California State Medi-Cal Health Information Technology Plan- Appendices

October 2018

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APPENDICES

APPENDIX 1: SUMMARY OF RECENT HIT SURVEYS IN CALIFORNIA

Survey Name	Survey Administrator (s)	Organizations Surveyed	Geographic Scope	Sample	CA Response Rate	N	Survey Method	Yrs. Data Collected	Repeated in Future	Survey Interval	Survey instrument Available	Data Publically Available
National Ambulatory Medical Care Survey	Centers for Disease Control and Preventions	Office-Based Physicians	National	sample of office-based physicians	a		Mail, web, phone	2015	Yes	Annual	Yes	Yes
Study of Physician Use of HIT in California	University of California, San Francisco; California Medical Board of California	Physicians	CA	Random sample of physicians renewing medical license	NA	n/a	Paper, online	2013				
Study of Physician Use of HIT in California	University of California, San Francisco; California Medical Board of California	Physicians	CA	Random sample of physicians renewing medical license	NA	n/a	Paper, online	Jan-April 2011	Yes	Annual through 2013	Yes	Only in aggregate
Use of Electronic Records by Nurse Practitioners and Nurse Midwives	University of California, San Francisco; California Medicaid Research Institute	Nurse Practitioners and Nurse Midwives	CA	sample of members	54%	4862	Mail, web	2011-2012	n/a	n/a	Yes	Yes
Landscape Assessment Summary Report	McKinsey&Company; The Lewin Group	Physicians	CA	sample	NA	n/a	a	2010	n/a	n/a	No	Yes
Adoption of Electronic Health Records Systems among U.S. Non-Federal Acute Care Hospitals: 2008-2015	American Hospital Association	Hospitals	National	National	61%	320	Mail, web, phone	2008-2015	Yes	Annual	No	Yes
Adoption of Certified Electronic Health Records Systems and Electronic Information Sharing in Physician Offices: United States, 2013 and 2014	Centers for Disease Control and Preventions	Office-Based Physicians	National	Random sample	a	a	Mail, phone	2013-2014	Maybe	Annual	No	Yes
California Primary Care Association Survey	California Primary Care Association	Community Clinics and Health Centers	CA	sample of member and non-members	a	a	a	2014	No	n/a	a	No
The Availability of Electronic Health Records in California Physician Practices	University of California, San Francisco	Physicians	CA	sample of member			mail	June-July 2013	a	a	Yes	Yes
Health Information Technology (HIT) Landscape Survey	California Primary Care Association	Community Clinics and Health Centers	CA	sample of member and non-members	a	120	a	2012	No	n/a	a	Yes

Survey Name	Survey Administrator (s)	Organizations Surveyed	Geographic Scope	Sample	CA Response Rate	N	Survey Method	Yrs. Data Collected	Repeated in Future	Survey Interval	Survey instrument Available	Data Publically Available
Progress Towards Meaningful Use Among Critical Access and Other Small Rural Hospitals Working with Regional Extension Centers	Health Resources and Services Administration	Critical Access and Small Rural Hospitals	National	Universe	a	a	ONC CRM Tool and National Critical Access Hospital Database	2012	a	n/a	No	Yes
Health Information Technology In California: Milestones and Miles to Go	University of California, Centers for Disease Control and Prevention's National Center for Health Statistics, Health Resources and Services Administrations, American Hospital Associations, SK&A, Healthcare Information and Management Systems Society	Physicians, Acute Care and Ambulatory Facilities, Hospitals, Health Centers						2010-2013	a	n/a	No	Yes
Health Information Technology in California Dental Practices: Survey Findings	California HealthCare Foundation	Dentists	CA	sample of members	3.7%	19534	email, mail	Jan - April 2010	a	n/a	No	Yes
Meaningful Use Survey for Dentists	Department of Health Care Services	Dentists	CA	sample of participating dentists	12%		web-based survey	Oct-Dec 2017	a	n/a	No	Yes

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APPENDIX 2: MEDICAL BOARD SURVEY ON EHR USE

Dear Physician,

The Medical Board of California (MBC), in conjunction with a team of experienced researchers from the University of California, San Francisco (UCSF), is seeking information regarding physician practices in California. You have been randomly selected to answer a few questions regarding the characteristics of your practice and your use of electronic health records. Your responses to these questions are critical in forming public policy. The information you provide is voluntary and confidential and will not affect the timing or any other aspect of your license renewal. It will be analyzed by the research team at UCSF. Findings will be presented only in aggregate. No personal or identifying information will be shared with payers or other parties.

We would greatly appreciate your answering the following questionnaire and including your responses, along with your other license renewal information, in the envelope provided. Alternatively, if you are completing your renewal on line, you may submit your responses through the Web site. The study questions have been reviewed and approved by the MBC and UCSF's Committee on Human Research.

Debbie Nelson
Medical Board of California
(916) 263-2480

Janet Coffman, PhD
University of California, San Francisco
(415) 476-2435

Please answer each question by completely shading the appropriate circle like this ●

1. PRACTICE SETTING *What is your principal practice location? (check only one)*

Medical office: Solo practice	○	Kaiser Permanente	○
Medical office: Small medical partnership (2 to 9 physicians)	○	Community health center/public clinic	○
Medical office: Group practice (10 to 49 physicians)	○	VA or military	○
Medical office: Large group practice (50+ physicians)	○	Other (specify _____)	○

2. PRACTICE TYPE *Of the time you devote to patient care (100%), what percentage of time do you provide care in each of the following settings?*

	Ambulatory care	Inpatient care	Emergency department	Diagnostic services (e.g., radiology, pathology)	Other
0%	○	○	○	○	○
1 to 19%	○	○	○	○	○
20 to 39%	○	○	○	○	○
40 to 59%	○	○	○	○	○
60 to 79%	○	○	○	○	○
89 to 89%	○	○	○	○	○
90 to 100%	○	○	○	○	○

3. PAYERS *Of your total number of patients (100%), what percentage are:*

	Private, commercial, other insurance	Medicare	Medi-Cal	Healthy Families	Other (e.g., VA, CHAMPUS)	Uninsured
0%	○	○	○	○	○	○
1 to 9%	○	○	○	○	○	○
10 to 19%	○	○	○	○	○	○
20 to 29%	○	○	○	○	○	○
30 to 39%	○	○	○	○	○	○
40 to 49%	○	○	○	○	○	○
50 to 59%	○	○	○	○	○	○
60 to 69%	○	○	○	○	○	○
70 to 79%	○	○	○	○	○	○
80 to 89%	○	○	○	○	○	○
90 to 99%	○	○	○	○	○	○
100%	○	○	○	○	○	○

4. INCENTIVES FOR HEALTH IT USE

In 2011, Medicare and Medi-Cal will begin offering financial incentives for physicians to adopt, implement, or upgrade computerized medical records systems (also known as electronic health records or electronic medical

records) and use them meaningfully in practice. Do you or your principal practice organization plan to apply for these incentive payments? Please check only ONE answer from the list below.

- I intend to apply for incentive payments but uncertain whether Medicare or Medi-Cal ○
- I intend to apply for the Medicare incentive ○
- I intend to apply for the Medi-Cal incentive ○
- I do not at this time plan to apply for either incentive or need more information to make a decision ○
- I am not eligible for either the Medicare or the Medi-Cal incentive ○

5. USE OF COMPUTERS IN YOUR MAIN PRACTICE LOCATION *Does your main practice site have a computerized medical records system?* Yes ○ No ○ Don't know ○

***If you answered "Yes",** please answer the following questions about the (A) **availability of features** of your main practice site's computerized medical records system and (B) **the extent to which you use features**.*

	Part I — Availability of Features			Part II — Use of Features			
	No	Do not Know	Yes	Do not use	Use *some* of the time	Use *most or all* of the time	Not applicable to my practice or specialty
a. Patient demographics (e.g., race/ethnicity)	○	○	○ → Go to Part II	○	○	○	○
b. Clinical notes (e.g., office visit notes)	○	○	○ → Go to Part II	○	○	○	○
c. Patient problem list/summary	○	○	○ → Go to Part II	○	○	○	○
d. Lists of medications each patient takes	○	○	○ → Go to Part II	○	○	○	○
e. List of medication allergies	○	○	○ → Go to Part II	○	○	○	○
f. Ordering and transmitting prescriptions electronically	○	○	○ → Go to Part II	○	○	○	○
g. Ordering laboratory tests	○	○	○ → Go to Part II	○	○	○	○
h. Viewing or receiving laboratory test results	○	○	○ → Go to Part II	○	○	○	○
i. Ordering radiology tests	○	○	○ → Go to Part II	○	○	○	○
j. Viewing printed records of radiology test results	○	○	○ → Go to Part II	○	○	○	○
k. Viewing images from radiology tests	○	○	○ → Go to Part II	○	○	○	○
l. Generating lists of patients by specific condition	○	○	○ → Go to Part II	○	○	○	○
m. Generating routine reports of quality indicators	○	○	○ → Go to Part II	○	○	○	○
n. Transmit information electronically to entities outside your practice to which you frequently refer patients OR from which patients are referred to you?	○	○	○ → Go to Part II	○	○	○	○
o. Transmitting data to immunization registries?	○	○	○ → Go to Part II	○	○	○	○
p. Patients able to access their own electronic record	○	○	○ → Go to Part II	○	○	○	○

Appendix A. Survey Instrument

Dear Physician,

The University of California, San Francisco (UCSF) and its team of experienced researchers, with the assistance of the Medical Board of California (MBC), is seeking information regarding physician practices in California. Your responses to these questions are critical in forming public policy. Your participation in this endeavor is voluntary and the information will be treated confidentially and will not affect the timing or any other aspect of your license renewal. The supplied information will be analyzed by the research team at UCSF and the findings will be presented only in aggregate. No personal or identifying information will be shared with payers or other parties, and a specified protocol will be followed to safeguard the information you provide. The UCSF research team may contact your office to confirm some of the information you supplied.

We would greatly appreciate your answering the following questionnaire and including your responses, along with your other license renewal information, in the envelope provided. Alternatively, if you are completing your renewal on line, you may submit your responses through the Web site. The study questions have been reviewed and approved by the MBC and UCSF's Committee on Human Research.

Janet Coffman, PhD, Associate Professor
University of California, San Francisco
(415) 476-2435

Natalie Lowe
Medical Board of California
(916) 263-2382

Please answer each question by completely shading the appropriate circle like this ●

1. USE OF COMPUTERS IN YOUR MAIN PRACTICE LOCATION *Does your main practice location have a computerized medical records system (also known as an electronic health record or an electronic medical record)?*

Yes ○ ***See below*** No ○ ***Go to Question 3*** Do Not Know ○

If you answered "Yes" above, please answer the following questions about your main practice location's computerized medical records system. **If a feature is available, please indicate to what extent you use it.**	***YES, the feature is available***				***NO, the feature is not available***	***DO NOT KNOW***
	Do not use	*Use some of the time*	*Use most or all of the time*	*Not applicable to my practice or specialty*		
a. Patient demographics (e.g., race/ethnicity)	○	○	○	○	○	○
b. Clinical notes (e.g., office visit notes)	○	○	○	○	○	○
c. Patient problem list/summary	○	○	○	○	○	○
d. List of medications patient takes	○	○	○	○	○	○
e. List of medication allergies	○	○	○	○	○	○
f. Ordering and transmitting prescriptions electronically	○	○	○	○	○	○
g. Ordering laboratory tests	○	○	○	○	○	○
h. Viewing or receiving laboratory test results	○	○	○	○	○	○
i. Ordering radiology tests	○	○	○	○	○	○
j. Viewing printed records of radiology test results	○	○	○	○	○	○
k. Viewing images from radiology tests	○	○	○	○	○	○
l. Generating lists of patients by specific condition	○	○	○	○	○	○
m. Generating routine reports of quality indicators	○	○	○	○	○	○
n. Transmitting information electronically to entities outside your practice to which you frequently refer patients OR from which patients are referred to you	○	○	○	○	○	○
o. Transmitting data to immunization registries	○	○	○	○	○	○
p. Patients able to access their own electronic record	○	○	○	○	○	○

2. SATISFACTION *If you answered "Yes" to Question 1, how satisfied are you with the computerized medical records system at your main practice location.*

Very satisfied ○ Somewhat satisfied ○ Somewhat dissatisfied ○ Very dissatisfied ○ ***Go to Question 4***

3. IF YOU DO NOT NOW HAVE A COMPUTERIZED MEDICAL RECORDS SYSTEM AT YOUR MAIN PRACTICE LOCATION *Does your practice plan to purchase one within the next 2 years?* Yes ○ No ○ Undecided ○

4. INCENTIVES FOR EHR USE *In 2011, Medicare and Medi-Cal began offering financial incentives for physicians to adopt, implement, or upgrade computerized medical records systems (also known as electronic health records or electronic medical records) and use them meaningfully in practice. Please check only ONE answer from the list.*

I have registered for the Medi-Cal incentive. ○ ***Go to Question 6***

I have registered for the Medicare incentive. ○ ***Go to Question 6***

I plan to register for the Medi-Cal incentive. ○ ***Go to Question 6***

I plan to register for the Medicare incentive. ○ ***Go to Question 6***

I plan to register for incentive payments but am uncertain as to whether Medicare or Medi-Cal. ○ ***Go to Question 6***

I do not plan to register for either the Medi-Cal or the Medicare incentive. ○ ***Go to Question 5***

5. REASONS FOR NOT REGISTERING *If you do not plan to register for either the Medi-Cal or Medicare incentive, please indicate why not.*

Do not plan to use an EHR ○ Money provided not sufficient ○ Do not believe I am eligible ○ Other reason ○

6. PRACTICE TYPE *What is your principal practice location? (check only one)*

Solo practice	○	Kaiser Permanente	○
Small medical partnership (2 to 9 physicians)	○	Community health center/public clinic	○
Group practice (10 to 49 physicians)	○	VA or military	○
Large group practice including academia (50+ physicians)	○	Other (specify _____)	○

7. TIME SPENT IN HOSPITAL SETTINGS *Do you spend 90% or more of your time in hospital settings (inpatient or emergency department)?*

Yes ○ No ○

8. PATIENT AGES *What percentages of your patients are in the following age groups? (write in percentages, total should sum to 100%.)*

Age 0-17 Years	Age 18-64 Years	Age 65 Years or Older	Total
_____ +	_____ +	_____ =	100%

9. PAYERS *Of your total number of patients (100%), what percentage are:*

	Private, commercial, other insurance	Medicare	Medi-Cal	Healthy Families	Other (e.g., VA, CHAMPUS)	Uninsured
0%	○	○	○	○	○	○
1 to 9%	○	○	○	○	○	○
10 to 19%	○	○	○	○	○	○
20 to 29%	○	○	○	○	○	○
30 to 39%	○	○	○	○	○	○
40 to 49%	○	○	○	○	○	○
50 to 59%	○	○	○	○	○	○
60 to 69%	○	○	○	○	○	○
70 to 79%	○	○	○	○	○	○
80 to 89%	○	○	○	○	○	○
90 to 99%	○	○	○	○	○	○
100%	○	○	○	○	○	○

APPENDIX 3: HRSA HIT FUNDING

HEALTH CENTER CONTROLLED NETWORK GRANTS (H2Q)

Grantee Name	Program Name	Financial Assistance	Award Year	Grant Project Period End Date
Coalition of Orange County Community Clinics	Health Center Controlled Networks (H2Q)	$500,000.00	2016	07/31/2019
Coalition of Orange County Community Clinics	Health Center Controlled Networks (H2Q)	$500,000.00	2017	07/31/2019
Coalition of Orange County Community Clinics	Health Center Controlled Networks (H2Q)	$500,000.00	2018	07/31/2019
COMMUNITY CLINIC ASSOCIATION OF LOS ANGELES COUNTY	Health Center Controlled Networks (H2Q)	$625,000.00	2013	07/31/2016
COMMUNITY CLINIC ASSOCIATION OF LOS ANGELES COUNTY	Health Center Controlled Networks (H2Q)	$1,041,667.00	2015	07/31/2016
COMMUNITY CLINIC ASSOCIATION OF LOS ANGELES COUNTY	Health Center Controlled Networks (H2Q)	$625,000.00	2014	07/31/2016
COMMUNITY CLINIC ASSOCIATION OF LOS ANGELES COUNTY	Health Center Controlled Networks (H2Q)	$1,250,000.00	2016	07/31/2019
COMMUNITY CLINIC ASSOCIATION OF LOS ANGELES COUNTY	Health Center Controlled Networks (H2Q)	$1,250,000.00	2017	07/31/2019
COMMUNITY CLINIC ASSOCIATION OF LOS ANGELES COUNTY	Health Center Controlled Networks (H2Q)	$1,250,000.00	2018	07/31/2019
Council of Community Clinics	Health Center Controlled Networks (H2Q)	$400,000.00	2013	07/31/2016
Council of Community Clinics	Health Center Controlled Networks (H2Q)	$666,667.00	2015	07/31/2016
Council of Community Clinics	Health Center Controlled Networks (H2Q)	$400,000.00	2014	07/31/2016
Council of Community Clinics	Health Center Controlled Networks (H2Q)	$500,000.00	2016	07/31/2019
Council of Community Clinics	Health Center Controlled Networks (H2Q)	$500,000.00	2017	07/31/2019
Council of Community Clinics	Health Center Controlled Networks (H2Q)	$500,000.00	2018	07/31/2019
Golden Valley Health Centers	Health Center Controlled Networks (H2Q)	$475,000.00	2013	07/31/2016
Golden Valley Health Centers	Health Center Controlled Networks (H2Q)	$791,667.00	2015	07/31/2016
Golden Valley Health Centers	Health Center Controlled Networks (H2Q)	$475,000.00	2014	07/31/2016
REDWOOD COMMUNITY HEALTH COALITION	Health Center Controlled Networks (H2Q)	$500,000.00	2016	07/31/2019
REDWOOD COMMUNITY HEALTH COALITION	Health Center Controlled Networks (H2Q)	$500,000.00	2017	07/31/2019
REDWOOD COMMUNITY HEALTH COALITION	Health Center Controlled Networks (H2Q)	$500,000.00	2018	07/31/2019
REDWOOD COMMUNITY HEALTH NETWORK	Health Center Controlled Networks (H2Q)	$400,000.00	2013	07/31/2016
REDWOOD COMMUNITY HEALTH NETWORK	Health Center Controlled Networks (H2Q)	$666,667.00	2015	07/31/2016
REDWOOD COMMUNITY HEALTH NETWORK	Health Center Controlled Networks (H2Q)	$400,000.00	2014	07/31/2016
United Health Centers of The San Joaquin Valley	Health Center Controlled Networks (H2Q)	$500,000.00	2016	07/31/2019
United Health Centers of The San Joaquin Valley	Health Center Controlled Networks (H2Q)	$500,000.00	2017	07/31/2019
United Health Centers of The San Joaquin Valley	Health Center Controlled Networks (H2Q)	$500,000.00	2018	07/31/2019
		$16,716,668.00		

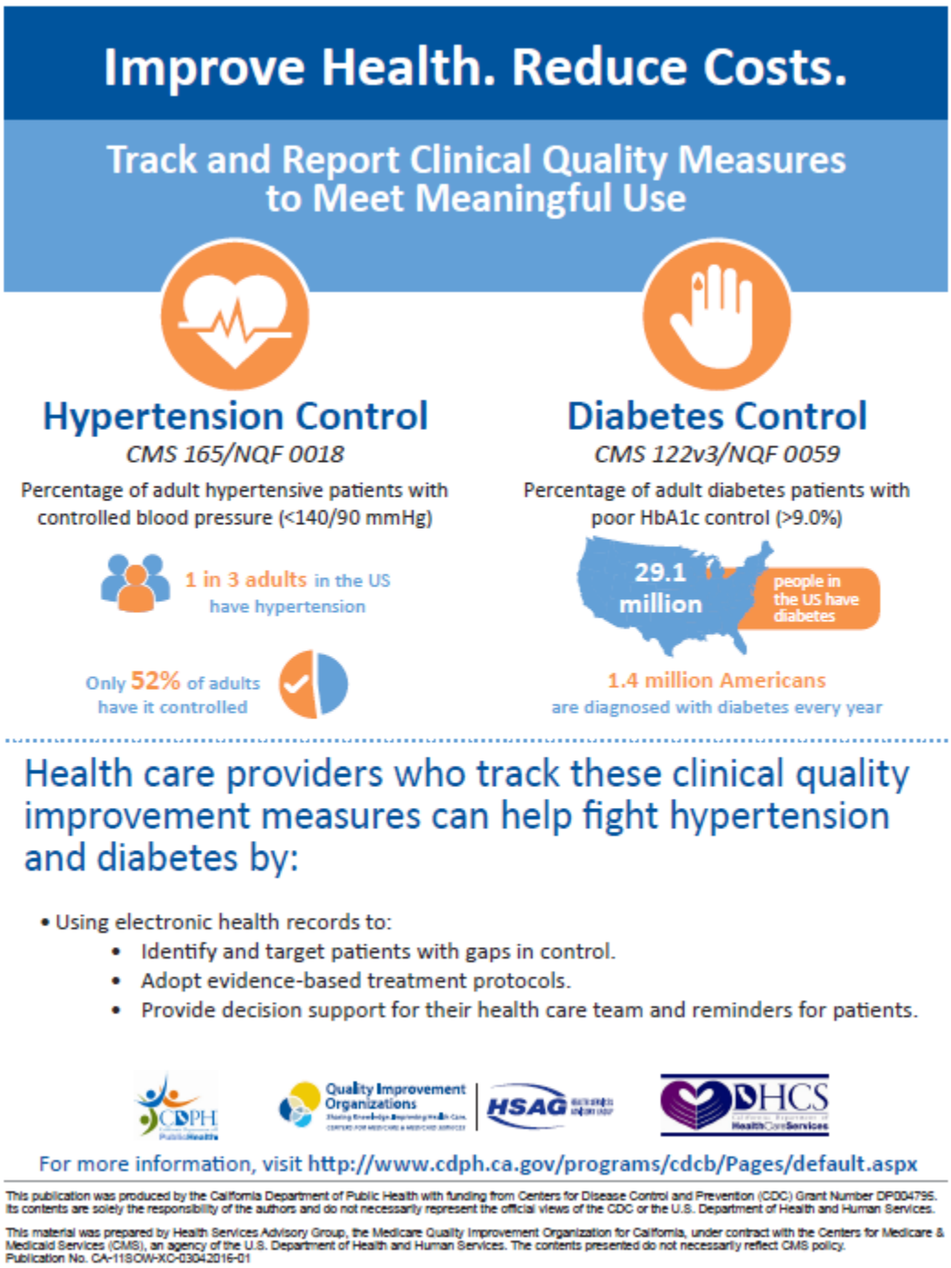
RURAL HEALTH INFORMATION TECHNOLOGY WORKFORCE (R01) GRANTS

Grantee Name	Program Name	Financial Assistance	Award Year	Grant Project Period End Date
LIVINGSTON COMMUNITY HEALTH	Rural Health Information Technology Workforce Program (R01)	$300,000.00	2013	08/31/2016
LIVINGSTON COMMUNITY HEALTH	Rural Health Information Technology Workforce Program (R01)	$300,000.00	2015	08/31/2016
LIVINGSTON COMMUNITY HEALTH	Rural Health Information Technology Workforce Program (R01)	$300,000.00	2014	08/31/2016
		$900,000.00		

