituents. Business process changes represent the shifts that need to occur in provider offices, hospitals, supporting services, and local and state government to make this change from paper and non-interacting systems to electronic and interactive systems. Automating a paper-based process without making changes to the process that takes advantage of the automation is not the most efficient use of automation. To best leverage the HITECH resources, California recognizes that significant changes will need to occur in the existing and new workforce to change workflow in ways that improve efficiency and quality of care and services provided.

FIGURE 30: CALIFORNIA'S LONG-TERM HIT STRATEGY



On the next page, **Figure 31** summarizes the long term vision for the Medi-Cal EHR Incentive Program established by a work group of convened stakeholders and experts in January 2010.

FIGURE 31: MEDI-CAL EHR INCENTIVE PROGRAM LONG-TERM VISION



5.2.1 HEALTH INFORMATION EXCHANGE

Cal eConnect, in collaboration with DHCS, the state HIT Coordinator, and the California e-Prescribing Consortium (Cal eRx), plans to conduct a gap analysis and baseline assessment of e-prescribing adoption and use in the state over the next 4 months. This assessment will build on the Medi-Cal data described above for a broader statewide snapshot, taking advantage of a new data-sharing agreement between ONC and Surescripts (signed in late January 2011) to provide states with detailed e-prescribing utilization information. It will also account for e-prescribing users outside of the Surescripts network (e.g., Kaiser, VA and 340(b) practices).

Upon completion of the baseline assessment, Cal eConnect will develop a 3-5 year strategic plan to enable e-prescribing and medication management in the state, to be submitted to DHCS, the state HIT Coordinator, and other stakeholders for input and approval. It is anticipated that two immediate priorities to be described in the strategic plan are:

- Developing technical e-prescribing messaging and interoperability specifications for the Cal eConnect core HIE services
- Conducting reference implementations of the e-prescribing messaging and interoperability functions of Cal eConnect core HIE services

DHCS also recognizes that the use of the National Council for Prescription Drug Programs' (NCPDP) Script e-prescribing standard is not currently used by certified EHR systems to capture medication data. The use of RxNorm in EHR systems is completely separate and not interoperable with NCPDP e-prescribing data fields for the purpose of exchanging prescription information or medication histories. In addition, many of the EHRs use proprietary nomenclature to identify drug data that is not compatible with RxNorm or NCPDP for reporting purposes.

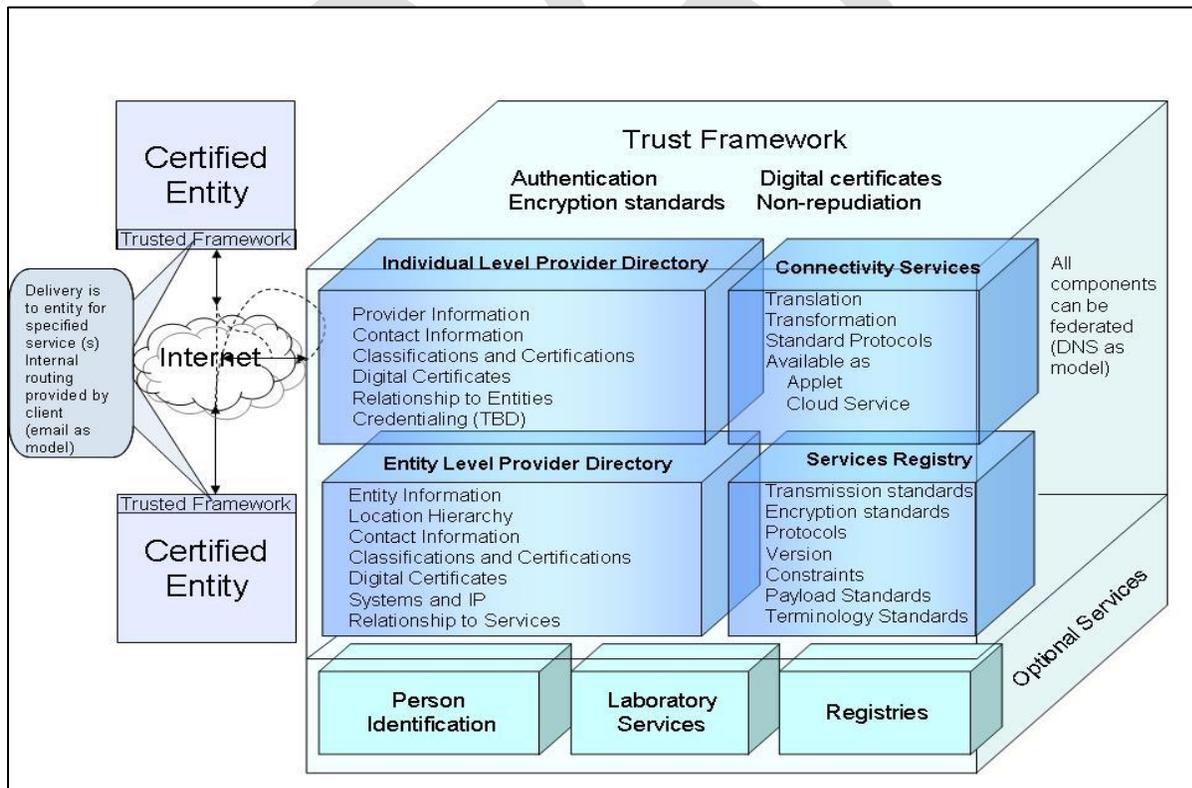
Health Information Exchange is a major component in the long term planning for meaningful use of EHRs. Development of HIE capacity is being led by through the HIE Cooperative Agreement by CHHS and Cal eConnect. This capacity is essential for achieving meaningful use, especially in Stages 2 and 3. The timelines for development of HIE capacity are reflected in the California HIE Strategic, Operational and Implementation planning documents. Federal, state and local government will benefit and most likely become purchasers of HIE services over the course of the Medi-Cal EHR Incentive Program.