SMALL HEALTH CARE PROVIDER QUALITY IMPROVEMENT (G20) GRANT

Grantee Name	Program Name	Financial Assistance	Award Year	Grant Project Period End Date
ADVENTIST HEALTH SYSTEM/WEST	Small Health Care Provider Quality Improvement (G20)	$199,141.00	2016	07/31/2019
ADVENTIST HEALTH SYSTEM/WEST	Small Health Care Provider Quality Improvement (G20)	$195,173.00	2017	07/31/2019
ADVENTIST HEALTH SYSTEM/WEST	Small Health Care Provider Quality Improvement (G20)	$199,935.00	2018	07/31/2019
Altura Centers For Health	Small Health Care Provider Quality Improvement (G20)	$150,000.00	2013	07/31/2016
Altura Centers For Health	Small Health Care Provider Quality Improvement (G20)	$175,000.00	2014	07/31/2016
Altura Centers For Health	Small Health Care Provider Quality Improvement (G20)	$150,000.00	2015	07/31/2016
Clinicas De Salud Del Pueblo, Inc.	Small Health Care Provider Quality Improvement (G20)	$150,000.00	2013	07/31/2016
Clinicas De Salud Del Pueblo, Inc.	Small Health Care Provider Quality Improvement (G20)	$150,000.00	2014	07/31/2016
Clinicas De Salud Del Pueblo, Inc.	Small Health Care Provider Quality Improvement (G20)	$150,000.00	2015	07/31/2016
Hi-desert Memorial Health Care District	Small Health Care Provider Quality Improvement (G20)	$200,000.00	2016	07/31/2019
Hi-desert Memorial Health Care District	Small Health Care Provider Quality Improvement (G20)	$200,000.00	2017	07/31/2019
Hi-desert Memorial Health Care District	Small Health Care Provider Quality Improvement (G20)	$200,000.00	2018	07/31/2019
Mountain Health & Community Services, Inc.	Small Health Care Provider Quality Improvement (G20)	$200,000.00	2016	07/31/2019
Mountain Health & Community Services, Inc.	Small Health Care Provider Quality Improvement (G20)	$200,000.00	2017	07/31/2019
Mountain Health & Community Services, Inc.	Small Health Care Provider Quality Improvement (G20)	$200,000.00	2018	07/31/2019
QUARTZ VALLEY INDIAN RESERVATION	Small Health Care Provider Quality Improvement (G20)	$148,810.00	2013	07/31/2017
QUARTZ VALLEY INDIAN RESERVATION	Small Health Care Provider Quality Improvement (G20)	$149,267.00	2014	07/31/2017
QUARTZ VALLEY INDIAN RESERVATION	Small Health Care Provider Quality Improvement (G20)	$149,622.00	2015	07/31/2017
		$3,166,948.00		

APPENDIX 4: PUBLIC HEALTH BROCHURE



Improve Health. Reduce Costs.

Track and Report Clinical Quality Measures to Meet Meaningful Use

Flu Immunizations
CMS 147v2/NQF 0041

Colorectal Cancer Screening
CMS 130v2/NQF 0034

Just like the flu, colorectal cancer is **preventable**, **treatable**, and **beatable** when found **early**.

2nd leading cause of cancer death in CA for women and men combined

Five-year survival rate in CA is 92% when detected early

But only 42% of colorectal cancers are detected early

Health care providers who track these clinical quality improvement measures can help prevent the flu and colorectal cancer by:

- Identifying and targeting patients eligible for flu shot and colorectal cancer screening test.
- Distributing the Colorectal Cancer Fecal Immunochemical Test (FIT) to the patient when getting their flu shot.
- Adopting standardized screening reminder protocols.
- Implementing algorithms within electronic health systems that assure patients are being reminded to get screened and obtain their flu shot.

Screen your patients. It could save their lives!

APPENDIX 5: CALIFORNIA EHEALTH PARTNERS/ORGANIZATIONS

(Asterisks denotes program received ARRA/HITECH funding)*

Beacon Grantee—UC San Diego*

The Beacon Community Cooperative Agreement Program provided funding to communities to build and strengthen their health information technology (health IT) infrastructure and exchange capabilities to demonstrate the vision of the future where hospitals, clinicians and patients are meaningful users of health IT, and together the community achieves measurable improvements in health care quality, safety, efficiency, and population health. The UC San Diego Health System received a $15 million grant aimed at partnering with local health entities to improve patient care, safety and efficiency through information technology in the San Diego community.
For more information, go to the University of California, San Diego News Center.

Cal eConnect*

Cal eConnect was the governance entity designated by the state to provide leadership and implement, with public input, Strategic and Operational Plans already developed by the state. Cal eConnect was also charged with developing a sustainable business model, establishing ground rules and policies to ensure safety and security within HIE, engaging patients (particularly those who are vulnerable and underserved), identifying core HIE services, and arranging for provision of such services.
(*No website available).*

Cal eRx

Cal eRx was an organization promoting e-prescribing (eRx) as part of an electronic health record (EHR) as the standard of care. Its objectives were to inform a statewide plan in order increase provider adoption of e-prescribing, promote payer provision of eligibility and other information, increase pharmacy productivity, and raise confidence and demand amongst consumers and purchasers.
(*No website available).*

CalHIPSO*

Founded by clinical providers from the California Medical Association, the California Primary Care Association, and the California Association of Public Hospitals & Health Systems, the California Health Information Partnership and Services Organization (CalHIPSO) is a non-profit organization that offers a variety of programs and services designed to help clinical providers transition from a paper-based practice to one that successfully uses electronic health records. CalHIPSO is responsible for a wide range of activities related to identifying and signing up physicians for EHRs, vendor vetting, workforce development, regulatory activities, reporting, developing and implementing privacy and security best practices, and group purchasing. CalHIPSO provides services to all of California, except for Los Angeles and Orange counties.

California Department of Public Health

The California Department of Public Health (CDPH) is working together with state departments, agencies, local health departments, and other organizations to establish safe and secure health information exchange. Our departmental goal is to align public health programs to meet federal requirements for MU. We are assessing programs to be able to receive electronic laboratory and syndromic surveillance data from eligible providers and hospitals. We are also researching solutions to improve immunization information exchange between providers and immunization registries within the state. In addition, CDPH is continuing to identify public health programs that are impacted by MU and to explore implications to improve public health efficiencies and outcomes.

California Health Workforce Alliance (CHWA)*

The California Health Workforce Alliance (CHWA) seeks to develop and support activities that will educationally and professionally develop more than one million persons. Through a public-private partnership to implement strategies to meet California's emerging health workforce needs, the alliance will link state, regional, and institutional workforce initiatives to reduce duplicated efforts, develop a master plan, and advance current health workforce needs. In the next 30 years, CHWA will develop initiatives that educationally and developmentally prepare more than one million healthcare workers.

California Telehealth Network (CTN)*

The California Telehealth Network (CTN) is a program funded by the Federal Communication Commission's Rural Health Care Program. Its aim is to significantly increase access to acute, primary and preventive health care in rural America through the use of telecommunications in healthcare settings.

California Office of Health Information Integrity (OHII)*

The California Office of Health Information Integrity (CalOHII) develops new privacy and security standards to enable the adoption and application of HIE in California. CalOHII is also engaged in the expansion of broadband throughout California, the implementation of telehealth, and providing support to the Health Information Technology Financing study. Facilitated by CalOHII, the Privacy and Security Advisory Board (PSAB) develops and recommends the new standards. Adoption of privacy and security standards for HIE will ensure that a person's critical health information can move safely and securely to the point of care.

CalOptima Regional Extension Center (COREC)*

Through a $4.6 million federal grant, CalOptima will serve as Orange County's Regional Extension Center (REC), providing education and technical assistance to primary care physicians as they make the move to the new technology.

CAHIE

The California Association of Health Information Exchanges (CAHIE) is an association of individuals and organizations focused on securely sharing health information in pursuit of the triple aim. CAHIE was formed to promote collaboration to solve difficult policy and technology problems, and to facilitate statewide health information sharing through voluntary self-governance. CAHIE developed the California DURSA, a multi-party data sharing agreement which allows participants to interoperate using recognized standards and launched the California Trusted Exchange Network (CTEN).

eHealth Coordinating Committee*

The eHealth Coordinating Committee was a multi-stakeholder committee created to coordinate various HITECH and eHealth initiatives. The Coordinating Committee, with counsel from five workgroups, identified services that may be shared by participants and propose plans to fund and coordinate their delivery. This body's goal was to identify barriers to success for the various partners and propose solutions, providing direct assistance where possible and desired.
(*No website available)*

eHealth Advisory Board

The eHealth Advisory Board supports coordinated and collaborative efforts among a diversity of healthcare stakeholders to adopt HIT, exchange health information, and develop and comply with statewide policy guidelines. The Board also seeks to maximize California's competitiveness in applying for federal HIE implementation funding and ensure accountability and transparency in the expenditure of public funds. Finally, the Board aims to improve public health using health information exchange through stronger public health surveillance and emergency response capabilities.
(*No website available)*

HITEC-LA*

HITEC-LA is the exclusive federally-designated HIT Regional Extension Center (REC) for Los Angeles County, 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.

Medi-Cal EHR Incentive Program*

The Health Information Technology for Economic and Clinical Health Act (HITECH Act) established programs under Medicare and Medicaid to provide incentive payments to eligible professionals and eligible hospitals as they demonstrate meaningful use of certified EHR technology. Beginning in 2011, eligible Medi-Cal providers and hospitals will be able to receive incentive payments to assist in purchasing, installing, and using electronic health records in their practices. Additional program information is available on the State Level Registry for the Medi-Cal EHR Incentive Program.

Object Health

Object Health is a consulting group that assists health care organizations, communities, and government agencies adopt and implement health information technologies to improve the effectiveness of community health care delivery. Object Health is a service partner of HITEC-LA.

Western Regional HIT Consortium*

To address the need for qualified healthcare workers, the Western Regional HIT Consortium worked to rapidly create or expand health IT academic programs at community colleges in the Western region, consisting of Arizona, California, Hawaii, and Nevada. Efforts included educating health IT professionals that facilitated the implementation and support of EHRs.
(No website available)

APPENDIX 6: STATE OF CALIFORNIA HIE: THE LEGACY OF CALIFORNIA'S STATE HIE COOPERATIVE AGREEMENT PROGRAM

January 2014

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Look for the video icon throughout this report for commentary from California HIE leaders.

About the Report

By enabling providers and patients to securely share personal health information electronically, when and where it is needed for care, health information exchange (HIE) holds great promise for improving health care quality, safety, and efficiency in California and nationally. HIE is also a critical component for success of health care reform, public and population health management, patient engagement, and cost control.

In February 2010, the California Health and Human Services Agency was awarded a four-year, $38.8 million federal grant to encourage and fuel adoption of health information exchange throughout the state. Called the State Health Information Exchange Cooperative Agreement Program, the grant was part of the Health Information Technology for Economic and Clinical Health Act (HITECH).

This report highlights the lasting legacy of the unprecedented opportunity offered by the Cooperative Agreement. It is not meant as a comprehensive evaluation of the award's outcomes.[1] Rather, it describes major advancements and achievements in California that will have lasting impact and continue to stimulate HIE in California for years to come.

> The grant set in motion initial efforts necessary to make large-scale health information exchange possible.

[1] An evaluation for ONC of the California State HIE Cooperative Grant Program is being conducted by Robert H. Miller, PhD, Adjunct Professor of Health Economics, UC San Francisco.

Background

Although California received the largest Cooperative Agreement grant given to the 50 states, it was clear at the time of the award that it would not be sufficient to solve all the challenges associated with electronic exchange. The $38.8M represented less than .001 percent of what is spent on healthcare in California in a single year. However, the funding was critical to set in motion efforts necessary to initiate large-scale health information exchange.

The grant was awarded to the California Health and Human Services Agency and administered by the **California Office of Health Information Integrity** under the direction of the Deputy Secretary for HIE, who also serves as director of **CalOHII**. To administer much of the grant's programmatic requirements, CalOHII entered into an interagency agreement in mid-2011 with California Health eQuality (**CHeQ**), a program of UC Davis Health System's Institute for Population Health Improvement. Prior to the CHeQ agreement, Cal eConnect, a non-profit organization, was responsible for the programmatic work.

The Cooperative Agreement was not prescriptive as to governance, policy, or technology, giving states the ability to experiment with different models in determining solutions best suited to their particular environment and population.

While some states developed and operated single-solution statewide HIEs, California's size and diversity did not lend itself to one statewide exchange. Further, legislative policy and stakeholder preference called for a model that was limited in scope. The result was a privately driven, publicly assisted HIE infrastructure.

Public assistance through the Cooperative Agreement focused on:

- developing necessary technical and trust standards and agreements;
- providing grants to local health information organizations (HIOs) to expand and improve their operations;
- removing barriers to HIE interoperability;

California created a privately driven and publicly assisted HIE infrastructure.

- coordinating with Medi-Cal and other state and local public health programs to support meaningful use of electronic health records and population health management; and
- convening, educating, and informing HIE stakeholders.

Perhaps the most important stimulus to HIE in California has been the commitment of hundreds of volunteer public and private stakeholders from the California healthcare community, working in collaboration with CHHS. Through committees, work groups, webinars, and statewide summits, these stakeholders have shared ideas and provided feedback, encouragement, and support to each other; they have served as change agents within their own communities and healthcare organizations, encouraging culture change and a focus on patient needs over competitive concerns.

With this context in mind, the following summarizes significant changes and improvements resulting from the HITECH Cooperative Agreement that will have lasting impact on California's healthcare landscape.

Hear more about how California has benefited from the Cooperative Agreement from Pamela Lane, MS, RHIA, CPHIMS, Deputy Secretary Health Information Exchange, California Health and Human Services Agency.

Perhaps the most important stimulus to HIE in California has been the commitment of hundreds of volunteer public and private stakeholders.

Expansion and Strengthening of Community Health Information Organizations

Early in California's quest to make patients' records available electronically, stakeholders voiced a strong preference for a decentralized approach to HIE.[2] Because healthcare is provided at the local level, the prevailing sentiment was that each community is different and should develop systems that best meet their particular needs.

While California hospitals and integrated delivery systems have been steadily building their internal HIE capabilities, at the start of 2009 – a year before the federal grant was awarded – only one community health information organization was operational and three others were in various stages of development. At the end of 2013, eight HIOs were operational and nine were in various stages of development. The growth and strengthening of HIO presence is due in large part to HIE expansion grants provided since 2010 to individual community HIOs. Grants were targeted for HIE planning, infrastructure, innovation, and demonstration projects.

With the end of the federal funding in February 2014, HIOs will continue to evaluate ways to financially sustain themselves while continuing to seek engagement of a critical mass of providers. Communities are finding innovative ways of bringing HIE to local providers and patients. Some communities are choosing to sign on with an established HIO to provide exchange capability, as the San Joaquin HIE has done with the Inland Empire HIE. Others, such as SacValley MedShare, are starting their own HIO backed by committed provider organizations.

[2] California Health Information Strategic and Operational Plan, March 2010

> One of the State's top priorities has been to create a trust environment for clinicians to share patient information.

Hear more about the impact of grants on HIO growth and expansion from Robert (Rim) Cothren, PhD, former Technical Director, CHeQ; Executive Director, California Association of Health Information Exchanges.

Watch a visual dramatization of the growth of HIE/HIOs over the past 17 years in California.

Visit **chegpoint.org** for a snapshot of HIE activity around California.

Creation of a Trusted Environment for Information Sharing

One of California's top priorities has been to create a trust environment for clinicians to share patient information. A "trust framework" is necessary so that physicians and organizations that want to share information within California or nationally can do so, without having to to execute a point-to-point data agreement every time.

A Model Modular Participant Agreement (**MMPA**), developed with assistance from volunteer group of stakeholders, establishes minimum standards to enable both large and small organizations to efficiently set up legal data exchange agreements. While it's not possible to have a one-size-fits-all agreement, the MMPA includes legal agreement essentials necessary for data sharing. One HIO estimated that the model reduced the time for agreement development from seven months to less than two months, with a savings of up to $25,000 in legal expenses.

As part of the Cooperative Agreement grant, CHHS helped launch two organizations that will continue to provide guidance on trust and support working relationships and collaboration among healthcare organizations that need to share health information.

The California Association for Health Information Exchange

CAHIE grew out of a statewide group of community and enterprise HIO leaders -- many working for organizations that are traditionally competitors – who came together during 2013 to address gaps in interoperability and find solutions to ensuring safe and secure HIE throughout California.

With the support from CalOHII, participants have worked to establish a California trust framework, based on national standards and protocols for trusted exchange, and to create pathways that allow all providers to interoperate using Direct (to push data) and HealtheWay's eHealth Exchange (to query for information providers need).

CAHIE will continue working to establish a light-weight self-governance function for trusted exchange in California and address additional functions members require to achieve a trusted exchange relationship with each other, such as provider directories and patient matching.

National Association for Trusted Exchange

NATE is a national organization created to help state HIE officials establish standards and best practices, including the coordination of policy efforts to support interstate exchange. NATE grew out of the work of the Western States Consortium, of which California was a leading member and piloted interstate exchange with Oregon. As a member of NATE, California continues to provide leadership through identifying policy and governance drivers for interstate information exchange.

Hear how California's trust environment has evolved since 2010 from Robert (Rim) Cothren, PhD, formerTechnical Director, CHeQ; Executive Director, California Association of Health Information Exchanges.

Privacy & Security Policy Direction Setting

California stakeholders have long been divided over the best way to promote and enhance the electronic movement of health information while still protecting Californians' constitutional right to privacy. Although many stakeholders pressed for legislation that would dictate a single patient consent policy, advancing a legislative solution was not within CalOHII's authority.

To learn more about the impact of different consent policies, CalOHII conducted **demonstrations projects** with three HIOs. Findings revealed the following: When offered the choice, a large majority of patients elect to share their health information electronically. Both opt-in and opt-out policies are effective means of managing consent when implemented as part of a comprehensive privacy and security framework. The success of a consent management policy depends on numerous factors, including provider engagement, training and education of provider and office staff, patient demographics, and HIE governance.

Both opt-in and opt-out policies have benefits and risks and the model chosen by an HIO and its participants is an individual business decision that reflects the organization's needs and business processes. No matter what the policy, keeping patients well informed about how their information will be shared and used is key.

Hear about the need to change the conversation about consent from CalOHII's Cassandra McTaggart, Chief, Health Information Policy & Standards Division.

It is critically important to change the conversation about consent.

Support for Electronic Health Record Adoption

Electronic health records (EHRs) are fundamental to building the HIE infrastructure. The federal Medicare and Medicaid **EHR Incentive Program** is aimed at encouraging providers and hospitals to adopt EHRs by offering financial incentives to upgrade or install and progressively use an EHR in a meaningful way. HIE functionality is necessary to demonstrate "meaningful use" at different "stages" of progress.

While the Cooperative Agreement did not directly fund EHRs, it enabled CalOHII to coordinate with the **Department of Health Care Services** and Regional Extension Centers[3] to leverage and support each other's efforts and help drive EHR adoption and meaningful use of health information technology and HIE.

As of November 2013, more than 10,000 Medi-Cal providers and 216 hospitals were using EHRs and had met meaningful use requirements to qualify for incentive payments totaling about $630 million. More than 28,000 California providers/hospitals participating in Medicare and Medicare Advantage EHR Incentive Programs administered by the federal Centers for Medicare & Medicaid Services (CMS) were using EHRs and had met meaningful use requirements qualifying for over $910 million in payments.

More robust convergence of EHR and HIE adoption is anticipated in the near future with the proposed Stage 3 meaningful use objectives, which require providers to exchange information across unaffiliated organizations and differing EHR technologies.

[3] There were three regional extension centers (RECs) in California: Health Information Technology Extension Center for Los Angeles (HITEC-LA), serving Los Angeles County, Cal Optima Regional Extension Center (COREC), serving Orange County, California Health Information Partnership and Services Organization (CalHIPSO) serving all counties except LA and Orange. In addition, the California Rural Indian Health Board, which is a sub-grantee of the National Indian Health Board (NIHB) served areas throughout the state.

Investing in improving public health information has long lasting impact for managing public and population health.

Support for Population Health Management: Registries and Gateway

Investing in improving public health information has long lasting impact for managing public and population health, such as tracking immunizations and patients with chronic diseases and cancer.

Among investments made by the Cooperative Agreement was an updated system for the California Department of Public Health (CDPH) to help providers meet meaningful use requirements for electronically submitting immunization data. The new California Immunization Gateway Service replaces a manual process for registering, testing, and submitting immunization data to the **California Immunization Registry** (CAIR).

Long term, the goal is to develop an integrated, statewide-computerized registry to network each child's full immunization history. The system will ensure that health care providers have rapid access to complete and up-to-date immunization records so they can avoid both missed opportunities to immunize and unnecessary duplicate immunizations.

By design, the technology used for the Immunization Gateway enabled CDPH to develop the **Health Information Exchange Gateway**, which improved CDPH's capabilities for data exchange, analysis, and reporting. CDPH exchanges data with a wide range of stakeholders, including clinicians, hospitals, laboratories, local public health jurisdictions, and federal agencies. The Gateway serves as a single point of entry for submitting data to many state public health programs, enabling providers and hospitals to meet meaningful use requirements of the EHR Incentive Program in the short term, and greatly improving efficiency of all submissions in the long term.

Hear more about the impact of the Gateways from Este Geraghty, MD, MPH, MS, Deputy Director, Center for Health Statistics and Informatics, California Department of Public Health.

Related to this effort is **Project INSPIRE**, based at UC Davis and funded by the Cooperative Agreement through the CHeQ program. The premise of Project INSPIRE is that the same key patient data elements that are useful for registries are also critical for good care of high impact conditions such as cancer. Project INSPIRE focuses on more efficiently and effectively capturing data at the point of care and creating a "health information home" for a longitudinal record "registry" that is accessible to all of a patient's providers.

Inputting data into disease registries has been a challenge with paper records. However, with the widespread adoption of EHRs, key data can be taken directly from the EHR and, with a few intermediate electronic steps, sent to the appropriate registry in nearly real time. Individual care outcomes will improve as clinicians gain a clearer view of their patients' conditions and can better coordinate care. Population health will improve as well when public health officials and researchers have access to de-identified patient data in the registries.

Hear more about the potential of Project INSPIRE from Mike Hogarth, MD, Professor of Pathology & Laboratory Science, School of Medicine, UC Davis.

Reforming the healthcare system and its payment schemes will rely on HIE for collecting, analyzing, and sharing data.

Increased ePrescribing Rates Through Pharmacy Education

California made adoption of electronic exchange of pharmacy data a priority. Increasing the rate of ePrescribing has long-term effects of improved accuracy, efficiency, and patient compliance monitoring.

The Partners in E program was funded to address the challenge of low ePrescribing rates among independent pharmacies. A survey revealed that many pharmacists do not feel technologically prepared to take on the processes of continual electronic communication and to tackle the technical dilemmas presented during the workday.

To drive interest and adoption, an innovative train-the-trainer program was developed. Students from California's eight schools of pharmacy provide one-on-one assistance to independent community pharmacists that serve large numbers of Medi-Cal patients. As of the end of 2013, nearly 1,000 pharmacy students had completed the program.

With its success attracting widespread recognition, Partners in E is collaborating with the Healthcare Information and Management Systems Society (HIMSS) and the American Association of Colleges of Pharmacy (AACP) to fill the critical gap in pharmacy education nationally.

Support for Emergency Medical Services' Adoption of HIE

The transfer of patients from ambulances to emergency rooms is one of the most critical and information-dependent points in healthcare. Hour-old information is considered useless. CalOHII and the State Emergency Medical Services Authority (EMSA) collaborated to make HIE an integral part of California's emergency medical services and enable real-time exchange of patient health information between providers in the field and healthcare facilities.

An environmental assessment funded by the Cooperative Agreement grant found that all the EMS providers that work with the state's 33 local EMS agencies are converting from paper to electronic patient care records. However, most are still in the early stages of being able to electronically transmit information about patients to the hospital where they are being transported. As yet, none are receiving information about patients' conditions after hospital admission, which could assist with care improvement.

The grant helped three local EMS agencies — Contra Costa, Monterey, and Inland Counties Emergency Medical Agency — carry out demonstration projects to advance HIE in their service areas and funded a two-day statewide summit, which sparked collaboration among EMS agencies and EMSA that will continue into the future.

Hear more about the importance of HIE to transforming pre-hospital care in California from Howard Backer, MD, MPH, FACEP, Director of the California Emergency Medical Services Authority (EMSA).

Support for Helping Patients Electronically Coordinate Their Care

A project funded in part by the Cooperative Agreement and administered by NATE is aimed at ensuring the successful transfer of provider-held medical data into a patient-controlled personal health record. **The PHR project** is focused on creating trust among providers of the information uploaded from a patient's PHR. This is an important step toward finding ways to speed health information exchange and address physicians' concerns that "patient mediated exchange" may not be complete or accurate. Patient choice to disclose data expedites receipt of the patient's records and simplifies compliance with privacy laws and rules. By making patient medical records more portable, communication can occur faster, patients become more engaged in their care, and they can coordinate their care online across multiple providers.

Support for Healthcare and Payment Reform

A variety of federal and state programs aimed at reforming the healthcare system and its payment schemes will rely on HIE for collecting, analyzing, and sharing data. The list includes Medicare payment reform, quality initiatives, Patient-Centered Medical Homes, Accountable Care Organizations, and Covered California, the state's health insurance exchange.

The HIE infrastructure created under the Cooperative Agreement -- and the timely information HIE will produce -- is critical to the success of two major California health and healthcare improvement initiatives. Governor Jerry Brown's **Let's Get Healthy California**, launched in December 2012, establishes six major goals and 39 health indicators to track California's progress toward becoming the healthiest state in the nation. California is participating in the State Innovation Models Initiative, a federally-funded program to plan, design, and test new payment and service delivery models aimed at improving health system and payment performance.

Under healthcare reform, healthcare financing is quickly moving away from fee-for-service and toward payment systems based on performance and value. Both health plans and physician organizations will benefit when data can be securely and easily shared and analyzed, an essential step in "pay for performance" (P4P). Shared data will also be necessary for other performance programs, including CMS's Medicare "Stars," which offers millions of dollars in incentive payments to Medicare Advantage health plans based on meeting performance measures. Through a grant to the Integrated Healthcare Association (**IHA**), physician organizations and health plans prepared for the new programs by evaluating the use of HIE and Direct query architecture for quality performance measurement and analysis.

Conclusion

It is clear that the HITECH HIE State Cooperative Agreement Program played an essential role in stimulating California's healthcare system's transition from an information poor culture to one in which information is rich, available, and useable. HIE has improved accountability, interdependency, and evidence-based treatment in California. HIE is making it possible to more easily and quickly measure and improve the quality of care. At the heart of every effort is the patient, who has always been the intended beneficiary of HIE.

Hear more about the impact of the HITECH Cooperative Agreement from Linette Scott, MD, MPH, Chief Medical Information Officer, California Department of Health Care Services.

This publication was made possible by Grant Number 90HT0029 from the Office of the National Coordinator for HIT.

APPENDIX 7: HIE/HIT POTENTIAL INITIATIVES AND DESCRIPTIONS

Potential Initiatives	Info Recipient	Potential Initiative Description
MyMedi-Cal v2.0	***Members***	Portal to allow members and designees to view their information regarding claims related data and encounter related information (if Managed Care Plan). This is not meant to replace a Provider or Provider Group EHR Portal. For Members who do not have access to an EHR Portal, this allows access only to claims related data and encounter data (as supplied by the Provider). Provides access to review a members own electronic health information for accuracy and completeness.
Medications Reconciliation	***Providers***	Medications Reconciliation initiative would send prescription claims information to the Providers EHR system (for load) or provide a secure portal for the Provider to login and review. The purpose is for Providers to meet MU requirements for the EHR Incentive Program, support care coordination, and be able to verify prescriptions they gave a Member were picked-up.
ProviderMyMedi-Cal	***Providers***	Access to member's information same as Member in the MyMedi-Cal initiative. Information available will be based on paid claims data and encounter data submitted. May provide information to Provider not available in their organization's EHR, such as prior to enrollment member care (based on treatment relationship established per HIPAA).
Provider Care Coordination	***Providers***	Temporary access by non-Medi-Cal providers, with member approval, to ProviderMyMedi-Cal information for that encounter. Will allow for better coordination of care, however does not usurp the Provider's responsibility to provide appropriate information to out of network Provider / Specialist as needed.
Rural Provider Support	***Providers***	For counties and rural providers where they do not have EHR systems, provide basic SaaS solution. Allows for gathering of claims, encounter data, CCD records electronically saving manual processing. Increases EHR adoption in low income areas.
CCD Records Information Base	***CHHS and DHCS***	Receive CCD records in ONC C-CDA standard for collection and analysis of information. See CHHS Internal Constituents. Would be used in Initiatives for: MyMedi-Cal, ProviderMyMedi-Cal, Provider Care Coordination and Rural Provider Support. CCD information also

Potential Initiatives	Info Recipient	Potential Initiative Description
		supports population health and program integrity functions.
Intra CHHS Agency Information Share	***CHHS and DHCS***	Receive available and applicable data for analysis from other departments in CHHS with member or provider Medi-Cal population data. Examples: OSHPD discharge data, CDPH immunization information.
Intra State Agencies Info Share	***CHHS and DHCS***	Information on Providers licensing and status, identify verification from Vital Records, DMV, DOJ Fraud investigation alerts, etc.
Inter State SMAs Info Share	***CHHS and DHCS***	Information on Providers, new Member enrollments / transfers, and shared population data in border areas.
Health Plan Population, Member information	***Health Plans***	Periodic updates (monthly) on Medi-Cal populations in Provider areas, and other information as available.
Health Plan Payments and Financial Information	***Health Plans***	Periodic updates of financial information for Health Plan Organizations.
Plan Requirements Compliance	***Health Plans***	Information on Health Plan Organization's performance and compliance to program requirements: quality of care, completeness and accuracy of CCD records and claims, and other data as identified.
Big Data, Analysis and Statistics	***CHHS Internal***	Use of CCD records, claims data, member and provider information for statistical analysis, fraud analysis (member and provider), quality of care, population trending and EHR information as required.
Medi-Cal Program Clinical Data Analysis	***CHHS Internal***	Shared clinical data and analysis with CHHS and CHHS Departments for the Medi-Cal Program.
Intra CHHS Member EHR information exchange	***CHHS Internal***	Cross Department Member (Patient) related ePHI information that is pertinent to improved quality of care and program management.
Federal Governance Reporting and eEHI	***CMS***	Medi-Cal Program Performance, Quality, Financial Forecasts, APDs, MITA SSA, and any other required reporting.
Federal Governance and Reporting	***DHS HIPAA***	HIPAA Compliance reporting. Use of analytics and CCD records for identifying and contributing to Medi-Cal compliance.
Federal Governance Reporting and eEHI	***CDC***	CDC reporting of specific member incidents that fall within CDC requirements. Coordination with CDPH. Examples may include an encounter record or CCD for

Potential Initiatives	Info Recipient	Potential Initiative Description
		outside Member's county of residence or State.
Member Case Management and Care Coordination	***Counties and other CA Agencies***	County Program Providers and County Social Services Providers to have access to pertinent information regarding Case Management for Medi-Cal Member. Access through ProviderMyMedi-Cal portal. Includes Medication Reconciliation access as part of initiation roll-out.
Member updates	***Vital Records, DMV, CDPH***	Updates cross Agency on Member deaths and births for audit and cross-reference as well as Public Health episode tracking.
Member Transfer to another State (SMA)	***SMA outside CA (State Medicaid Administrator)***	Notification by other SMA of new member enrollment or member transfer (CA in and out identified) to CA Medi-Cal Administration of eligibility transition. DHCS to provide info to current providers through provider portal or EHR system.
Provider Care Transition	***SMA outside CA***	Provider to Provider communication of Member care is primary process. Medi-Cal to provide temporary access to new SMA Provider ProviderMyMedi-Cal for Member as compliant with HIPAA.
Out of State Treatment Encounter	***SMA outside CA***	Temporary access for out of State Provider to ProviderMyMedi-Cal for specific encounter treatment. Requires appropriate authorization, authentication and HIPAA compliance.

APPENDIX 8: CLINICAL QUALITY MEASURE (CQM) DATA 2012-2016

For CQM definitions and details, please visit the eCQI Resource Center

Please go to next page for CQM data table.

Responses where the Denominator equals zero, and/or where Performance Rate is greater than 100% were omitted from these counts. For 2012 and 2013, Performance Rates were manually calculated.
Population performance rate: performance rate for the measure weighted by the number of patients reported by each provider.
Average provider performance rate: average performance rate reported by providers not weighted for the number of patients reported for the measure.