California has identified core functionality that will be implemented by Cal eConnect to support the exchange necessary for meaningful use. The Core HIE services consist of an Entity Level Provider Directory (ELPD), an Individual Level Provider Directory (ILPD), and connectivity services to include a Services Registry (SR) and Connectivity Services

(CS) Registry. These services provide the following primary functions:

- A trusted process for positively identifying persons and organizations with which one intends to exchange health information. Positive identification is provided through entries in the ELPD and ILPD, a designated electronic registry of legal entities and individual providers that have been certified as authentic and reputable by a trusted third-party. Certified entities, in turn, provide trusted identifying information about the specific persons, departments and other principals within their spheres of control with which health information may be directly exchanged.
- A trusted registry of health network nodes that can send or receive HIE transactions across organizations. The identities of these network nodes are also maintained as entries in the ELPD and SR and are certified as authentic and reputable by a trusted third-party. The entries allow the information systems that send and receive HIE transactions to verify each other's legitimacy, mutually authenticate each other, and protect health information in transit from disclosure or corruption. Each registered network node in the ELPD and SR must be associated with a single legal entity also registered there.

FIGURE 32: CAL eCONNECT TRUST FRAMEWORK



California Medi-Cal Health Information Technology Plan

- A trusted directory of electronic addresses for entities or individuals with which health information may be exchanged (i.e., organizations, departments, applications). These addresses, which may be maintained within the ELPD or ILPD and SR, are specific to the various kinds of HIE transactions offered (e.g., sending laboratory results, requesting medication lists). Users or information systems may use these directory entries to determine the correct address for sending specific kinds of transactions intended for specific recipients.
- A trusted directory of the communication protocols and data standards that may be used to exchange health information with specific principals (i.e., organizations, departments, applications and/or individuals). These directory entries, also maintained in the SR, inform programmers and information systems about the set of transactions that are supported by various organizations, departments, applications and persons, and the appropriate communications protocols and data standards to use for each one.

With respect to the architecture depicted in **Figure 32**, the administrative systems and clinical data registries operated by state and local governments comprise enterprises that need to exchange information with each other and with enterprises in the private sector for purposes of collecting or disseminating patient-specific health information. Examples of such enterprises include DHCS (and its MMIS systems), and the state and local departments of public health (and their various registries). Several examples are provided below.

California's MMIS may interact with HIE Services in at least two ways:

- The MMIS may leverage the Entity Registry Service and (possibly) the Provider Identity Service to authenticate and authorize requests from providers for administrative information, such as eligibility and benefits information for Medi-Cal beneficiaries. In this mode, requests to MMIS would include authentication and authorization assertions signed by legal entities registered in the Entity Registry Service. If MMIS trusted the legal entities thus registered, this trust would obviate the need for MMIS to maintain its own registry of providers authorized to access to MMIS (e.g., include their passwords) and to perform the authentication itself. These functions could be delegated to the trusted legal entities.
- The MMIS may leverage the Entity Registry Service and Provider Directory Service to request access to clinical information from providers, such as medication lists or laboratory results for Medi-Cal beneficiaries. In this mode, MMIS would, itself, be a registered legal entity in the Entity Registry Service. An MMIS user would locate the provider of interest in the Provider Directory Service and submit a request to retrieve clinical

information for a specific Medi-Cal beneficiary (identified by name, DOB and Client ID, for example). The contacted provider would authenticate the request using MMIS’s entry in the Entity Registry Service. The information would be sent back over a secure channel, as both the MMIS system and the provider’s EHR are health network nodes also registered in the Entity Registry Service.

Immunization registries could use the Core HIE services when authenticating requests from providers to submit or retrieve immunization records. This process would be very similar to that described above for the MMIS.

Public health databases that are used to monitor reportable diseases could also use the Core HIE services when authenticating requests from providers to submit data (including laboratory results and syndromic findings) and from public health agencies to access the data.