Clinical Quality Measures	2012				2013				2014				2015				2016 (Incomplete. Data through 4/27/17, 2016 deadline was			
	# Providers Reporting	Avg. # Patients Reported	Population Performance Rate	Average Provider Performance Rate	# Providers Reporting	Avg. # Patients Reported	Population Performance Rate	Average Provider Performance Rate	# Providers Reporting	Avg. # Patients Reported	Population Performance Rate	Average Provider Performance Rate	# Providers Reporting	Avg. # Patients Reported	Population Performance Rate	Average Provider Performance Rate	# Providers Reporting	Avg. # Patients Reported	Population Performance Rate	Average Provider Performance Rate
CMS (NA) / NQF 0001	342	27.7	41%	15%	652	54.7	23%	20%	181	25.3	9%	14%	-	-	-	-	-	-	-	-
CMS (NA) / NQF 0012	21	135.7	87%	60%	42	227.7	67%	65%	2	21.5	86%	50%	-	-	-	-	-	-	-	-
CMS (NA) / NQF 0013	1215	116.6	88%	89%	2555	172.5	84%	92%	1131	86.4	89%	95%	-	-	-	-	-	-	-	-
CMS (NA) / NQF 0014	4	16.5	100%	100%	8	31.9	65%	61%	-	-	-	-	-	-	-	-	-	-	-	-
CMS (NA) / NQF 0027 - Numerator 1	182	644.3	15%	19%	500	502.0	17%	19%	124	663.4	19%	18%	-	-	-	-	-	-	-	-
CMS (NA) / NQF 0027 - Numerator 2	-	-	-	-	-	-	-	-	124	647.8	10%	12%	-	-	-	-	-	-	-	-
CMS (NA) / NQF 0047	423	23.1	78%	79%	617	45.9	68%	77%	131	20.0	80%	87%	-	-	-	-	-	-	-	-
CMS (NA) / NQF 0061	600	131.6	42%	46%	1071	135.4	49%	51%	620	119.3	40%	48%	-	-	-	-	-	-	-	-
CMS (NA) / NQF 0067	12	61.1	69%	63%	38	27.1	47%	63%	71	3.1	86%	95%	-	-	-	-	-	-	-	-
CMS (NA) / NQF 0073	17	118.0	63%	74%	28	52.1	73%	77%	89	17.7	61%	82%	-	-	-	-	-	-	-	-
CMS (NA) / NQF 0074	9	34.8	85%	84%	39	18.6	71%	73%	3	2.0	67%	83%	-	-	-	-	-	-	-	-
CMS (NA) / NQF 0084	2	3.0	33%	33%	4	5.0	55%	65%	2	3.0	83%	90%	-	-	-	-	-	-	-	-
CMS (NA) / NQF 0575	239	151.9	23%	27%	451	139.7	39%	39%	255	139.7	25%	29%	-	-	-	-	-	-	-	-
CMS 2 / NQF 0418	-	-	-	-	-	-	-	-	855	221.4	21%	15%	1156	231.7	20%	17%	897	282.7	17%	19%
CMS 22 / NQF (NA)	-	-	-	-	1	1961.0	11%	27%	393	202.5	29%	36%	865	213.2	33%	40%	591	289.8	37%	42%
CMS 50 / NQF (NA)	-	-	-	-	-	-	-	-	382	88.1	18%	19%	772	72.0	31%	18%	526	73.6	24%	18%
CMS 52 / NQF 0405 - Population 1	-	-	-	-	-	-	-	-	2	75.5	100%	100%	-	-	-	-	-	-	-	-
CMS 52 / NQF 0405 - Population 2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CMS 52 / NQF 0405 - Population 3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CMS 56 / NQF (NA)	-	-	-	-	-	-	-	-	1	10.0	100%	100%	5	1.8	56%	53%	2	2.0	25%	17%
CMS 61 / NQF (NA) - Population 1	-	-	-	-	-	-	-	-	101	162.8	23%	34%	219	87.1	46%	37%	228	92.3	27%	28%
CMS 61 / NQF (NA) - Population 2	-	-	-	-	-	-	-	-	73	48.4	28%	30%	195	68.8	30%	23%	227	62.1	16%	18%
CMS 61 / NQF (NA) - Population 3	-	-	-	-	-	-	-	-	141	64.4	35%	24%	238	145.0	35%	38%	263	176.0	36%	40%
CMS 62 / NQF 0403	-	-	-	-	-	-	-	-	7	44.4	98%	36%	17	76.4	34%	29%	18	3.3	27%	34%
CMS 64 / NQF (NA) - Population 1	-	-	-	-	-	-	-	-	19	62.6	30%	64%	146	31.5	68%	58%	171	29.2	44%	49%
CMS 64 / NQF (NA) - Population 2	-	-	-	-	-	-	-	-	21	52.8	40%	68%	159	22.6	76%	70%	167	18.3	50%	65%
CMS 64 / NQF (NA) - Population 3	-	-	-	-	-	-	-	-	25	67.7	62%	76%	180	74.0	89%	91%	189	91.5	71%	84%
CMS 65 / NQF (NA)	-	-	-	-	1	421.0	44%	44%	52	89.9	48%	18%	100	56.4	27%	20%	46	46.7	21%	18%
CMS 66 / NQF (NA)	-	-	-	-	-	-	-	-	2	7.0	71%	50%	3	50.0	2%	67%	1	8.0	0%	0%
CMS 68 / NQF 0419	-	-	-	-	2	89202.0	6%	33%	1340	374.0	66%	70%	2575	466.9	72%	72%	2194	517.9	75%	78%
CMS 69 / NQF 0421 - Numerator 1	1247	158.7	44%	47%	2736	191.0	43%	46%	2272	127.0	46%	49%	1450	112.5	42%	47%	956	166.9	45%	50%
CMS 69 / NQF 0421 - Numerator 2	1530	187.9	40%	40%	3420	305.9	38%	38%	2962	189.3	37%	40%	1935	189.8	39%	42%	1558	164.5	44%	47%
CMS 74 / NQF (NA) - Stratum 1	-	-	-	-	-	-	-	-	335	161.7	7%	11%	229	173.3	18%	30%	148	186.4	26%	33%
CMS 74 / NQF (NA) - Stratum 2	-	-	-	-	-	-	-	-	337	112.1	5%	7%	227	105.9	23%	31%	158	118.1	22%	28%
CMS 74 / NQF (NA) - Stratum 3	-	-	-	-	-	-	-	-	343	62.3	4%	6%	238	69.5	16%	20%	149	86.4	20%	24%
CMS 75 / NQF (NA)	-	-	-	-	-	-	-	-	614	371.3	3%	5%	814	314.9	6%	9%	615	324.3	7%	10%
CMS 77 / NQF (NA)	-	-	-	-	-	-	-	-	2	25.5	100%	100%	4	103.5	75%	76%	1	1.0	0%	0%
CMS 82 / NQF 1401	-	-	-	-	-	-	-	-	36	32.5	29%	41%	44	35.4	25%	32%	9	74.4	1%	2%
CMS 90 / NQF (NA)	-	-	-	-	-	-	-	-	73	31.2	64%	12%	99	8.5	24%	8%	63	3.3	8%	10%
CMS 117 / NQF 0038	-	-	-	-	-	-	-	-	700	37.8	27%	22%	848	32.8	23%	21%	874	28.7	22%	18%
CMS 117 / NQF 0038 - Immunization 1	417	59.2	58%	51%	503	87.7	49%	48%	165	67.4	43%	55%	-	-	-	-	-	-	-	-
CMS 117 / NQF 0038 - Immunization 2	421	55.0	46%	46%	498	80.9	45%	48%	153	57.9	61%	62%	-	-	-	-	-	-	-	-
CMS 117 / NQF 0038 - Immunization 3	421	55.1	38%	40%	498	80.9	53%	54%	153	58.1	63%	64%	-	-	-	-	-	-	-	-
CMS 117 / NQF 0038 - Immunization 4	420	55.0	43%	36%	498	80.9	57%	51%	153	57.7	69%	68%	-	-	-	-	-	-	-	-
CMS 117 / NQF 0038 - Immunization 5	420	55.0	70%	56%	498	80.9	59%	51%	153	57.7	61%	60%	-	-	-	-	-	-	-	-
CMS 117 / NQF 0038 - Immunization 6	420	55.0	59%	59%	499	80.7	59%	63%	153	57.7	70%	72%	-	-	-	-	-	-	-	-
CMS 117 / NQF 0038 - Immunization 7	420	54.5	64%	58%	497	80.9	51%	51%	153	57.7	49%	57%	-	-	-	-	-	-	-	-
CMS 117 / NQF 0038 - Immunization 8	418	54.7	28%	33%	500	80.3	29%	37%	153	57.7	38%	50%	-	-	-	-	-	-	-	-
CMS 117 / NQF 0038 - Immunization 9	418	54.7	69%	57%	498	80.9	60%	54%	153	67.3	55%	69%	-	-	-	-	-	-	-	-
CMS 117 / NQF 0038 - Immunization 10	416	54.6	59%	46%	502	80.3	47%	45%	153	67.3	41%	58%	-	-	-	-	-	-	-	-
CMS 117 / NQF 0038 - Immunization 11	415	54.8	48%	34%	499	80.0	46%	36%	153	57.7	46%	50%	-	-	-	-	-	-	-	-
CMS 117 / NQF 0038 - Immunization 12	414	65.2	53%	49%	498	82.1	45%	39%	153	57.7	41%	46%	-	-	-	-	-	-	-	-
CMS 122 / NQF 0059	497	146.9	8%	11%	932	151.3	32%	28%	1468	97.0	42%	41%	1458	66.3	65%	73%	1173	64.6	61%	64%
CMS 123 / NQF 0056	88	90.7	33%	26%	193	94.0	39%	31%	376	88.2	29%	22%	248	69.6	26%	23%	415	67.4	22%	24%
CMS 124 / NQF 0032	425	486.4	54%	45%	831	584.4	56%	48%	990	344.6	57%	40%	1314	216.9	30%	33%	1111	184.2	37%	34%
CMS 125 / NQF 0031	313	275.2	36%	29%	854	238.8	38%	34%	999	169.7	45%	43%	1296	115.3	44%	39%	1083	98.6	52%	48%
CMS 126 / NQF 0036 - Population 1	411	48.8	47%	59%	691	81.8	53%	60%	144	26.3	47%	54%	-	-	-	-	-	-	-	-
CMS 126 / NQF 0036 - Population 2	400	33.8	45%	56%	696	59.3	51%	58%	150	24.7	35%	47%	-	-	-	-	-	-	-	-
CMS 126 / NQF 0036 - Population 3	419	74.5	46%	59%	721	131.9	52%	59%	158	50.2	40%	47%	-	-	-	-	-	-	-	-
CMS 126 / NQF 0036 - Stratum 1	-	-	-	-	-	-	-	-	136	19.1	45%	56%	211	19.4	51%	59%	194	17.3	42%	52%
CMS 126 / NQF 0036 - Stratum 2	-	-	-	-	-	-	-	-	118	7.2	58%	55%	182	10.4	50%	60%	160	11.0	39%	54%
CMS 126 / NQF 0036 - Stratum 3	-	-	-	-	-	-	-	-	52	12.1	35%	49%	78	13.6	49%	53%	87	13.1	26%	52%
CMS 126 / NQF 0036 - Stratum 4	-	-	-	-	-	-	-	-	38	11.3	32%	47%	60	14.8	50%	61%	70	15.6	16%	37%
CMS 126 / NQF 0036 - Stratum 5	-	-	-	-	-	-	-	-	187	23.4	60%	51%	315	24.8	54%	61%	222	20.7	54%	61%
CMS 127 / NQF 0043	132	76.8	44%	49%	297	112.9	39%	40%	650	83.2	39%	45%	843	75.8	50%	52%	709	84.6	53%	54%
CMS 128 / NQF 0105 - Numerator 1	8	16.8	62%	71%	22	85.7	29%	75%	38	99.8	13%	59%	17	16.1	27%	66%	55	17.2	46%	73%
CMS 128 / NQF 0105 - Numerator 2	9	31.4	64%	49%	22	92.6	21%	69%	38	101.0	11%	45%	17	16.1	26%	69%	54	21.1	49%	67%
CMS 129 / NQF 0389	1	38.0	97%	97%	-	-	-	-	1	480.0	0%	0%	1	100.0	100%	100%	1	95.0	0%	0%
CMS 130 / NQF 0034	131	253.8	24%	25%	394	285.4	29%	23%	653	205.3	27%	28%	859	161.7	25%	24%	490	180.7	29%	26%
CMS 131 / NQF 0055	46	68.6	27%	28%	123	75.2	46%	28%	120	104.6	29%	22%	125	74.2	25%	23%	101	111.5	45%	37%
CMS 132 / NQF 0564	-	-	-	-	-	-	-	-	9	61.6	0%	11%	10	46.5	7%	30%	11	59.8	5%	2%
CMS 133 / NQF 0565	-	-	-	-	1	1.0	0%	0%	5	43.6	51%	60%	4	86.5	92%	92%	12	89.3	77%	69%
CMS 134 / NQF 0062	101	150.3	54%	75%	225	129.5	82%	74%	651	69.9	70%	71%	817	64.4	76%	72%	737	66.9	77%	74%
CMS 135 / NQF 0081	-	-	-	-	1	1.0	100%	100%	9	27.8	74%	89%	34	6.5	79%	79%	16	11.3	86%	80%
CMS 136 / NQF 0108 - Population 1	-	-	-	-	-	-	-	-	67	5.6	64%	54%	87	12.2	28%	51%	78	8.7	30%	54%
CMS 136 / NQF 0108 - Population 2	-	-	-	-	-	-	-	-	29	7.0	83%	44%	34	19.2	17%	50%	64	6.1	20%	31%
CMS 137 / NQF 0004 - Population 1 - N	13	95.5	9%	49%	15	117.1	24%	37%	2	3.0	33%	20%	4	2.5	40%	50%	6	12.3	16%	17%
CMS 137 / NQF 0004 - Population 1 - N	12	99.6	5%	23%	14	124.2	24%	32%	4	84.8	67%	22%	4	2.5	10%	25%	6	12.3	15%	13%
CMS 137 / NQF 0004 - Population 2 - N	12	122.8	25%	62%	14	124.4	6%	24%	9	80.0	60%	28%	6	4.3	31%	36%	10	10.8	17%	13%
CMS 137 / NQF 0004 - Population 2 - N	12	122.8	14%	31%	14	124.4	5%	16%	9	43.1	49%	27%	6	4.3	4%	17%	10	10.0	11%	9%
CMS 137 / NQF 0004 - Population 3 - N	12	125.1	26%	62%	15	116.2	2%	22%	10	72.7	57%	27%	7	4.6	34%	40%	9	10.4	18%	13%
CMS 137 / NQF 0004 - Population 3 - N	12	125.1	14%	31%	15	116.2	1%	13%	10	74.5	58%	18%	8	5.0	3%	13%	9	10.4	11%	7%
CMS 138 / NQF 0028 - Numerator 1	1717	141.0	78%	81%	3493	234.6	80%	84%	3251	139.7	71%	74%	2901	155.0	72%	73%	2225	168.5	77%	80%
CMS 138 / NQF 0028 - Numerator 2	1285	64.8	34%	37%	2636	81.8	34%	42%	1211	44.6	43%	46%	-	-	-	-	-	-	-	-
CMS 139 / NQF 0101	-	-	-	-	-	-	-	-	50	92.7	32%	24%	420	58.6	47%	45%	416	90.6	47%	52%
CMS 140 / NQF 0387	-	-	-	-	-	-	-	-	-	-	-	-	1	1.0	100%	0%	-	-	-	-
CMS 141 / NQF 0385	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CMS 142 / NQF 0089	6	43.2	95%	62%	2	25.0	2%	50%	5	361.6	62%	37%	11	128.6	90%	60%	13	124.1	67%	76%
CMS 143 / NQF 0086	6	77.2	95%	80%	13	148.6	76%	83%	13	116.9	42%	61%	16	70.5	64%	57%	22	126.8	64%	66%
CMS 144 / NQF 0083	1	2.0	100%	100%	-	-	-	-	5	23.2	89%	86%	5	28.8	28%	41%	7	9.3	83%	95%
CMS 145 / NQF 0070 - Population 1	5	32.0	53%	59%	7	10.4	66%	57%	32	5.9	91%	95%	10	15.7	52%	57%	6	56.5	87%	60%
CMS 145 / NQF 0070 - Population 2	-	-	-	-	-	-	-	-	6	7.2	88%	81%	11	13.5	60%	70%	4	109.5	86%	46%
CMS 146 / NQF 0002	310	26.0	49%	64%	584	39.9	49%	57%	581	16.7	42%	47%	579	13.3	37%	53%	369	12.1	41%	55%
CMS 147 / NQF 0041	95	80.1	25%	22%	108	85.8	11%	16%	1505	139.0	37%	31%	2052	150.3	36%	37%	1620	158.4	39%	37%
CMS 148 / NQF 0060	-	-	-	-	-	-	-	-	173	10.3	81%	76%	126	13.4	73%	67%	123	20.8	53%	63%
CMS 149 / NQF (NA)	-	-	-	-	-	-	-	-	14	19.0	69%	17%	10	10.4	36%	35%	9	23.6	17%	45%
CMS 153 / NQF 0033 - Population 1	193	58.3	62%	51%	524	104.7	73%	53%	742	33.3	55%	37%	677	16.6	53%	39%	530	18.6	44%	32%
CMS 153 / NQF 0033 - Population 2	173	31.8	67%	52%	424	61.2	73%	55%	517	36.1	58%	38%	416	27.0	49%	44%	320	30.8	49%	40%
CMS 153 / NQF 0033 - Population 3	174	43.6	64%	53%	397	85.9	78%	60%	706	36.2	60%	41%	702	58.9	44%	40%	572	38.5	55%	36%
CMS 154 / NQF 0069	-	-	-	-	-	-	-	-	729	58.0	75%	90%	926	57.1	70%	92%	742	69.8	76%	90%
CMS 155 / NQF 0024 - Population 1 - N	648	300.8	82%	80%	1093	469.6	84%	76%	1122	185.4	87%	87%	901	173.1	86%	84%	669	170.6	87%	87%
CMS 155 / NQF 0024 - Population 1 - N	634	298.7	25%	21%	1076	468.4	41%	30%	1091	184.6	30%	27%	896	170.9	19%	19%	666	164.7	22%	20%
CMS 155 / NQF 0024 - Population 1 - N	633	295.4	23%	18%	1078	560.8	29%	31%	1091	179.8	23%	23%	891	172.6	18%	18%	667	173.8	22%	18%
CMS 155 / NQF 0024 - Population 2 - N	591	230.5	77%	78%	931	407.9	79%	73%	1138	109.6	74%	82%	980	76.1	80%	82%	706	92.3	81%	83%
CMS 155 / NQF 0024 - Population 2 - N	577	229.0	24%	18%	923	405.6	39%	29%	1109	101.2	27%	23%	974	74.0	20%	18%	699	87.4	27%	22%
CMS 155 / NQF 0024 - Population 2 - N	587	225.8	21%	15%	923	390.4	36%	29%	1111	104.1	20%	19%	968	72.8	22%	17%	696	94.2	26%	21%
CMS 155 / NQF 0024 - Population 3 - N	630	132.5	69%	77%	1075	215.9	75%	75%	1194	188.4	83%	83%	1089	207.3	86%	80%	777	217.1	86%	84%
CMS 155 / NQF 0024 - Population 3 - N	621	129.9	20%	18%	1061	212.5	35%	29%	1161	187.1	28%	25%	1083	207.3	20%	19%	771	213.8	23%	20%
CMS 155 / NQF 0024 - Population 3 - N	621	129.3	18%	16%	1012	213.5	34%	27%	1167	187.7	25%	22%	1079	203.6	19%	17%	770	219.7	22%	19%
CMS 156 / NQF 0022 - Numerator 1	-	-	-	-	1	1391.0	45%	45%	666	84.3	25%	26%	1225	74.2	19%	22%	757	108.8	12%	15%
CMS 156 / NQF 0022 - Numerator 2	-	-	-	-	1	1391.0	15%	15%	648	88.8	14%	13%	1219	74.1	7%	7%	733	107.3	5%	6%
CMS 157 / NQF 0384	-	-	-	-	-	-	-	-	6	31.7	25%	56%	8	303.1	76%	69%	1	986.0	65%	64%
CMS 158 / NQF 0608	-	-	-	-	-	-	-	-	51	58.7	88%	87%	38	62.1	89%	84%	26	18.7	76%	83%
CMS 159 / NQF 0710	-	-	-	-	-	-	-	-	2	241.0	42%	21%	-	-	-	-	4	68.3	9%	5%
CMS 160 / NQF 0712 - Population 1	-	-	-	-	-	-	-	-	10	148.7	52%	47%	38	36.2	23%	31%	50	40.2	33%	30%
CMS 160 / NQF 0712 - Population 2	-	-	-	-	-	-	-	-	10	136.2	56%	46%	26	34.0	21%	30%	26	62.1	35%	41%
CMS 160 / NQF 0712 - Population 3	-	-	-	-	-	-	-	-	4	89.5	11%	15%	38	34.5	25%	27%	48	41.1	34%	30%
CMS 161 / NQF 0104	-	-	-	-	-	-	-	-	8	187.9	27%	29%	3	28.7	90%	31%	26	20.2	21%	28%
CMS 163 / NQF 0064 - Numerator 1	499	158.1	16%	19%	760	161.3	34%	34%	891	103.2	22%	26%	376	59.3	26%	24%	319	75.1	31%	31%
CMS 163 / NQF 0064 - Numerator 2	494	156.0	8%	12%	752	162.4	20%	21%	446	155.4	10%	11%	-	-	-	-	-	-	-	-
CMS 164 / NQF 0068	7	91.1	45%	59%	52	40.8	55%	66%	548	25.0	72%	74%	531	24.4	67%	70%	384	36.7	73%	74%
CMS 165 / NQF 0018	309	139.7	62%	64%	970	127.7	61%	62%	1587	131.3	61%	58%	2058	104.1	59%	55%	1469	171.8	46%	58%
CMS 166 / NQF 0052	47	16.6	95%	96%	54	31.5	99%	94%	335	18.1	44%	76%	555	16.1	52%	64%	494	17.1	49%	84%
CMS 167 / NQF 0088	6	48.0	93%	64%	14	109.2	73%	58%	12	108.6	41%	62%	13	68.8	85%	68%	41	45.1	56%	20%
CMS 169 / NQF 0110	-	-	-	-	-	-	-	-	2	108.0	100%	100%	1	87.0	20%	20%	16	13.4	29%	19%
CMS 177 / NQF 1365	-	-	-	-	-	-	-	-	17	3.5	7%	6%	23	8.6	34%	20%	16	13.3	31%	5%
CMS 179 / NQF (NA)	-	-	-	-	-	-	-	-	1	4.0	75%	75%	1	5.0	1800%	5%	3	336.7	15%	57%
CMS 182 / NQF 0075 - Numerator 1	2	69.0	25%	18%	18	29.7	53%	68%	71	40.4	17%	25%	120	73.4	41%	38%	75	83.4	12%	26%
CMS 182 / NQF 0075 - Numerator 2	2	69.0	25%	18%	17	31.4	34%	47%	70	37.0	12%	16%	118	71.8	18%	25%	75	83.6	11%	21%

APPENDIX 9: VISION FOR EHR ADOPTION BY MEDI-CAL PROVIDERS

December 2009

Overview of the HITECH EHR Incentive Program

Congress has appropriated $46.8 billion in Health Information Technology for Economic and Clinical Health Act (HITECH), a component of the American Reinvestment and Recovery Act (ARRA), to encourage Medicaid and Medicare providers, hospitals, and clinics to adopt and become meaningful users of electronic health records (EHRs.) The infusion of new funding towards EHRs represents a tremendous opportunity to improve the quality, safety, and efficacy of health care.

The bulk of this funding will support incentive payments for Medicare and Medicaid providers who meet certain criteria for patient volume and who demonstrate "meaningful use" of the new technology. Criteria for meaningful use and provider eligibility are currently being defined by The Centers for Medicare & Medicaid Services (CMS), and further guidance will be provided. Program components outlined to date include:

- Providers may only participate in either the Medicare or Medicaid incentive program.
- A single provider can receive up to $63,750 in Medi-Cal incentives over five years.
- Providers must become "meaningful users" of EHRs based on criteria currently under development by CMS (Medicare) and the states (Medicaid). Goals of meaningful use will likely include improving the quality, safety, efficiency, and reduce health disparities; engaging patients and families; improving care coordination; improving population and public health data; and ensuring adequate privacy and security protections for personal health information. Specific requirements include the capability to exchange electronic health information, electronic prescribing for office-based physicians, and the submission of information on clinical quality and other measure.[11]
- The first EHR incentive payments may be issued in 2011.

As the state agency charged with administering Medicaid payments, the California Department of Health Care Services (DHCS) is poised to play a significant role in the new EHR initiative. The DHCS is currently in the process of planning for this EHR Incentive program, and as of December

[1] "American Recovery and Reinvestment Act of 2009." *Wikipedia: The Free Encyclopedia* Wikimedia Foundation, Inc. Last modified: November 18, 2010. Date accessed: November 22, 2010.

2009, has created a vision for the use of ARRA funds to increase adoption and meaningful use of EHRs among Medi-Cal providers.

Introduction to the Vision

This document contains the overall vision for the use of ARRA funds to increase adoption and meaningful use of EHRs among Medi-Cal providers in California.

The vision is ambitious. It is intended to inspire action by the DHCS, which will provide leadership for this effort, and by a broad set of stakeholders – health care providers, payers, government entities, legislators, and the people of California – who will share in the benefits of EHR adoption and meaningful use and who have a shared responsibility to ensure its success.

The DHCS will provide leadership and rely upon stakeholders to realize this vision. This effort will also be closely coordinated with other Health IT-related projects and programs in the State of California.

The structure we have adopted for this vision is the meaningful use framework proposed by the HIT Policy Committee, thus ensuring all the planning efforts will be aligned with national requirements. This vision will be used to guide detailed strategic and implementation planning by the DHCS, and as well as provide guidance for other stakeholder planning efforts.

Process to Date: Crafting the Vision

This vision was created by the DHCS in partnership with the California HealthCare Foundation and with assistance from FSG Social Impact Advisors. In developing the vision, FSG spoke with over 100 stakeholders including DHCS senior leadership, staff from 16 DHCS divisions, staff from six other departments of the California Health and Human Services Agency, and over 65 external stakeholders from provider, payer, and consumer communities.

A draft vision was vetted at an in-person Visioning Session that was attended by 38 individuals from multiple stakeholder groups and the DHCS and then revised during a comment period for vision session participants and all external stakeholders interviewed during the visioning process.

Next Steps: Creating the DHCS Strategic and Implementation Plan

The DHCS has engaged The Lewin Group and McKinsey & Company to lead Phase II of the EHR Incentive Payment Program planning process. The work of Phase II begins with a landscape assessment of California providers and EHR vendors. The landscape assessment will be followed by the development an incentive payment program plan with three components:

- Strategic plan: define program components and performance targets
- Campaign plan: approach to increasing awareness of the EHR incentive payment program
- Implementation plan: detailed guidance on implementing the incentive payment program

The strategic and implementation plan will use the vision as a guide but will focus specifically on the next five years for the EHR incentive program and DHCS activities. The Lewin Group and McKinsey & Company will continue to engage stakeholders throughout the secondary planning process and project implementation phase. The DHCS will establish a Health Enterprise Steering Committee and will ensure stakeholders continue to be engaged through current or newly established workgroups, webinars, and monthly updates.

The Vision

The Promise of the Electronic Health Records
Electronic Health Records are a key enabling technology for improving the quality, safety, and efficiency of the health care system. In creating the vision for the Medicaid incentive program, the DHCS is cognizant of the ultimate goals for promoting the adoption of this technology, as defined by the HIT Policy Committee:

- Improve quality, safety, and efficiency and reduce health disparities
- Engage patients and families
- Improve care coordination
- Improve population and public health
- Ensure adequate privacy and security protections for personal health information

Vision for the EHR Incentive Program

The health and wellbeing of all Californians will be dramatically improved by the widespread adoption and use of Electronic Health Records.

Vision Element 1: Provider EHR Adoption

Goals for Provider EHR Adoption

1.1 By March 2011 the Medi-Cal EHR Incentive Program Provider Portal will be operational and accepting information from the National Level Registry and from practitioners and hospitals.

1.2 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.

1.3 By May 2011, the Medi-Cal EHR Incentive Program will have begun issuing incentive payments to practitioners and hospitals.

1.4 By December 31, 2011, 100% of practitioners and hospitals receiving Medi-Cal EHR Incentive Program funding will have received information and training in using their EHRs to achieve meaningful use.

1.5 By December 31, 2011, at least 50% of Medi-Cal practitioners and hospitals eligible for Medi-Cal EHR Incentive Program funds will have applied for and been awarded funding for adopting, implementing, or upgrading an EHR.

1.6 By December 31, 2013, 60% of Medi-Cal practitioners and 70% of hospitals receiving funding in 2011 will have achieved meaningful use and received funding for that accomplishment.

1.7 By 2015, 90% of Medi-Cal providers eligible for incentive payments will have adopted EHRs for meaningful use in their practices. The EHRs adopted are secure, interoperable, and certified.

Vision Element 2: Improve Quality, Safety, and Efficiency and Reduce Health Disparities

2.1 By 2015, 90% of Medi-Cal providers will have implemented clinical decision support tools within their EHRs. These tools are intelligent and initially target 3-4 conditions that are prevalent, costly, and drivers of high morbidity and mortality.

2.2 By 2013, statewide provider performance standards are used to improve health outcomes. These standards will increase quality and safety, reduce health disparities, and incentivize medical homes for Medi-Cal patients.

2.3 The use of EHRs results in cost efficiencies for payers by 2015 and 90% of Medi-Cal providers by 2018. These savings will be generated through administrative and clinical process improvements enabled by EHRs.

Vision Element 3: Engage Patients and Families

3.1 All patients of Medi-Cal providers with EHRs will have electronic access to their Personal Health Record (PHR) and self-management tools by 2015. Patient tools are affordable,

actionable, culturally and linguistically appropriate, and accessible through widely available technologies. The PHR and self-management tools enable patients to communicate with their providers.

Vision Element 4: Improve Care Coordination

4.1 By 2013, upon EHR adoption, Medi-Cal providers and patients are able to use available electronic information from patients' other clinical providers to make informed health care decisions at the point of care. Data will be standardized and integrated across providers.

4.2 By 2013, key partners will share information with eligible providers upon adoption of EHRs to ensure full access to health data. These partners include labs, pharmacies, and radiology facilities.

Vision Element 5: Improve Population and Public Health

Goals for Improving Population and Public Health

5.1 By 2013, patient and population health data from EHRs will be shared bi-directionally between providers the DHCS, the Department of Public Health, the Office of Statewide Health Planning and Development, and other approved institutions to support the essential functions of public health, and to inform the effectiveness, quality, access, and cost of care.

5.2 By December 31, 2014, a portable, EHR-based health record will have been developed and tested for California's foster children.

5.3 By December 31, 2014, an interoperable EHR for medical and behavioral health will have been developed and tested for California's mental health population.

5.4 By December 31, 2014, a continuity of care document that includes behavioral health will have been developed and tested for California's mental health population.

5.5 By December 31, 2014 pilot the inclusion of behavior health information in a regional HIE.

5.6 De-identified data collected from EHRs is used to publicly report on trends in the quality of care provided to Medi-Cal beneficiaries by 2015. Consumers should be educated about the findings from such reports. References to Medi-Cal providers

throughout the Vision refer to Medi-Cal providers eligible for ARRA incentive payments

5.7 By December 31, 2015, 90% of independent pharmacies in California will be connected to an e-Prescribing network.

5.8 By December 31, 2015, 80% of community clinics will have fully implemented certified EHRs.

5.9 By December 31, 2015, 50% of providers in California will be able to electronically transmit immunization information to an immunization registry.

5.10 By December 31, 2015, 90% of hospital, regional, and public health laboratories will be able to electronically transmit laboratory results to providers.

5.11 By December 31, 2015, 80% of providers and hospitals will be able to transmit reportable disease and syndromic surveillance information to the local and State public health departments

Vision Element 6: Ensure Adequate Privacy and Security Protections for Personal Health Information

6.1 By 2011, the state will ensure that Medi-Cal beneficiaries, on request, have electronic access to their Health Information Exchange disclosures.

6.2 By 2011, California will establish policies that balance protection of patient privacy with the appropriate sharing of health information. Such policies will be consistent with national requirements and will protect health information accessed by providers, payers, other California public agencies, and other states. Policies apply to data in EHRs, PHRs, and health information exchange.

APPENDIX 10: CALIFORNIA'S PREVIOUS 5-YEAR PLAN (2011-2016)

In January 2010, the DHCS convened a statewide group of experts to design the vision for the Medi-Cal EHR Incentive Program (Appendix 8). The vision elements defined by this group were written before the Final Rule was adopted and were ambitious and set an aggressive agenda for successful achievement of MU criteria by Medi-Cal providers. The original vision elements are listed below, followed by an update on the progress made towards meeting those goals:

- By 2011, the state will ensure that Medi-Cal beneficiaries, on request, have access to their HIE disclosures.
    - *The DHCS responds to member requests for an accounting of disclosures by the DHCS of a member's protected health information. DHCS uses Business Associate Agreements (BAAs) to help manage the accounting of disclosures required under federal law; the BAAs obligate health plans under contract with DHCS to account for disclosures. Since the DHCS does not directly exchange health information with any of the state Health Information Organizations (HIOs), disclosures by an HIO are not managed by DHCS. The California Data Use and Reciprocal Support Agreement (CalDURSA) obligates all participating California HIOs to abide by HIPAA's Accounting of Disclosure requirements. DHCS' CTAP program provides milestone payments to contractors who provide technical assistance to providers who enroll with an HIO that is a CalDURSA signatory (see Section 1.8). Please note, however, that the HIPAA accounting of disclosure provisions do not apply to payment, treatment, or operations, the main purpose of HIE.*

- By 2011, California will establish policies that balance protection of patient privacy with the appropriate sharing of health information
    - *The CalDURSA, created in 2014, was modeled after the Federal DURSA and serves as a multi-party trust agreement for HIE that allows all signatories to interoperate using recognized standards. As of March 2017, 13 HIOs are signatories of the CalDURSA. In*

addition to the federal laws relating to patient privacy, and the CalDURSA, existing state laws further protect patients[2].

- By 2013, statewide provider performance standards are used to improve health outcomes.
    - *The DHCS Quality Strategy (2012-2017)[3] was developed using the National Strategy for Quality Improvement in Health Care (NQS) as a foundation for improving population health and health care in all departmental programs.*
    - *California monitors the performance of Medi-Cal contracted health plans using HEDIS and Consumer Assessment of Healthcare Providers and Systems (CAHPS). DHCS' Managed Care Quality and Monitoring Division (MCQMD) produces the Managed Care Performance Dashboard that contains comprehensive data on a variety of measures including enrollment, health care utilization, appeals and grievances, network adequacy, and quality of care. Information contained in the Dashboard assists DHCS and its stakeholders in observing and understanding managed care plan (MCP) performance statewide, by plan model, and by MCP. These Managed Care Performance Dashboards are produced quarterly[4].*
- 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.
    - *Many of California's HIOs have the ability to share information bi-directionally between providers who are HIO participants (see Section 1.12). Currently, public health registries are only able to accept data, however as of late 2017, CAIR 2.0 is capable of bi-directional data sharing in compliance with MU requirements.*

[2] CHHS, Federal and State Health Laws. Accessed on April 25, 2018

[3] DHCS, Strategy for Quality Improvement in Health Care

[4] DHCS, Medi-Cal Managed Care Performance Dashboard

- 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.
    - *Based on Lewin & McKinsey's original estimate of 10,000 eligible providers, California surpassed this goal with 17,679 providers receiving Year 1 payments by December 2015 (176%). However, due to the 2014 expansion of Medicaid under the Patient Protection and ACA and the transition of the Healthy Families Program (HFP) to Medi-Cal, the estimated number of eligible providers increased. A 2013 survey conducted by UCSF and the Medical Board estimates that approximately 22,200 providers are eligible for incentive payments, approximately 80% of these received year 1 payments by December 2015. We are anticipating that at the end of the 2016 program year at least 23,000 eligible providers will have applied.*
- By 2015, 90% of eligible Medi-Cal providers will have implemented clinical decision support tools with their EHRs.
    - *All providers who meet MU have implemented clinical decision support tools in their EHRs. As of December 2015, 6,157 providers had achieved MU, or 61% based on Lewin & McKinsey's original estimate of 10,000 eligible providers. This percentage drops to 28% when based on the 2013 UCSF survey, which increased the estimated number of eligible providers to 22,000 due to the expansion of Medicaid under the ACA and the transition of the Healthy Families Program (HFP) to Medi-Cal.*
- By 2015, all Medi-Cal beneficiaries of providers with EHRs will have access to their Personal Health Record and self-management tools.
    - *As of March 2015, 85% of Medi-Cal beneficiaries of providers who achieved Stage 1 MU had access to their Personal Health Record, as reported under the Patient Electronic Access (view, download, transmit) core objective.*
- 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.
    - *Providers are required to adopt certified electronic health record technology (CEHRT) which meets the requirements defined at 45*

CFR 170.102. Among these requirements is the ability for the certified EHR to exchange electronic health information with, and integrate such information from other sources. In order to successfully meet Stage 2 and 3 MU, providers are required to meet the HIE/summary of care MU objective by transmitting the summary of care electronically using CEHRT.

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

- In October 2011, the SLR will be operational and accepting information from the National Level Registry and from hospitals.
    - *The SLR began accepting hospital attestations in October 2011.*
- By November 2011, the SLR will be accepting Group registration and attestation.
    - *The SLR began accepting group attestations in November 2011.*
- By November 2011, the Medi-Cal EHR Incentive Program will have begun issuing incentive payments to hospitals.
    - *Incentive payments to hospitals were issued beginning in December 2011.*
- By December 2011, the SLR will be accepting eligible professional registration and attestation.
    - *The SLR began accepting eligible professional attestations in January 2012.*
- By December 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.
    - *DHCS utilized RECs, program stakeholders, provider associations, and the Medical Board to disseminate information about the Medi-Cal EHR Incentive Program to providers prior to and after launching the program in October 2011.*
- By February 2012, the Medi-Cal EHR incentive Program will have begun issuing incentive payments to eligible professionals.

- *Incentive payments to eligible professionals were issued beginning in May 2012.*

- By March 31, 2012, at least 35% of Medi-Cal providers 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.
    - *6,713 providers had applied for AIU by March 2012, this constitutes 67% of those eligible (based on Lewin & McKinsey's original estimate of 10,000 eligible providers) registering and receiving a payment by March 2012. Subsequent to 2012, the program saw an increase in eligible providers due to the Medicaid expansion under ACA and transition of the Healthy Families Program (HFP) to Medi-Cal. A survey conducted by UCSF in 2013 increased the estimated number of eligible providers to 22,000.*
    - *For hospitals, of the 242 estimated to be eligible, 178 had applied for AIU by March 2012, or 73%.*
- By July 31, 2012, 100% of practitioners and hospitals receiving Medi-Cal EHR Incentive Program funding will have received information on using their EHRs to achieve MU.
    - *Beginning with the start of the program, DHCS has regularly updated Medi-Cal EHR Incentive Program providers and other stakeholders (RECs, hospital associations, etc.) with important information about MU through email notifications and website announcements.*
- By December 31, 2012, at least 70% of Medi-Cal providers 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.
    - *Based on Lewin & McKinsey's original estimate of 10,000 eligible providers, 82% (8,279) had applied by December 2012, and 62% (6,263) had received payment by that date. According to the updated estimate of 22,000 eligible providers derived from the 2013 UCSF survey, these figures change to 38% and 28% respectively.*

- *For hospitals, the registration goal was exceeded at 116% (282) applications received for AIU, and 86% (209) had also received a payment by December 2012.*

- By December 31, 2012, 50% of providers and hospitals that received Medi-Cal EHR Incentive Program funding in 2011 will have achieved MU and received funding for this accomplishment.
    - *31 hospitals received AIU incentive payments in 2011. By December 2012, 16 (50%) hospitals had received payment for MU. Due to program delays, no EPs were paid in calendar year 2011.*
- 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 2013, of Lewin & McKinsey's original estimate of 10,000 providers eligible, 10,891 had applied, or about 109%. As a result of the Medicaid expansion under ACA and the transition of the Healthy Families Program (HFP) to Medi-Cal, an updated estimate of 22,000 providers eligible (from the 2013 UCSF Survey) changes this figure to 50%.*
    - *Of the estimated 242 hospitals eligible, 255 had applied, or 105%.*
- By December 31, 2013, 70% of Medi-Cal providers and hospitals receiving funding in 2011 will have achieved MU and received funding for that accomplishment.
    - *31 hospitals received funding in 2011. By December 2013, all 31 hospitals (100%) had received payment for achieving their first year of MU. Due to program delays, no EPs were paid in calendar year 2011, however 2,472 providers received payments for MU by December 2013.*

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

- By December 31, 2014, a portable, EHR-based health record will have been developed and tested for California's foster children.

- *In 2012 DHCS sought approval from CMS for funding the Ventura County FHL, a project aimed to increase electronic information exchange and coordination of care among California's foster children. Although the funding was not approved, the project was launched in the summer of 2015. The Ventura County FHL provides a portable electronic personal record for over 1,000 foster children in Ventura County that is used by foster parents and social workers to coordinate care. The project addressed the issue of incomplete and disorganized records, a common problem for foster children who experience frequent changes in family placement, physicians, and schools. Such gaps in essential records can result in inappropriate or insufficient medical care. Future goals for the FHL include development of a version accessible for older foster youth and inclusion of information from Ventura County school systems.*

- *In 2014, The Children's Partnership, Altruit, and FollowMe, Inc., and the University of California, Davis, implemented HealthShack as a personal health record system in Sacramento County to support foster youth in transitioning out of care. HealthShack, allows foster youth to create an electronic record containing key personal and medical records. In 2014, access to HealthShack was expanded to include young people between the ages of 18-20 or those who are aging out of foster care in Sacramento County.*

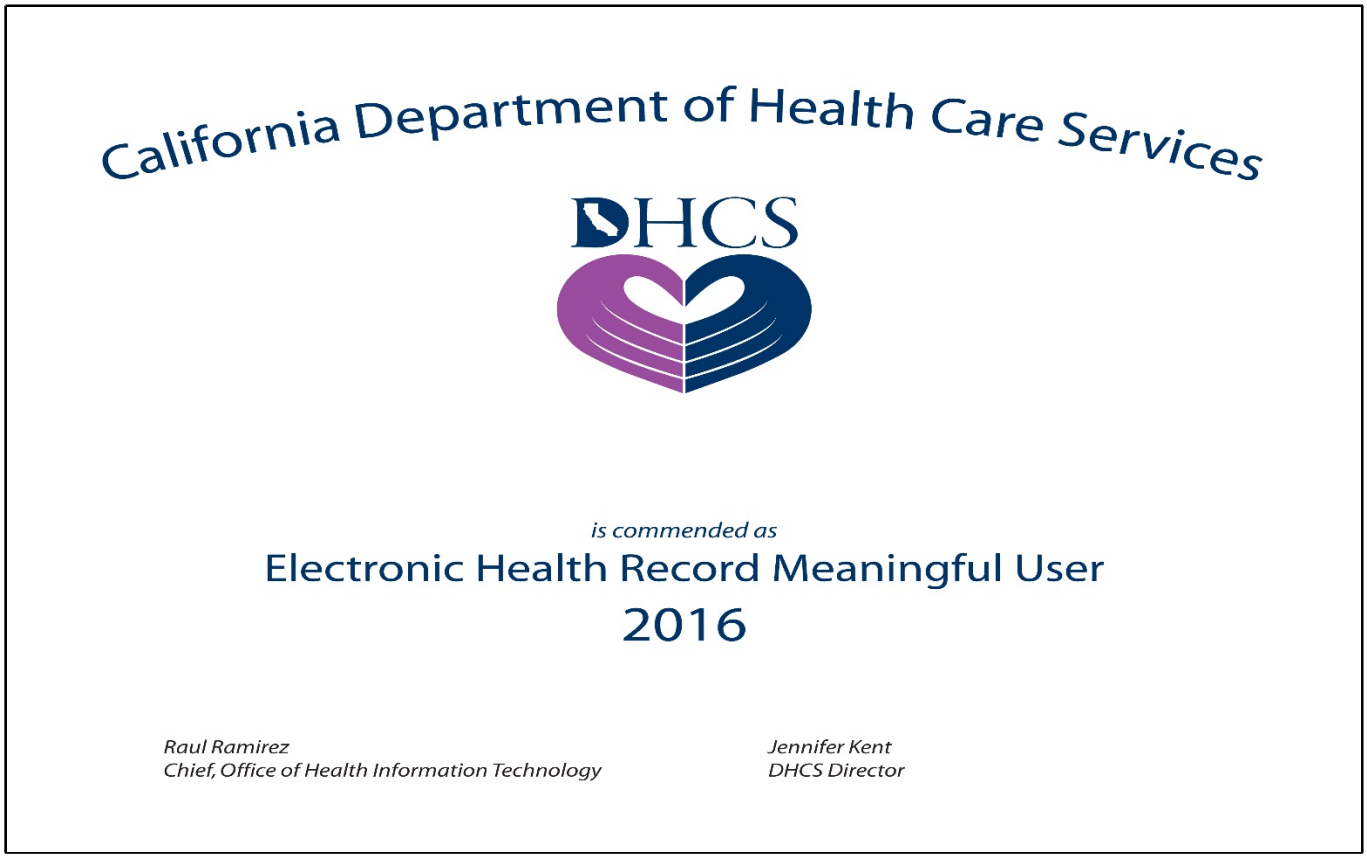
- By December 31, 2015, an interoperable EHR for medical and behavioral health will have been developed and tested for California's mental health population.
    - *Counties received $453.4 million for CF/TN projects. Funds need to be expended though FY 2017-18. The funds may be used for the improvement or replacement of existing systems. Four technology vendors, using 9 products, have been implemented by the counties. All of the EHRs are MU certified.*
- By December 31, 2015, a continuity of care document (CCD) that includes behavioral health will have been developed and tested for California's mental health population.
    - *All of the EHRs have the ability to import and export CCDs. The CCD includes patient demographics, diagnoses, medications, allergies, treatment plans, encounter notes, and other data relevant to patient*

care. Consent documentation for the CCD can be stored in the HIE. This connects an electronic version of the consent documentation of the release containing the data recorded on the CCD.

- By December 31, 2015, 90% of independent pharmacies in California will be connected to an e-prescribing network
    - *According to the 2014 Surescripts National Progress Report, nationally 88% of independent pharmacies (and 98% of chain pharmacies) are connected to an e-Prescribing network. California ranks within the top ten states e-Prescribing controlled substances.*
- By December 31, 2015, 80% of community clinics will have fully implemented certified EHRs.
    - *According to the 2013 UCSF survey, 80% of EPs in community clinics have access to an EHR. Additionally, according to an April 2014 survey completed by CPCA clinics, approximately 81% of respondents are using EHRs.*
- By December 31, 2015, 50% of providers in California will be able to electronically transmit immunization information to an immunization registry.
    - *According to the 2013 UCSF survey, 54% of the physicians surveyed indicated that they have an EHR with the ability to transmit data to immunization registries. All immunization registries in California are capable of receiving electronic transmissions.*
- By December 31, 2015, 90% of hospital, regional, and public health laboratories will be able to electronically transmit laboratory results to providers.
    - *Consolidated data regarding transmission from laboratories to provider EHRs is not available as approximately half of laboratory tests in California are performed by over 17,000 hospital, regional, public health, and provider office laboratories. However, the two largest commercial laboratories in the state (Quest Diagnostics and Labcorp) perform between 50% and 60% of outpatient laboratory tests in California and are able to integrate with EHRs. Additionally, both provide access via e-portals for providers to access lab results.*

- 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.
    - *CDHP's CalREDIE is used by 58 of the 61 local health departments LHDs in California to report all diseases, the remaining 3 LHDs are using CalREDIE in some capacity. The CalREDIE Provider Portal enables providers and hospitals to electronically submit reportable disease information to their LHDs. Currently 37 of the 61 LHDs are using the Provider Portal. Hospitals and providers whose LHD does not utilize the Provider Portal are still able to submit reportable disease information via manual transmission.*

APPENDIX 11: MEANINGFUL USE (MU) CERTIFICATE



APPENDIX 12: DENTAL MEANINGFUL USE (MU) SURVEY

Meaningful Use Dental Survey

The Office of Health Information Technology (OHIT), of the California Department of Health Care Services administers the Medi-Cal Electronic Health Record program that has provided over $1.4 billion for hospitals and health professionals to adopt and use electronic health records (EHRs) over the last 5 years. As the program will continue until 2021, hospitals and providers can continue to receive funding by demonstrating meaningful use of EHRs during this time. Slightly less than 50% of program participants have demonstrated meaningful use, with dentists having the lowest rate at less than 10%. OHIT would like to better understand the unique barriers to demonstrating meaningful use of EHRs that dentists face. You, or your office, has been identified as a program participant that received an incentive payment to adopt an EHR, but who has not subsequently received incentive funding for demonstrating meaningful use. We would like to ask you to complete the following questions to help us understand the barriers to meaningful use in the dental community.

Completing this survey will have no effect on your ability to receive incentive or other payments from DHCS in the future.

Note on confidentiality: Your individual responses will remain confidential. Overall findings will be summarized and used for reporting purposes.

1. Are you the dentist or a contact person for the dentist(s)? (select one)

   _____ Dentist

   _____ Contact Person

2. If you are a dentist, indicate the number of dentists in your primary practice location (select one).

   _____ 1-5

   _____ 6-19

   _____ 20 or greater

   _____ Other. Please specify the number of dentists in the primary practice location.

3. If you are the contact person for the dentist(s), how many dentists do you represent?

   _____ 1-5

   _____ 6-19

   _____ 20 or greater

_____ Other. Please specify the number of dentists that you represent.

4. Please indicate primary practice location for you or the dentist(s) you represent (select one).
   _____ Private practice (Owner/billing provider)

   _____ Federally Qualified Health Center/Rural Health Center/Indian Health Center

   _____ Community Health Center

   _____ Dental School/other educational setting.

   _____ Other (please specify).

5. Do you or the dentist(s) that you represent intend to apply for meaningful use incentive payments in the future? (select one)
   _____ Yes (Instead of drop down, use logic for a "yes" response.)

   _____ No

6. When do you intend to submit a meaningful use application? (Logic applied if answer to #5 is "yes'.)
   _____ 2017 _____2018 _____ 2019 _____2020 _____ 2021

   The next series of questions are specific to the unique barriers experience by dentists when demonstrating meaningful use. Even if you do not intend to apply for meaningful use, your responses and feedback are appreciated.

7. I do not regularly use my certified Electronic Health Record (EHR)/Electronic Dental Record (EDR).
   _____ Yes
   _____ No

8. My certified EHR/EDR is not user friendly for dentists.
   _____ Strongly agree
   _____ Agree
   _____ Neutral/Neither agree nor disagree
   _____ Disagree
   _____ Strongly disagree

9. The conversion process from paper-based to electronic charts available in the EHR/EDR is too difficult.
   _____ Strongly agree
   _____ Agree
   _____ Neutral/Neither agree nor disagree

_____ Disagree
_____ Strongly disagree

10. My certified EHR/EDR does not offer dental appropriate modules and/or applications.
    _____ Strongly agree
    _____ Agree
    _____ Neutral/Neither agree nor disagree
    _____ Disagree
    _____ Strongly disagree

11. My EHR/EDR needs to be upgraded to comply with current meaningful use requirements.
    _____ Yes
    _____ No

12. It is difficult to qualify for MU because I practice in multiple locations equipped with different EHR/EDR technologies.
    _____ Strongly agree
    _____ Agree
    _____ Neutral/Neither agree nor disagree
    _____ Disagree
    _____ Strongly disagree

13. The $8,500 meaningful use payments does not justify the effort needed to meet meaningful use. _____ Strongly agree
    _____ Agree
    _____ Neutral/Neither agree nor disagree
    _____ Disagree
    _____ Strongly disagree

14. I am aware that many meaningful use measures do not apply to dentists and can be excluded.
    _____ Strongly agree
    _____ Agree
    _____ Neutral/Neither agree nor disagree
    _____ Disagree
    _____ Strongly disagree

15. My patients do not have email addresses, making it difficult to meet the patient portal requirements.
    _____ Yes
    _____ No

16. I do not believe I can qualify for meaningful use because I am a dentist.
    _____ Strongly agree
    _____ Agree
    _____ Neutral/Neither agree nor disagree
    _____ Disagree
    _____ Strongly disagree

17. I need more information about meaningful use requirements.
    _____ Yes (Include option for EP to provide email address to receive tip sheet).
    _____ No

18. Please enter your email address if you would like to receive more information regarding meaningful use requirements for dentists. (This question only appears if respondent requests more information.)

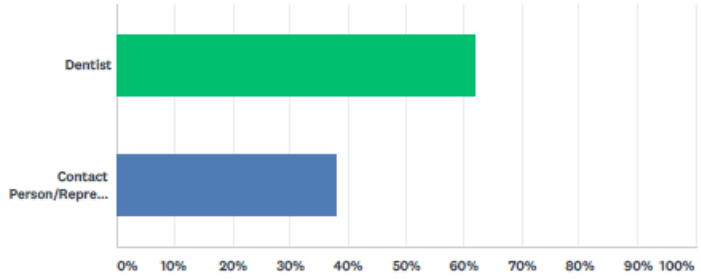
19. Thank you for your responses. If you have any additional comments, please let us know.

APPENDIX 13: DENTAL MEANINGFUL USE (MU) SURVEY RESULTS

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q1 Are you the dentist or the contact person/representative for the dentist(s)? Please select one.

Answered: 368 Skipped: 0

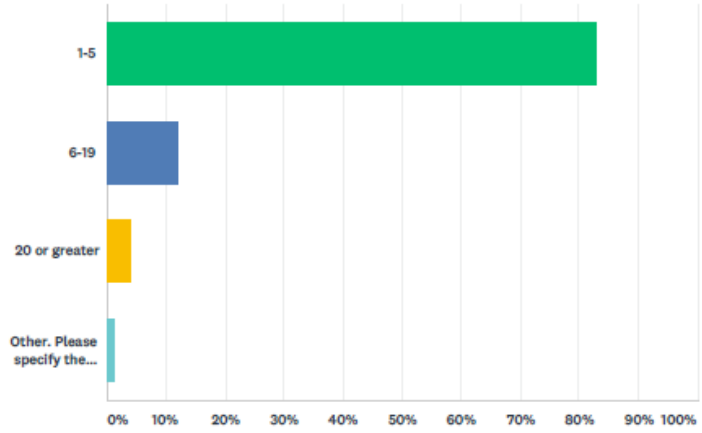


ANSWER CHOICES	RESPONSES	
Dentist	61.96%	228
Contact Person/Representative	38.04%	140
TOTAL		368

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q2 If you are the dentist, indicate the number of dentists in your primary practice location.