California’s Office of Statewide Health Planning and Development (OSHPD) collects over 16 million patient records annually from hospitals and licensed ambulatory surgery clinics. The data are used by OSHPD to measure quality of care as well as service utilization and cost and are provided to researchers under strict control. Facilities report these data by uploading files via an Internet web page. Data are then subject to editing and correction. These data reporting activities could potentially use Core CS-HIE Services to transmit data.

5.2.2 HIE AND MEANINGFUL USE

In developing the HIE operational plan for California, an assessment of the meaningful use objectives in relation to HIE capabilities was conducted. A subset of objectives were identified for which HIE is essential or may be beneficial.

TABLE 33: MEANINGFUL USE CRITERIA FOR WHICH HIE IS ESSENTIAL OR BENEFICIAL

| Meaningful Use Criteria | Relevant HIE Capability |
|---|---|
| 1. Generate and transmit permissible prescriptions electronically. | Infrastructure for an EHR or EHR module to correctly address and securely transmit an electronic prescription (e-prescribing) to the desired dispensing pharmacy in the specified standard format. The transmission may occur directly or via a third-party. |
| 2. Incorporate clinical laboratory-test results into EHRs as structured data. | Infrastructure for laboratories to securely transmit structured laboratory results to the EHR or EHR module of the appropriate provider(s) in the specified standard format. The transmissions may occur directly between laboratories and EHRs or via a third-party. |

| Meaningful Use Criteria | Relevant HIE Capability |
|---|--|
| 3. Provide patients with an electronic copy of their health information upon request. | HIE capability is required if the electronic copy is to be transmitted to the patient via a network, either directly (e.g. via secure email) or through a third-party patient-authorized entity (e.g., a Personal Health Record [PHR]). In these cases, the capability is required to correctly address and securely transmit the information in an accepted format to the patient or the patient-authorized entity. |
| 4. Capability to electronically exchange key clinical information among providers of care and patient-authorized entities. | Infrastructure to correctly address and securely transmit the specified types of information (e.g., problem list, medication list) in an acceptable data format from one provider to another, from a provider to a patient-authorized entity or from a patient-authorized entity to a provider. |
| 5. Provide patients with timely electronic access to their health information within four business days of the information being available. | HIE capability may simplify electronic access provided to patients via a third-party patient-authorized entity, such as an “untethered” PHR. In this case, the same capability is required as for #4 above. |
| 6. Provide a summary-of-care record for each transition of care and referral. | HIE capability will simplify and promote the transition of care or referral made to a different organization, and most easily facilitate transfer of the summary-of-care record. |
| 7. Capability to submit electronic data to immunization registries and actual submission where required and accepted. | Infrastructure to securely transmit immunization events from any hospital or outpatient facility to the appropriate immunization registry for the appropriate patient in a specified data format, and to allow immunization registries to securely exchange data. |
| 8. Capability to provide electronic submission of reportable laboratory results to public health agencies and the actual submission where it can be received. | Infrastructure to securely transmit laboratory results from any hospital laboratory to the appropriate public health agency in a specified standard format. |
| 9. Capability to provide electronic syndromic surveillance data to public health agencies and the actual transmission according to applicable law and practice. | Infrastructure to securely transmit relevant clinical data from any hospital or outpatient facility to the appropriate public health agency in a specified standard format, including de-identification of the data, if required |
| 10. Generate lists of patients by specific condition to use for quality improvement, reduction of disparities and outreach. | The required capability will enable secure transmission of clinical data from the source organization to the aggregating organization, as well as resolve patient-identity discrepancies in the data at the time they are requested or received. |
| 11. Report ambulatory quality measures to CMS or to states. | Accurate generation of ambulatory quality measures may require the electronic aggregation of clinical data from multiple organizations (as above). In this case, the same HIE capability is required as for #10 above. |

| Meaningful Use Criteria | Relevant HIE Capability |
|--|---|
| <p>12. Perform medication reconciliation at relevant encounters and each transition of care.</p> | <p>Accurate medication reconciliation may require the electronic aggregation of medication data from multiple organizations where care was received or medications dispensed, either via (1) an ongoing collection of data from various organizations into an EHR, disease registry or data warehouse, (2) a real-time distributed query to the various organizations holding the relevant patients' medication history data, or (3) a real-time query to a third-party organization that aggregates patients' medication history data. In each case, an infrastructure is required to securely transmit clinical data from the source organization to the aggregating organization and to resolve patient-identity discrepancies in the data at the time they are requested or received.</p> |

5.2.3 CONCLUSION

DHCS and its partners recognize that California's long-term HIT plan is a work in progress. We anticipate that this will be a living plan that will have future updates that will reflect the changes to the environment and lessons learned as we advance the use of EHRs in California. We look forward to this challenge and to working hand-in-hand with our partners and CMS to craft a strategy that will make California a model for the entire nation.