Answered: 226 Skipped: 142

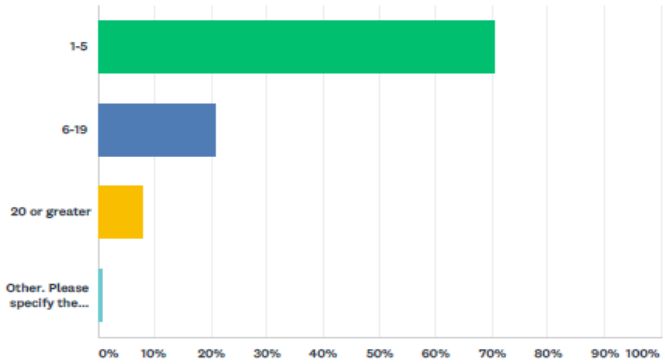


ANSWER CHOICES	RESPONSES	
1-5	82.74%	187
6-19	11.95%	27
20 or greater	3.98%	9
Other. Please specify the number of dentists in the primary practice location.	1.33%	3
TOTAL		226

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q3 If you are the contact person for the dentist(s), how many dentists do you represent?

Answered: 139 Skipped: 229

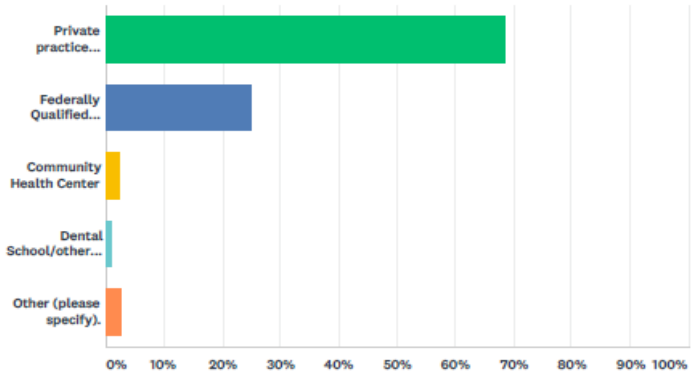


ANSWER CHOICES	RESPONSES	
1-5	70.50%	98
6-19	20.86%	29
20 or greater	7.91%	11
Other. Please specify the number of dentists that you represent.	0.72%	1
TOTAL		139

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q4 Please indicate the primary practice location for you or the dentist(s) you represent (select one).

Answered: 361 Skipped: 7

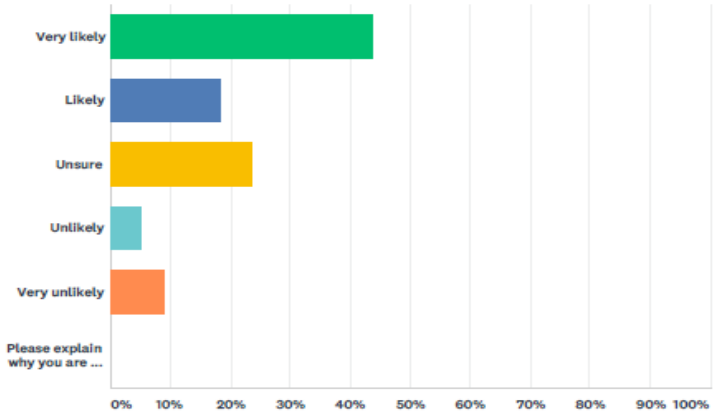


ANSWER CHOICES	RESPONSES	
Private practice (Owner/billing provider)	68.70%	248
Federally Qualified Health Center/Rural Health Center/Indian Health Center	25.21%	91
Community Health Center	2.22%	8
Dental School/other educational setting	1.11%	4
Other (please specify).	2.77%	10
TOTAL		361

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q5 How likely are you or the dentist(s) that you represent to apply for meaningful use incentive payments in the future? (select one)

Answered: 359 Skipped: 9

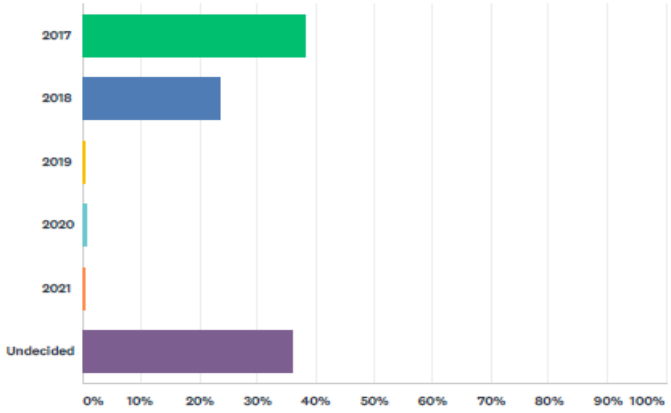


ANSWER CHOICES	RESPONSES	
Very likely	43.73%	157
Likely	18.38%	66
Unsure	23.68%	85
Unlikely	5.29%	19
Very unlikely	8.91%	32
Please explain why you are not sure if you will submit an application to receive meaningful use incentive funds.	0.00%	0
TOTAL		359

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q6 When do you intend to first submit a meaningful use application?

Answered: 219 Skipped: 149

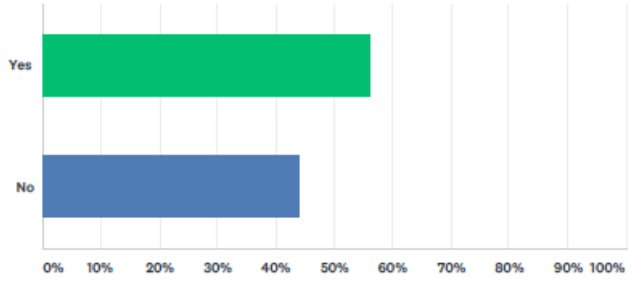


ANSWER CHOICES	RESPONSES	
2017	38.36%	84
2018	23.74%	52
2019	0.46%	1
2020	0.91%	2
2021	0.46%	1
Undecided	36.07%	79
TOTAL		219

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q7 I regularly use my certified Electronic Health Record (EHR)/Electronic Dental Record (EDR).

Answered: 341 Skipped: 27

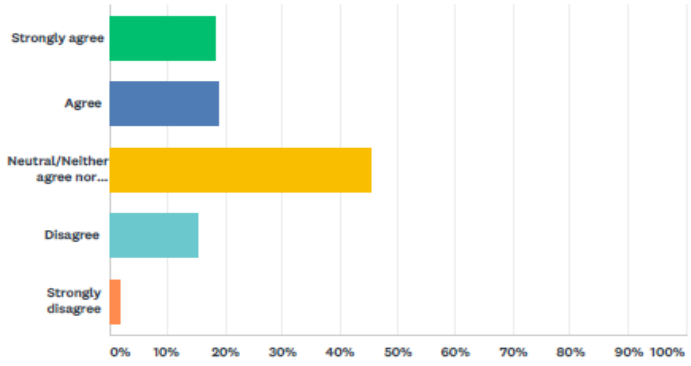


ANSWER CHOICES	RESPONSES	
Yes	56.01%	191
No	43.99%	150
TOTAL		341

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q8 My certified EHR/EDR is not user friendly for dentists.

Answered: 332 Skipped: 36

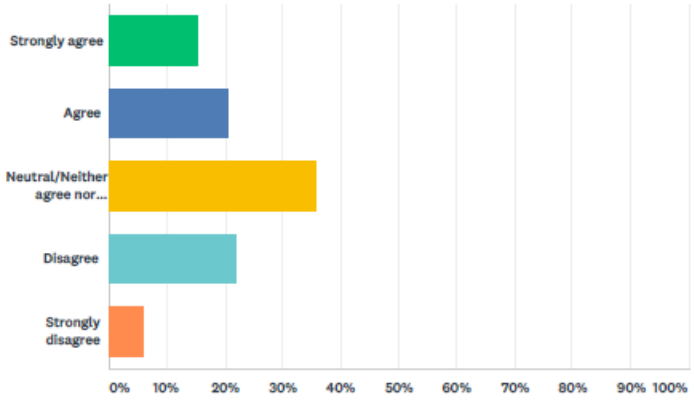


ANSWER CHOICES	RESPONSES	
Strongly agree	18.37%	61
Agree	18.98%	63
Neutral/Neither agree nor disagree	45.48%	151
Disagree	15.36%	51
Strongly disagree	1.81%	6
TOTAL		332

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q9 The conversion process from paper-based to electronic charts available in the EHR/EDR is too difficult.

Answered: 327 Skipped: 41

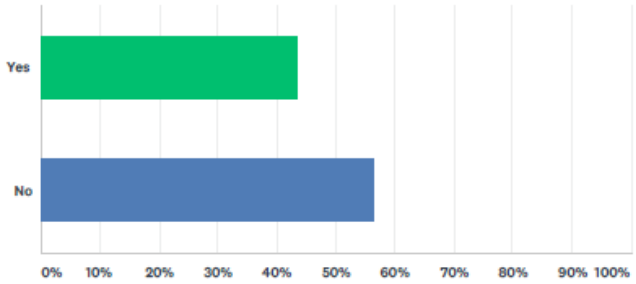


ANSWER CHOICES	RESPONSES	
Strongly agree	15.29%	50
Agree	20.80%	68
Neutral/Neither agree nor disagree	35.78%	117
Disagree	22.02%	72
Strongly disagree	6.12%	20
TOTAL		327

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q10 My certified EHR/EDR does not offer dental-appropriate modules and/or applications.

Answered: 320 Skipped: 48

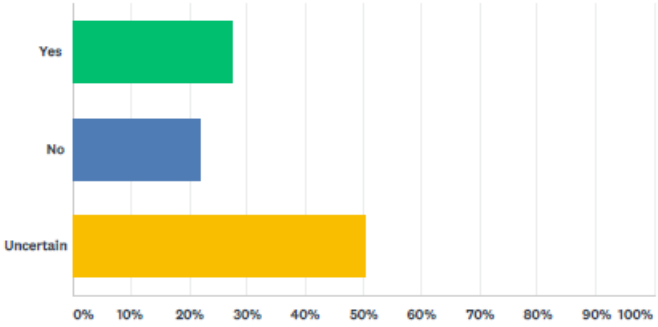


ANSWER CHOICES	RESPONSES	
Yes	43.44%	139
No	56.56%	181
TOTAL		320

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q11 My EHR/EDR needs to be upgraded to comply with current meaningful use requirements.

Answered: 318 Skipped: 50

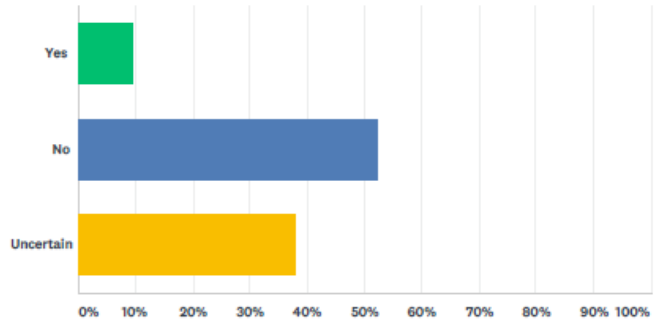


ANSWER CHOICES	RESPONSES	
Yes	27.67%	88
No	22.01%	70
Uncertain	50.31%	160
TOTAL		318

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q12 I do not believe I can qualify for meaningful use because I am a dentist.

Answered: 315 Skipped: 53

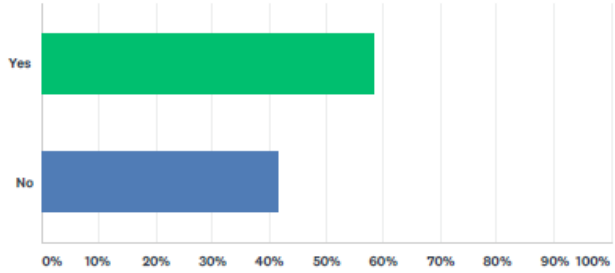


ANSWER CHOICES	RESPONSES	
Yes	9.52%	30
No	52.38%	165
Uncertain	38.10%	120
TOTAL		315

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q13 I am aware that many meaningful use measures do not apply to dentists and, therefore, can be excluded.

Answered: 313 Skipped: 55

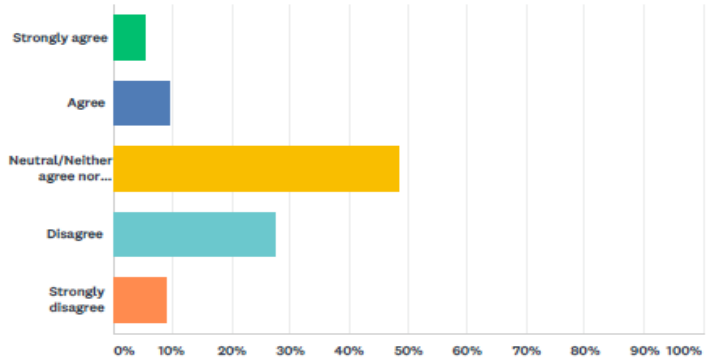


ANSWER CHOICES	RESPONSES	
Yes	58.47%	183
No	41.53%	130
TOTAL		313

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q14 It is difficult to qualify for MU because I practice in multiple locations with different EHR/EDR technologies.

Answered: 311 Skipped: 57

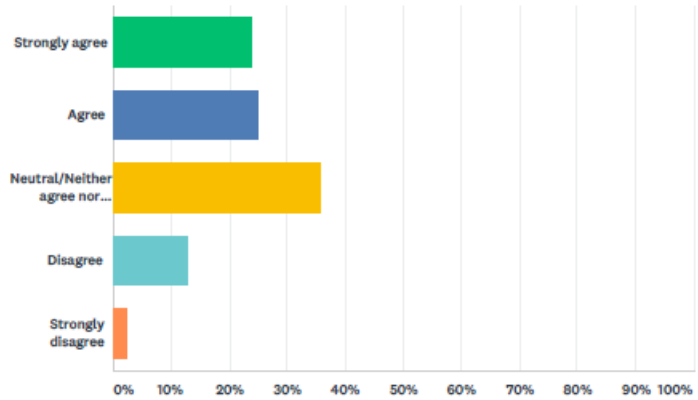


ANSWER CHOICES	RESPONSES	
Strongly agree	5.47%	17
Agree	9.32%	29
Neutral/Neither agree nor disagree	48.55%	151
Disagree	27.65%	86
Strongly disagree	9.00%	28
TOTAL		311

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q15 The annual $8,500 meaningful use payments do not justify the effort needed to meet meaningful use.

Answered: 310 Skipped: 58

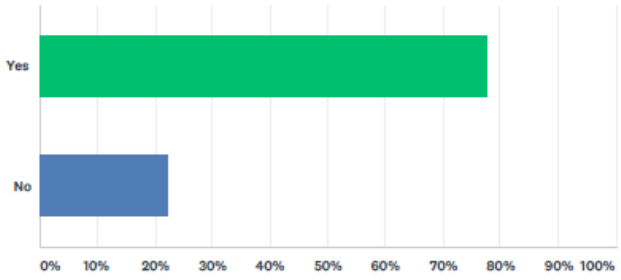


ANSWER CHOICES	RESPONSES	
Strongly agree	23.87%	74
Agree	25.16%	78
Neutral/Neither agree nor disagree	35.81%	111
Disagree	12.90%	40
Strongly disagree	2.26%	7
TOTAL		310

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q16 Many of my patients do not have email addresses or internet access, making it difficult to meet patient portal requirements.

Answered: 310 Skipped: 58

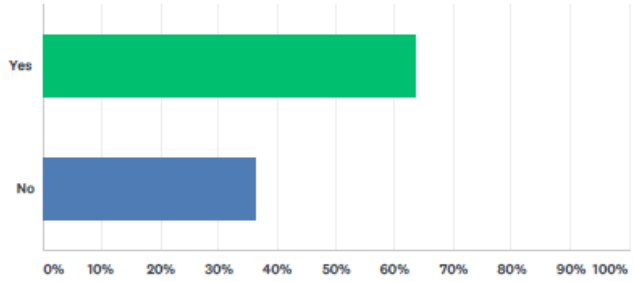


ANSWER CHOICES	RESPONSES	
Yes	77.74%	241
No	22.26%	69
TOTAL		310

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q17 I would like more information about meaningful use requirements.

Answered: 308 Skipped: 60



ANSWER CHOICES	RESPONSES	
Yes	63.64%	196
No	36.36%	112
TOTAL		308

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q18 Please enter your email address if you would like to receive more information regarding meaningful use requirements for dentists.

Answered: 193 Skipped: 175

Medi-Cal EHR Incentive Program Meaningful Use Survey for Dentists

Q19 Thank you for your responses. If you have any additional comments, please include those in the space provided below.

Answered: 57 Skipped: 311

APPENDIX 14: DENTAL MEANINGFUL USE (MU) TIP SHEET

Medi-Cal Electronic Health Record (EHR) Incentive Program

Tips for Dental Providers

General Program and Participation Requirements

Eligibility Requirements

- Be a licensed dentist in the State of California.
- Have 30% or more patient volume attributable to Medi-Cal patients in a 90-day period in the preceding calendar year.
- Participation in the Medi-Cal EHR Incentive Program prior to 2017.
- Program year participation does not need to be in consecutive years.

Meaningful Use

- A dentist can receive $8,500 per year by demonstrating meaningful use.
- To date, only 9% of dentists in the program have taken advantage of available meaningful use funds.
- It's not as hard as you think! Dentists can utilize many tips and work-arounds, including using exclusions, to attain meaningful use.

MU Objective (Stage 2)	Tips
Protect Patient Health Information	• Required for providers based on HIPAA requirements for the protection of electronic person health information (ePHI). • This can be done by internal staff or by a vendor.
Clinical Decision Support	• Exclusion available for drug-drug and drug-allergy interactions if an EP writes fewer than 100 medication orders.
Computerized Provider Order Entry (CPOE) for Medication, Lab, and Radiology Orders	• Individual exclusions available if EP writes fewer than 100 medication, lab, or radiology orders during the EHR reporting period.
Electronic Prescribing (eRX)	• Exclusion available for a dentist who writes fewer than 100 permissible prescriptions during the EHR reporting period.
Health Information Exchange	• Exclusion for less than 100 transitions of care during the EHR reporting period. • Applicable when patients are referred for additional dental services.
Patient-Specific Education	• Exclusion available for a dentist who has no office visits during the EHR reporting period.
Medication Reconciliation	• Exclusion available for a dentist who was not the recipient of any transitions of care during the EHR reporting period.
Patient Electronic Access	• Encourages the use of a patient portal to view, download, or transmit health information. Only 5% or greater of patients need to access information. • Exclusion may apply for dentists in counties with low broadband access.
Secure Electronic Messaging	• Encourages use of secure messaging to improve communication between the patient and the office. Only 5% or greater of patients need to receive messaging. • Exclusion available for dentists in counties with low broadband access.
Public Health Reporting	• Exclusions available if a dentist does not give immunizations, practice in county with syndromic surveillance or participates in a specialized registry. This may include most dentists.

- **The link to the CMS Fact Sheet has been included for each MU Objective listed above.**
- **Program information is available on the State Level Registry at: http://medi-cal.ehr.ca.gov/**
- **Additional Stage 2 details are available at: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2015_EHR2015_2017.pdf**

APPENDIX 15: OPTOMETRISTS AS ELIGIBLE PROVIDERS

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

Toby Douglas, Director
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Mr. Douglas:

Enclosed is an approved copy of California State Plan Amendment (SPA) 11-017. SPA 11-017 was submitted to my office on September 29, 2011 to add services that an optometrist is legally authorized to perform to the physician services section of the State Plan; the SPA also removes optometrist services from the other licensed practitioner services section of the State Plan. This SPA makes the necessary changes such that optometrists are eligible for the Electronic Health Record (EHR) incentive program.

The effective date of this SPA is October 1, 2011. Enclosed are the following approved SPA pages that should be incorporated into your approved State Plan:

- Attachment 3.1-A, page 3
- Limitations on Attachment 3.1-A, pages 10a.2 and 11
- Attachment 3.1-B, page 3
- Limitations on Attachment 3.1-B, pages 10a.2 and 11
- Section 3.1(f)(1), page 27

If you have any questions, please contact Kristin Dillon by phone at (415) 744-3579 or by email at Kristin.Dillon@cms.hhs.gov.

Sincerely,

/s/
Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosure

cc: Kathyryn Waje, California Department of Health Care Services
Pilar Williams, California Department of Health Care Services

APPENDIX 16: PHYSICIAN ASSISTANT- LED (PA-LED) FORM

Attestation that a Federally Qualified Health Center or Rural Health Center is Physician Assistant-Led (PA-Led)

Please note: for the purposes of the Medi-Cal EHR Incentive Program this includes FQHC-look-alike clinics, and Indian Health Clinics

Clinic Name: _____
Clinic Address: _____
Clinic NPI: _____
_____FQHC _____ RHC (check one)

Name of PA who presently leads the clinic: _____
NPI of PA who presently leads the clinic: _____

Criteria for Physician Assistant-Led: (check at least one)

For the day on which this form is signed the:
_____ PA is clinical director
or
_____ PA is dominant provider in the clinic

Compared to other providers: (check at least one)
_____ PA assigned the most patients
_____ PA with the most patient encounters
_____ PA with the most practice hours

Name of Eligible Physician Assistant: _____
Signature of Eligible Physician Assistant: _____
Date: _____

Please Note: This form must be signed within the valid attestation period for the program year (i.e. the calendar year and the grace period in the following calendar year). This form must be completed and submitted every year that the PA participates in the Medi-Cal EHR Incentive Program.

APPENDIX 17: STAYING HEALTH ASSESSMENT (SHA) FORM

State of California – Health and Human Services Agency | Department of Health Care Services

Staying Healthy Assessment

0 – 6 Months

Child's Name (first & last)	Date of Birth	☐ Female ☐ Male	Today's Date	In Child/Day Care? ☐ Yes ☐ No
Person Completing Form	☐ Parent ☐ Relative ☐ Friend ☐ Guardian ☐ Other (Specify)			Need Help with Form? ☐ Yes ☐ No

Please answer all the questions on this form as best you can. Circle "Skip" if you do not know an answer or do not wish to answer. Be sure to talk to the doctor if you have questions about anything on this form. Your answers will be protected as part of your medical record.

Need Interpreter? ☐ Yes ☐ No

					Clinic Use Only:
1	Do you breastfeed your baby?	Yes	No	Skip	Nutrition
2	Are you concerned about your baby's weight?	No	Yes	Skip	Physical Activity
3	Does your baby watch any TV?	No	Yes	Skip	
4	Does your home have a working smoke detector?	Yes	No	Skip	Safety
5	Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Skip	
6	If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Skip	
7	Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Skip	
8	Does your home have the phone number of the Poison Control Center (800-222-1222) posted by your phone?	Yes	No	Skip	
9	Do you always put your baby to sleep on her/his back?	Yes	No	Skip	
10	Do you always stay with your baby when she/he is in the bathtub?	Yes	No	Skip	

DHCS 7098 A (Rev 12/14) SHA (0 – 6 Months) Page 1 of 2

State of California – Health and Human Services Agency | Department of Health Care Services

11	Do you always place your baby in a rear facing car seat in the back seat?	Yes	No	Skip	
12	Is the car seat you use the right one for the age and size of your baby?	Yes	No	Skip	
13	Does your baby spend time in a home where a gun is kept?	No	Yes	Skip	
14	Do you give your baby a bottle with anything except formula, breast milk, or water?	No	Yes	Skip	Dental Health
15	Does your baby spend time with anyone who smokes?	No	Yes	Skip	Tobacco Exposure
16	Do you have any other questions or concerns about your baby's health, development, or behavior?	No	Yes	Skip	Other Questions

If yes, please describe:

Clinic Use Only	Counseled	Referred	Anticipatory Guidance	Follow-up Ordered	Comments:
☐ Nutrition	☐	☐	☐	☐	
☐ Physical Activity	☐	☐	☐	☐	
☐ Safety	☐	☐	☐	☐	
☐ Dental Health	☐	☐	☐	☐	
☐ Tobacco Exposure	☐	☐	☐	☐	☐ **Patient Declined the SHA**

PCP's Signature:	Print Name:	Date:

APPENDIX 18: REDWOOD MEDNET

www.redwoodmednet.org

Redwood MedNet launches iOS app for Medi-Cal Staying Healthy Assessment
28 June 2017

The Staying Healthy Assessment (SHA) is an individual health education survey developed by California Department of Health Care Services (DHCS). The SHA consists of seven age-specific pediatric questionnaires and two adult questionnaires. It is available in English and in all Medi-Cal threshold languages. Providers are required to administer the SHA to Medi-Cal beneficiaries as part of the Initial Health Assessment, and to periodically re-administer the assessment per contract requirements. Blank SHA forms are available to download as a PDF from DHCS. The survey is typically filled out by hand as a two page paper form.

During 2016 the Lake County Health Leadership Network, a rural community health collaborative, investigated electronic solutions to automate SHA data collection and to build a repository of SHA data for use as a local population health quality measure. The Health Leadership Network SHA Data Automation Project is funded by a planning grant from HRSA and an implementation grant from Partnership HealthPlan of California. In February 2017 Redwood MedNet demonstrated a software solution for automating SHA data collection to the Health Leadership Network, Partnership HealthPlan, and DHCS Office of Health IT. In March 2017 the Health Leadership Network requested a proposal from Redwood MedNet to build the SHA data service. In June 2017 Redwood MedNet and the Health Leadership Network signed a Letter of Agreement to build a pilot of software to automate SHA data collection.

The Redwood MedNet SHA data collection service is built as an iPad application using SMART on FHIR as the software stack, with Argonaut profiles to access patient demographics from the EHR. The SMART app exports assessment results as JSON data objects, provides the

rwmn.sha.data.20170628.v10 1 / 2

outpatient practice with an electronic file for each assessment, and populates a SHA repository for access with data visualization tools. The illustration below shows a high level diagram of the generic SMART on FHIR data service. Redwood MedNet is grateful for substantial guidance during development of the SHA data automation use case from Drajer LLC, CAHIE, DHCS Office of Health IT, Joshua Mandel, MD, from Boston Children's Hospital, and Michael Hogarth, MD, from UC Davis School of Medicine.

For more information about the Health Leadership Network SHA Data Automation Project contact smartonfhir@redwoodmednet.org.

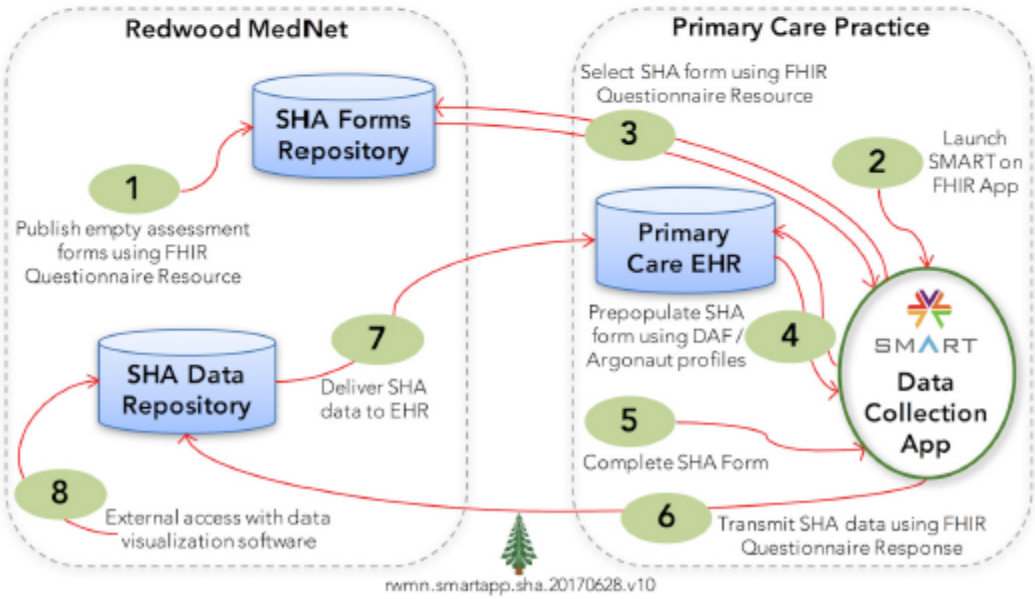
Links:

http://www.dhcs.ca.gov/formsandpubs/forms/Pages/StayingHealthy.aspx

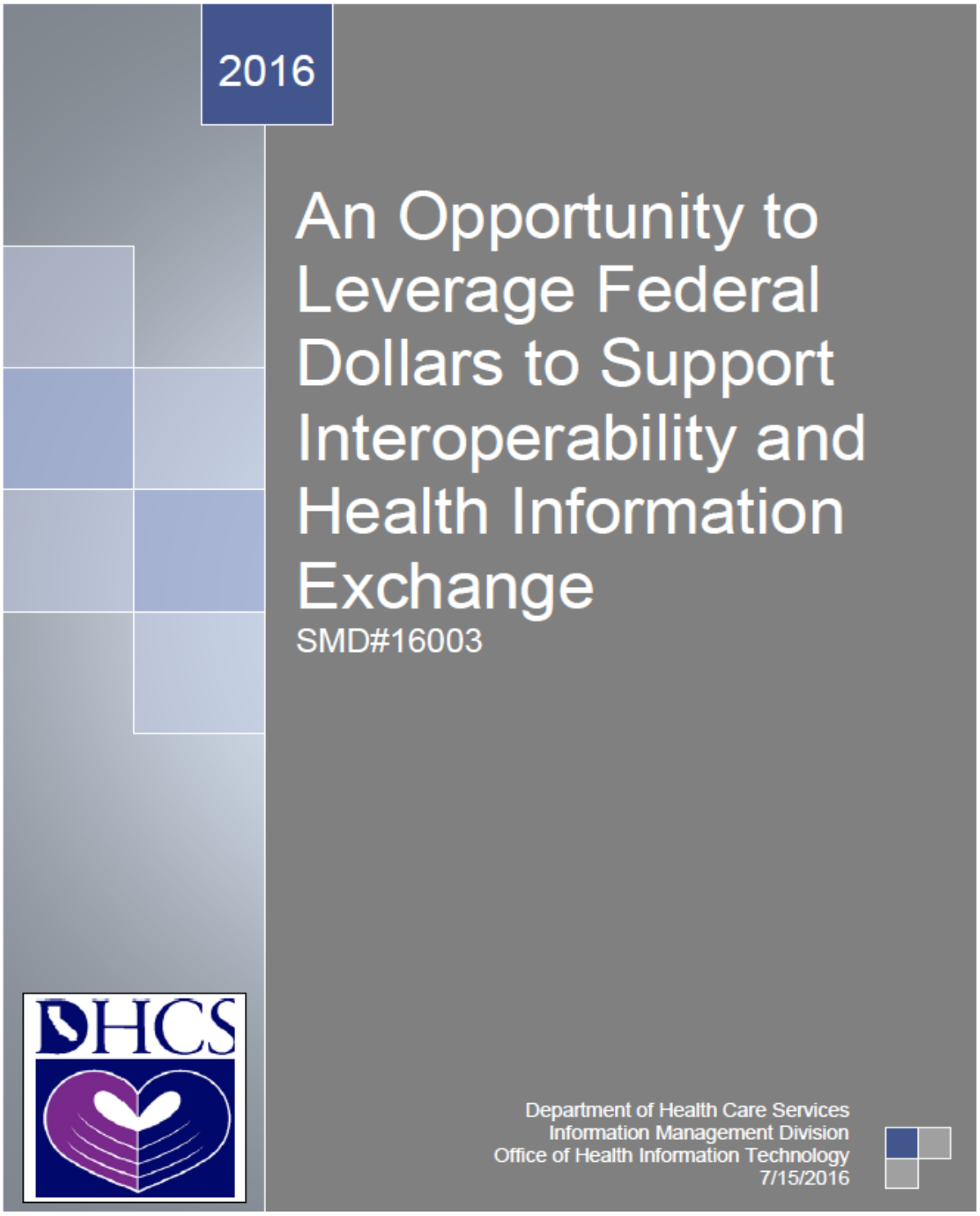
http://smarthealthit.org/

http://hl7.org/fhir/versions.html

http://www.partnershiphp.org



APPENDIX 19: HIE FUNDING OPPORTUNITY NOTICE



INTRODUCTION

The Centers for Medicare and Medicaid Services (CMS) Medicaid Data and Systems Group and Office of the National Coordinator (ONC) Office of Policy, partnered to update the guidance on how states may support health information exchange and interoperable systems to best support Medicaid providers in attesting to Meaningful Use Stages 2 and 3. This updated guidance allows State Medicaid Agencies to leverage Medicaid HITECH funds to support all Medicaid providers with whom Eligible Providers (EPs) wish to coordinate care with.

The mission of the California Department of Health Care Services (DHCS) is to provide Californians with access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services and long-term care. Our vision is to preserve and improve the overall health and well-being of all Californians.

DHCS's programs and quality strategy emphasize prevention-oriented health care that promotes health and well-being. This is done to: a) serve those with the greatest health care needs through the appropriate and effective expenditure of public resources, with a focus on improving the health of all Californians; b) enhancing quality, including the patient care experience, in all DHCS programs; and c) reduce the Department's per capita health care program costs. DHCS has embarked on a path of transformation and innovation supporting the Medi-Cal 2020[1] Waiver, to achieve its commitments to the public and the people it serves.

Updated guidance provided in SMD #16003 places DHCS is in a unique position to leverage Medicaid HITECH funds to support activities which align with the department's mission and vision, including HIE onboarding and systems for behavioral health providers, long term care providers, substance abuse treatment providers, home health providers, correctional health providers, social workers, emergency medical services providers and so on. It may also support the HIE on-boarding of laboratory, pharmacy or public health providers.

Given the breadth of potential activities eligible for HITECH funding at the local and state level, and recognizing the limited State staff resources available to support evaluation and funding of these activities, it is critical that efforts be coordinated and support DHCS's mission, including Medi-Cal 2020 waiver activities.

[1] http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx

Potential Uses

The underlying principle behind SMD#16003 and HITECH statute supporting the Medi-Cal EHR Incentive Program, supports the pursuit of initiatives to encourage the adoption of certified EHR technology which promote health care quality and the exchange of health care information under this title, subject to applicable laws and regulations governing such exchange. Activities include but are not limited to those which follow below.

HIE On-boarding

State Medicaid Agencies may use this enhanced funding to on-board Medicaid providers who are not incentive-eligible, including public health providers, pharmacies and laboratories. So, for example:

- Long term care providers may be on-boarded to a statewide provider directory
- Rehabilitation providers may be on-boarded to encounter alerting systems
- Pharmacies may be on-boarded to drug reconciliation systems
- Public health providers may be on-boarded to query exchanges
- EMS providers may be on-boarded to encounter alerting systems
- Medicaid social workers may be connected to care plan

Such on-boarding must connect the new Medicaid provider to an EP, and help that EP in achieving MU stage 2 and 3.

HIE Architecture

Several HIE modules and use cases are specifically called out for support:

- **Provider Directories**: with an emphasis on dynamic provider directories that allow for bidirectional connections to public health and that might be web-based, allowing for easy use by other Medicaid providers with low EHR adoption rates
- **Secure Messaging**: with an emphasis on partnering with DirectTrust
- **Encounter Alerting**
- **Care Plan Exchange**
- **Health Information Services Providers** (HISP) Services
- **Query Exchange**
- **Public Health Systems**

Any requested system must support Meaningful Use for a Medicaid EP in some manner. So, for example, the content in the Alerting feed or Care Plan must potentially help an EP meet an MU measure.

Public Health Systems

The major distinction from previous permitted funding options, is that Medicaid HITECH funds can be used for more than interfaces for EPs- now it can be used for the Public Health infrastructure more broadly to allow EPs to meet MU.

Provider Directories

- Enable HIE
- MMIS funding has always been available for Medicaid provider directories but the directory only supports Medicaid in most instances
- This new option would allow for the inclusion of non-eligible providers in a statewide HIE's provider directory, funded in part by Medicaid with HITECH funds

Care Plan Exchange

- Sending an electronic care plan between providers (physical and behavioral health, for example)
- MU alignment:
- Summary of Care
- Health Information Exchange
- View, download, transmit

Care Plan Scenarios

Scenario 1: Unidirectional Exchange of a Care Plan during a complete handoff of care form the sending Care Team (e.g. Hospital setting) to a receiving Care Team (e.g. Home Health Agency and PCP)

Scenario 2: Exchanging a Care Plan between Care Team Members and a Patient

- Setting 1: Hospital or ED where Patient is discharged from sends Care Plan to Care Team in non-acute care setting
- Setting 2: Care Team including Patient in Acute Care Setting creates harmonized Care Plan for exchange with a second Care Team in a non-acute care setting
- Setting 3: Patient receives Care Plan in their personal health record application or patient system.

Interoperability Standards

Medicaid systems must adhere to Medicaid Information Technology Architecture (MITA)*, which requires adherence to seven conditions and standards:

- Modularity Standards
- MITA Condition
- Industry Standard Condition
- Leverage Condition
- Business Result Condition
- Reporting Condition
- Interoperability Condition

Process

Funding for activities outlined in SMD#16003 go directly to the state Medicaid agency in the same way existing Medicaid HITECH administrative funds are distributed. Steps necessary to secure Federal funding include:

- Updating the State Medicaid Health Information Technology Plan (SMHP)[2] to include a high level description of the proposed initiatives or activities
- State submission of an IAPD (Implementation Advanced Planning Document), requesting approval of enhanced federal funding for the initiative. The IAPD must include a detailed description of the initiative, required staffing, comprehensive budget information, cost allocations, and details regarding the source of matching funds. IAPD's are submitted to CMS for review and approval.
- States must complete Appendix D (HIE information) for the IAPD as appropriate
- Federal funding for HIE and Interoperability activities described in SMD#16003 is in place until 2021 and is a 90/10 Federal State match. The state is responsible for securing the 10% match. As such, DHCS will need to work with potential recipients of this enhanced funding to identify a source for the 10% match. Please note, matching funds are subject to federal funding rules and cannot be provided directly from providers/entities benefiting from the enhanced funding.
- The funding is for HIE and interoperability **only**, not to purchase/provide EHRs.
- The funding supports one time implementation costs **only**, it is not available for maintenance and operational costs.
- The funding must be cost allocated if entities other than the state Medicaid agency benefit
- **All providers or systems supported by this funding must connect to Medicaid EPs.**

Submission Information

If you are interested in submitting an idea, provide the following detailed information in a document (limited to 10 pages) and send to Raul Ramirez, Chief, Office of Health Information Technology, via email at raul.ramirez@dhcs.ca.gov with the subject line "HIT Funding Opportunity"

Please include a Statement of Needs and Objectives including:

- A summary of project goals, objectives, and needs, and the anticipated benefits of the proposed project
- How does the project tie into Meaningful Use?
- How does it benefit Medicaid Meaningful Use EHR incentive providers?
- Potential costs
- Source of 10% Matching Funds
- Contributions

[2] http://www.dhcs.ca.gov/provgovpart/Documents/OHIT/CA_St_Medicaid_HIT_Plan_v2.4.pdf

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The submissions will be reviewed and will be points for further discussion as DHCS updates the SMHP "To-Be HIT Landscape" and "HIT Roadmap." The current CMS approved SMHP is posted on the DHCS website. There is no submission due date, as the SMHP is updated on an annual basis and funding runs to 2021.

DHCS expects to work with stakeholders to develop a series of projects represented by a series of IAPDs. Considerations for distinct projects may be funding sources and recipient characteristics, such as specific technical needs based on the current environment. These will be developed on a flow basis.

Examples of current projects that have received funding through this process prior to the SMD 16003 include:

- California Technical Assistance Program (http://www.dhcs.ca.gov/provgovpart/Pages/California_Technical_Assistance_Program_(CTAP).aspx)
- California Immunization Registry project (CAIR 2.0)
- California's Reportable Disease Information Exchange (CalREDIE)

To read the full SMD#16003 letter, please see https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16003.pdf .

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APPENDIX 20: 2014 FLEXIBILITY RULE – SMHP ADDENDUM

The SMHP addendum below was submitted to CMS and approved on 2/27/2014.

Background. On September 4, 2014 CMS issued The 2014 Edition EHR Certification Criteria Final Rule which is also known as the "Flexibility Rule." This rule enables hospitals and providers who have been unable to fully implement 2014 CEHRT because of delays in the availability of 2014 CEHRT to attest for meaningful use in 2014 using two alternative pathways--2013 Stage 1 objectives and measures or 2014 Stage 1 objectives and measures--depending on the meaningful use stage for which they are scheduled to report. California finished deploying the 2014 Stage 1 and Stage 2 objectives and measures into the State Level Registry (SLR) in May, 2014 and the Flexibility Rule now requires further changes to the SLR that are unexpected and substantial.

State Level Registry. DHCS, in partnership with its SLR vendor, Xerox, looked at different approaches to implementing the Flexibility Rule. The first approach considered was to allow hospitals and providers to use the alternative attestation pathways by completing and uploading an Excel form containing the data for the alternative objectives and measures. Although this "workaround" approach would have the advantage of not requiring extensive changes to the SLR, it was judged to have too many drawbacks in terms of staff work requirements and data integrity. DHCS decided that the Flexibility Rule requirements would have to be fully integrated into the electronic workflow of the SLR. Xerox subsequently submitted a work plan to DHCS that projects deployment of the required changes in the SLR for both hospitals and providers in mid-March, 2015.

DHCS in past years has used March 31st as the end date for the attestation grace period for providers. A deployment date of mid-March will allow providers only two weeks to apply to the SLR using the Flexibility Rule for 2014. For this reason, DHCS is requesting an extension of the 2014 grace period for providers to May 31, 2015*. In order to prevent providers from getting out of stage sequence by applying for meaningful use for 2015 before the end of this grace period, DHCS is also requesting to delay acceptance of 2015 meaningful use attestations from providers until June 1, 2015. DHCS has identified only three Medicaid-only hospital in California that may desire to use the Flexibility Rule for 2014. Of these hospitals, only one will be eligible to use a 90-day reporting period in 2015. Given these facts, DHCS requests to extend the 2014 grace period for these 3 hospitals until May 31, 2015*. DHCS will advise the one hospital with a 90-day reporting period in 2015 to not apply for 2015 until the 2014 attestation has been submitted and approved. For this reason DHCS is not requesting to block 2015 meaningful use attestations from hospitals during the extended grace period for these 3 hospitals.

DHCS intends to deploy all of the provisions of the Flexibility Rule in the SLR as delineated in the Federal Register. DHCS is not requesting accommodation from CMS except with regarding to the timing of deployment and 2014 grace period issues described above.

Auditing. DHCS does not yet have an approved auditing plan for meaningful use. DHCS will audit compliance with the Flexibility Rule in the same manner that is approved by CMS for auditing meaningful use in the future. However, one aspect of the Flexibility Rule will require special attention—the reason(s) and documentation that hospitals and providers provide to demonstrate their eligibility to use the Flexibility Rule. Hospitals and providers will be required to designate at least one of the following reasons in the SLR to establish their eligibility to use the Flexibility Rule:

- Software development delays
- Certification delays
- Implementation delays by the vendor
- Delays in release of the product or update by the vendor
- Unable to train staff, test the updates system, or put new workflows in place due to delay with installation of 2014 CEHRT by the vendor
- Other vendor related delays
- Inability to meet Summary of Care objective due to inability of receiving hospital(s)/provider(s) to receive transmission (applies to using 2014 Stage 1 instead of 2014 Stage 2 only)

Hospitals and providers will be given the ability to upload documentation into the SLR supporting the reason they designate. Hospitals and providers utilizing the Flexibility Rule will be subject to auditing at a slightly increased rate due to the special circumstances and the need to verify that the reasons and documentation are in compliance with the Flexibility Rule.

*Note: This addendum was submitted on 10/31/2014, and approved by CMS on 2/27/2015. On 5/28/14 California requested that CMS allow a further deadline extension for Program Year 2014 through 6/14/2015. This request was approved by CMS on 6/1/2015.

APPENDIX 21: 2015-17 MODIFICATION RULE – SMHP ADDENDUM

The updated SMHP addendum below was submitted to CMS and approved on 3/27/2017.

The new Final Rule requires a radical redesign of California's State Level Registry (SLR). The most challenging redesign issue is enabling providers in 2015 who are in Stage 1, to choose to attest measure by measure to either the new Stage 2 measure or the old Stage 1 measure. This level of flexibility is incompatible with the current SLR code base and, according to our SLR contractor (Conduent), would require well over $1 million and 18 months of time to deploy. We have previously informed CMS staff of this issue and, through conference calls and e-mail correspondence, believe we have come to agreement on an approach that will satisfy the requirements of the new Final Rule while enabling California to deploy a revised SLR in a relatively timely fashion.

California's basic approach will be to modify the SLR so that providers who would have been in Stage 1 in 2015 and 2016 can choose to attest to either a "Stage 1" or "Stage 2" version of the objectives and measures. For the "Stage 1" version, when alternate measures are available, only those measures will be displayed for attestation. When alternate exclusions are available for measures in either the "Stage 1" or "Stage 2" versions, neither the measures nor the related alternate exclusion will be displayed. The underlying assumption for this is that providers should not be asked to enter data for a measure if they cannot be held subject to proof or penalty upon audit for having attested to an alternate exclusion for that measure. The charts below display the objectives, measures, and alternative exclusions for eligible providers and hospital in 2015 and 2016. Screen shots of the SLR pages will be subsequently submitted for CMS review and approval before deployment, but these charts should provide a basic summary of which objectives and measures will be displayed in the SLR for each version in each year. Objectives, measures, and alternate exclusions that will not be displayed are shaded in grey in the charts.

California will deploy the 90-day reporting period in 2015 for all providers and change the reporting period for hospitals to end December 31, beginning in 2015. These changes are exactly as designated in the 2015-2017 Modification Final Rule.

Beginning with Program Year 2016, California will take advantage of the flexibility provided in the Stage 2 Final Rule in 2012 (Section 495.306) to allow EPs and EHs to use a 90-day representative period either in the 12 months before attestation or in the preceding calendar year (for EPs) or preceding federal fiscal year (for EHs). Previously, California had decided not to allow 90-day representative periods in the 12 months prior to attestation. This change will not affect California's current prequalification

methodologies for EPs and clinics that utilize the preceding calendar year as the representative period. California is adding this flexibility now to allow as many providers as possible to qualify for participation in 2016, since new providers cannot start the program after 2016.

California will deploy the 2016 and 2017 changes for objectives and measures for Stage 2 and Stage 3 exactly as designated in the Final Rule without change. California has submitted a separate SMHP Addendum for 2017 program year.

3/8/17 Addition

California will allow hospitals in Program Year 2016 to submit a new application to the program if they are able to provide 12 continuous months of auditable discharge data that ends before September 30, 2016. In previous years California has required the submission of 12 continuous months of discharge data that ends before October 1 of the prior calendar year. Since 2016 is the last year for providers to start the EHR Incentive Program, California has decided to allow the 12 continuous months of discharge data to end before September 30, 2016 so that newly opened hospitals that do not have 12 continuous months of discharge data ending before October 1, 2015 are able to qualify for the program. California believes that this flexibility is provided for in section 495.310(g)(1)(I)(B) of the Final Rule.

> "The discharge-related amount for the most recent continuous 12-month period selected by the State, but ending before the federal fiscal year that serves as the first payment year."

For Program Year 2016 California chooses to allow the submission of discharge data for the most recent 12-month continuous period that ends before the end, rather than the start, of the federal fiscal year that serves as the first payment year. In order to determine the growth rate, in the subsequent 3 program years these hospitals will be required to submit discharge data using the same time frame -- the most recent 12-month period that ends before the end of the federal fiscal year that serves as the payment year.

Eligible Providers

2015 Stage 1			2015 Stage 2			2016 Stage 1			2016 Stage 2		
OBJ 1	MEAS 1		**OBJ 1**	MEAS 1		**OBJ 1**	MEAS 1		**OBJ 1**	MEAS 1	
Alt OBJ 2	Alt MEAS 1	MEAS 1	**OBJ 2**	MEAS 1		**OBJ 2**	MEAS 1		**OBJ 2**	MEAS 1	
OBJ 2	MEAS 2			MEAS 2			MEAS 2			MEAS 2	
OBJ 3	*Alt MEAS 1*	MEAS 1	**OBJ 3**	MEAS 1		**OBJ 3**	MEAS 1		**OBJ 3**	MEAS 1	
	MEAS 2	Alt Excl 2		MEAS 2			MEAS 2	Alt Excl 2		MEAS 2	
	MEAS 3	Alt Excl 3		MEAS 3			MEAS 3	Alt Excl 3		MEAS 3	
OBJ 4	*Alt MEAS 1*	MEAS 1	**OBJ 4**	MEAS 1		**OBJ 4**	MEAS 1		**OBJ 4**	MEAS 1	
OBJ 5	MEAS 1	Alt Excl 1	**OBJ 5**	MEAS 1		**OBJ 5**	MEAS 1		**OBJ 5**	MEAS 1	
OBJ 6	MEAS 1	Alt Excl 1	**OBJ 6**	MEAS 1		**OBJ 6**	MEAS 1		**OBJ 6**	MEAS 1	
OBJ 7	MEAS 1	Alt Excl 1	**OBJ 7**	MEAS 1		**OBJ 7**	MEAS 1		**OBJ 7**	MEAS 1	
OBJ 8	MEAS 1		**OBJ 8**	MEAS 1		**OBJ 8**	MEAS 1		**OBJ 8**	MEAS 1	
	MEAS 2	Alt Excl 2		MEAS 2			MEAS 2			MEAS 2	
OBJ 9	MEAS 1*	Alt Excl 1	**OBJ 9**	MEAS 1*		**OBJ 9**	MEAS 1*		**OBJ 9**	MEAS 1*	
OBJ 10	MEAS 1		**OBJ 10**	MEAS 1		**OBJ 10**	MEAS 1		**OBJ 10**	MEAS 1	
	MEAS 2	Alt Excl**		MEAS 2	Alt Excl 2**		MEAS 2	Alt Excl 2**		MEAS 2	Alt Excl 2**
	MEAS 3 #1	Alt Excl**		MEAS 3 #1	Alt Excl 3**		MEAS 3 #1	Alt Excl 3**		MEAS 3 #1	Alt Excl 3**
	MEAS 3 #2			MEAS 3 #2 (?)			MEAS 3 #2 (?)			MEAS 3 #2 (?)	

Note: Cells in grey will not display in the State Level Registry

* This measure's requirements differs between 2015 and 2016, so the measure language in 2015 will be different from the measure language in 2016.

**The alternate exclusions for public health measures must be displayed along with the original measures, since the EP will need to select the specific measures to be excluded. In Stage 1 the alternate exclusions apply to all public health measures, while in Stage 2 the alternate exclusions can only apply to measures 2 and 3. Regardless of how many alternate exclusions claimed, the EP must still attest to at least 1 measure in Stage 1 and 2 measures in Stage 2.

Eligible Hospitals												
2015 Stage 1			**2015 Stage 2**			**2016 Stage 1**			**2016 Stage 2**		
OBJ 1	MEAS 1		**OBJ 1**	MEAS 1		**OBJ 1**	MEAS 1		**OBJ 1**	MEAS 1	
Alt OBJ 2	Alt MEAS 1	MEAS 1	**OBJ 2**	MEAS 1		**OBJ 2**	MEAS 1		**OBJ 2**	MEAS 1	
OBJ 2	MEAS 2			MEAS 2			MEAS 2			MEAS 2	
OBJ 3	Alt MEAS 1	MEAS 1	**OBJ 3**	MEAS 1		**OBJ 3**	MEAS 1		**OBJ 3**	MEAS 1	
	MEAS 2	Alt Excl 2		MEAS 2			MEAS 2	Alt Excl 2		MEAS 2	
	MEAS 3	Alt Excl 3		MEAS 3			MEAS 3	Alt Excl 3		MEAS 3	
OBJ 4	MEAS 1	Alt Excl 1	**OBJ 4**	MEAS 1	Alt Excl 1	OBJ 4	MEAS 1	Alt Excl 1	**OBJ 4**	MEAS 1	Alt Excl 1
OBJ 5	MEAS 1	Alt Excl 1	**OBJ 5**	MEAS 1		**OBJ 5**	MEAS 1		**OBJ 5**	MEAS 1	
OBJ 6	MEAS 1	Alt Excl 1	**OBJ 6**	MEAS 1		**OBJ 6**	MEAS 1		**OBJ 6**	MEAS 1	
OBJ 7	MEAS 1	Alt Excl 1	**OBJ 7**	MEAS 1		**OBJ 7**	MEAS 1		**OBJ 7**	MEAS 1	
OBJ 8	MEAS 1		**OBJ 8**	MEAS 1		**OBJ 8**	MEAS 1		**OBJ 8**	MEAS 1	
	MEAS 2	Alt Excl 2		MEAS 2			MEAS 2			MEAS 2	
OBJ 9											
OBJ 10	MEAS 1		**OBJ 10**	MEAS 1		**OBJ 10**	MEAS 1		**OBJ 10**	MEAS 1	
	MEAS 2	Alt Excl*		MEAS 2			MEAS 2			MEAS 2	
	MEAS 3 #1	Alt Excl*		MEAS 3 #1	Alt Excl 3*		MEAS 3 #1	Alt Excl*		MEAS 3 #1	Alt Excl 3*
	MEAS 3 #2	Alt Excl*		MEAS 3 #2			MEAS 3 #2			MEAS 3 #2	
	MEAS 3 #3			MEAS 3 #3			MEAS 3 #3			MEAS 3 #3	
	MEAS 4			MEAS 4			MEAS 4			MEAS 4	

Note: Cells in grey will not display in the State Level Registry

* The alternate exclusions for the public health measures must be displayed along with the original measures, since the EH will need to select the measures to be excluded. For Stage 1 the alternate exclusions apply to all measures, while in Stage 2 only measure 3 (specialized registries) can have an alternate exclusion. Regardless of the number of alternate exclusions claimed, EHs must attest to at least 2 measures in Stage 1 and 3 measures in Stage 2.

Timeline

- Closure of 2015 MU attestation under the old rule (EPs and EHs).
  - December 15, 2015
- Deployment of 2015 MU attestations under the new rule (EPs and EHs).
  - August 30, 2016
- Closure of tail period for 2015 MU attestations under the new rule (EPs and EHs).
  - December 13, 2016
- Deployment of 2016 MU attestations (EPs and EHs).
  - December 13, 2016
- Closure of tail period for 2016 MU attestations (EPs and EHs).
  - May 2, 2017
- Closure of AIU attestations.
  - AIU attestations will close for 2015 and 2016 when the MU attestations close for each year under the modification rule.

Outreach

DHCS will use multiple communication channels to inform hospitals and professionals about the attestation timelines for 2015-2017 including, but not limited to:

- The State Level Registry Homepage—DHCS will update this periodically as information on timelines become available from Conduent and as plans are approved by CMS
- California Technical Assistance Program (CTAP)—DHCS meets on a regular basis with the four contractors that have taken over the job of the regional extension centers in providing technical assistance to eligible professions for the Medi-Cal EHR Incentive Program in California. DHCS will work with the CTAP contractors to disseminate information about the timeline for attestations under the 2015-2017 Modification Rule.
- California Hospital Association (CHA)—DHCS is working with CHA to publish a newsletter to all hospitals in California about the Medi-Cal EHR Incentive Program and new deadlines under the 2015-2017 Modification Rule
- E-mail Announcements—DHCS periodically issues e-mail announcements about incentive program changes to key stakeholders. These announcements are in turn are routinely forwarded and published on the Internet and other media. DHCS anticipates sending out several e-mail announcements regarding the implementation of the 2015-2017 Modification Rule
- Bi-Monthly Stakeholder Communication Update – Provides update of important events and actions at DHCS to stakeholders. This communication medium will be used to communicate program status to EHs and EPs

Prepayment Validation

DHCS will continue to carry out prepayment validation of provider eligibility using the same methodology as in previous years. This is principally focused on reviewing supporting documentation as well as documentation of encounter numbers (for professionals) and hospital cost reports (for hospitals). Other validation is conducted through business rules build into the SLR. DHCS, like the Medicare EHR Incentive Program, does not conduct prepayment validation of meaningful use (MU) attestations, although providers are able to upload documents supporting MU attestations into the SLR.

Post-Payment Auditing

The 2015 changes to MU mainly involve the elimination of several measures and the introduction of alternate exclusions that allow providers to skip several measures. Both

in the preamble to the rule and in national telephone conferences, CMS staff have stated that use of these alternative exclusions cannot and should not be audited. For this reason, DHCS has decided not to make any changes in post-payment auditing strategy at this point, but will inform CMS if such changes are planned in the future

IAPD Changes

DHCS is not requesting an update to the IAPD for the 2015 modifications because all SLR changes are financed through DHCS's fiscal intermediary contract with Xerox, as part of maintenance of operation for the SLR.

APPENDIX 22: EXCLUDED AID CODES FOR MEDI-CAL EHR INCENTIVE PROGRAM

Aid Code	Program Description
2V	Trafficking and Crime Victims Assistance Program (TCVAP). Refugee Medical Assistance (RMA). Covers non-citizen victims of human trafficking, domestic violence and other serious crimes.
4V	TCVAP – RMA. Covers non-citizen victims of human trafficking, domestic violence and other serious crimes.
65	Katrina-Covers eligible evacuees of Hurricane Katrina.
7M	Minor Consent Program. Covers eligible minors at least 12 years of age and under the age of 21. Limited to services related to Sexually Transmitted Diseases, sexual assault, drug and alcohol abuse, and family planning. Paper Medi-Cal ID Card issued.
7N	Minor Consent Program. Covers eligible pregnant minors under the age of 21. Limited to services related to pregnancy and family planning. Paper Medi-Cal ID card issued.
7P	Minor Consent Program. Covers eligible minors at least 12 years of age and under the age of 21. Limited to services related to Sexually Transmitted Diseases, sexual assault, drug and alcohol abuse, family planning, and outpatient mental health treatment. Paper Medi-Cal ID card issued.
7R	Minor Consent Program. Covers eligible minors under age 12. Limited to services related to family planning and sexual assault. Paper Medi-Cal ID card issued.
71	Medi-Cal Dialysis Only Program/Medi-Cal Dialysis Supplement Program (DP/DSP). Covers eligible persons of any age who are eligible only for dialysis and related services.
73	Total Parenteral Nutrition (TPN). Covers eligible persons of any age who are eligible for parenteral hyperalimentation and related services and persons of any age who are eligible under the Medically Needy or Medically Indigent Programs.
81	MI – Adults Aid Paid Pending.

APPENDIX 23: CALIFORNIA HEALTH AND SAFETY CODE 1204(A)

California Health and Safety Code Section 1204(a)

1204. Clinics eligible for licensure pursuant to this chapter are primary care clinics and specialty clinics.

(a) (1) Only the following defined classes of primary care clinics shall be eligible for licensure:

(A) A "community clinic" means a clinic operated by a tax-exempt nonprofit corporation that is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services.

In a community clinic, any charges to the patient shall be based on the patient's ability to pay, utilizing a sliding fee scale. No corporation other than a nonprofit corporation, exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954 as amended, or a statutory successor thereof, shall operate a community clinic; provided, that the licensee of any community clinic so licensed on the effective date of this section shall not be required to obtain tax-exempt status under either federal or state law in order to be eligible for, or as a condition of, renewal of its license. No natural person or persons shall operate a community clinic.

(B) A "free clinic" means a clinic operated by a tax-exempt, nonprofit corporation supported in whole or in part by voluntary donations, bequests, gifts, grants, government funds or contributions that may be in the form of money, goods, or services. In a free clinic there shall be no charges directly to the patient for services rendered or for drugs, medicines, appliances, or apparatuses furnished. No corporation other than a nonprofit corporation exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954 as amended, or a statutory successor thereof, shall operate a free clinic; provided, that the licensee of any free clinic so licensed on the effective date of this section shall not be required to obtain tax-exempt status under either federal or state law in order to be eligible for, or as a condition of, renewal of its license. No natural person or persons shall operate a free clinic.

(2) Nothing in this subdivision shall prohibit a community clinic or a free clinic from providing services to patients whose services are reimbursed by third-party payers, or from entering into managed care contracts for services provided to private or public health plan subscribers, as long as the clinic meets the requirements identified in subparagraphs (A) and (B). For purposes of this subdivision, any payments made to a community clinic by a third-party payer, including, but not limited to, a health care

service plan, shall not constitute a charge to the patient. This paragraph is a clarification of existing law.

APPENDIX 24: LA COUNTY GROUP PROPOSAL

Los Angeles County Proposal for Approval of County-Specific Groups for Medi-Cal Electronic Health Record Incentive Payment Purposes
8/28/2012

BACKGROUND ON LOS ANGELES COUNTY'S PUBLIC HOSPITAL AND HEALTH CARE SYSTEM

The Los Angeles County (the "County") Department of Health Services ("DHS") operates the second largest public health system in the nation. DHS' health care system consists of four Designated Public Hospitals ("DPH") and numerous clinics, which provide inpatient hospital, outpatient hospital, and clinic services, train physicians and other health care clinicians, and conduct patient-care related research. These DPHs and clinics constitute the public "safety net" providers (providers of last resort) in their communities, treating a large number of uninsured and Medi-Cal patients every year. DHS' patient population, which consists primarily of the more than two million County residents without health insurance, uses these providers as their source of primary, urgent, and specialty care. Many of the services to the uninsured are paid in whole or in part by Medicaid under the State's Section 1115 Medicaid demonstration projects.

Because of the size and complexity of the County, DHS' health care services are operationally, clinically, and financially integrated at a regional level. DHS operates four DPHs: Harbor-UCLA Medical Center; LAC+USC Medical Center; Olive View-UCLA Medical Center; and Rancho Los Amigos National Rehabilitation Center. Each of these DPHs has a hospital outpatient department ("HOPD"), which includes many individual clinics. The County also operates two Multi-Service Ambulatory Care Centers ("MACC"); six Comprehensive Health Centers ("CHC"); and 14 primary care Health Centers ("HC"). The CHCs, HCs, and the High Desert MACC are organized into five different geographic "clusters." Four additional HCs are located at juvenile hall facility sites. Approximately 1,500 non-hospital based Eligible Professionals ("EP"), of which more than 600 are employed by the County, provide services in these HOPDs and clinic sites.

The HOPDs and DHS clinics (*i.e.*, MACCs, CHCs and HCs) are reimbursed under special payment rules under the California State Medicaid Plan, Attachment 4.19-B, Supplement 5. Medi-Cal reimburses these providers on the basis of an all-inclusive, per-visit rate. The costs that form the basis for these per-visit Medi-Cal rates, which include the costs of

covered professional services,[5] are determined based on the costs reported on the DHCS ("CBRC") Cost Reports submitted to the California Department of Health Care Services ("DHCS").

In total, 11 Medi-Cal CBRC Cost Reports are submitted to DHCS by the County. For cost-reporting purposes, the HOPDs and free-standing clinics are categorized as follows:

(1) each HOPD reports its aggregate costs and visits on a separate Medi-Cal CBRC Cost Report (totaling four Cost Reports);

(2) the clinics[6] in each of the five geographic clusters report their aggregate costs and visits on a separate Medi-Cal CBRC Cost Report for each geographic cluster (totaling five Cost Reports) (although each clinic site has a unique National Provider Identifier ("NPI") that it uses for billing purposes);

(3) the Martin Luther King Jr. MACC reports its aggregate costs and visits on a separate Medi-Cal CBRC Cost Report; and

(4) the four free-standing clinics in the juvenile hall facilities report their aggregate costs and visits on a single Medi-Cal CBRC Cost Report (although each clinic site has a unique NPI that it uses for billing purposes).

STATE'S DEFINITION OF A "GROUP" FOR PURPOSES OF EHR INCENTIVE PAYMENTS FOR ELIGIBLE PROFESSIONALS

Under the State Medicaid Health Information Technology Plan, there are three types of groups that are currently recognized for Medi-Cal EHR incentive payment purposes: (1) a clinic that is licensed by the California Department of Public Health ("1204a clinics"); (2) a group of providers that operates as a unified financial entity and has overarching oversight of clinical quality with a single Federal Employer Identification Number ("FEIN"), but subgroups of providers can have separate NPIs; and (3) a DPH System, defined by a single Tax Identification Number ("TIN"). The State has noted that it will consider exceptions to Category 3, on a case-by-case basis, to allow DPHs to create multiple groups even though they use a single TIN, provided that the proposed groups follow operational and clinical oversight lines of authority and the encounters of all providers under the designated group are used to establish the appropriate group's volume.

[5] State Medicaid Plan, Cost-Based Reimbursement, Attachment 4.19-B, Supplement 5, pp. 1-2.

[6] The clinics include HCs and CHCs, and, in the case of the Antelope Valley Cluster, the High Desert MACC.

REQUEST FOR EXCEPTION TO THE DEFINITION OF THE "GROUP" FOR A DESIGNATED PUBLIC HOSPITAL SYSTEM

DHS is requesting an exception from the definition of a group as established for DPH systems for two reasons.

First, it would not be appropriate to require DHS to register all County EPs in a single group based on the County's TIN, because such a group would include EPs who will not have access to DHS' certified EHR technology. The County has a single TIN, which is used by DHS, as well other County entities, such as the Department of Mental Health and the Sheriff's Department, which also provide health care services. Thus, the County's TIN is not associated solely with the DHS health care providers. DHS plans to implement an EHR system for DHS providers; however, the EHR system will not extend to the Department of Mental Health's clinics or the Sheriff's Department jail health care services. Therefore, DHS should be permitted to form groups that use the County's TIN but include only the CBRCs operated by DHS.

Second, because the CBRC cost reporting structure reflects the existing financial, clinical, and operational structure of DHS, it would be administratively burdensome to require DHS to track and report data at a system-wide level for purposes of qualification for the EHR incentive payments. Such an approach would hamper DHS' ability to use a readily available data source as documentation of visits for purposes of calculating Medicaid patient volume. Further, as described above, the visit, payer, and cost data for the CBRC sites are reported on 11 different Medi-Cal CBRC Cost Reports, which are filed annually and are audited by DHCS. Therefore, DHS should be approved to form groups for purposes of EP qualification for the EHR incentive payment program that are consistent with its CBRC cost reporting structure to facilitate its reporting of accurate, auditable visit data for the calculation of Medicaid patient volume.

PROPOSAL FOR DEFINITION OF GROUP BASED ON MEDI-CAL CBRC COST REPORTING STRUCTURE

DHS requests an exception to define its "groups" (hereinafter referred to as "CBRC Groups") consistent with the Medi-Cal CBRC Cost Reports for purposes of registering through the State Level Registry for EHR incentive payments. This group reporting structure for EHR incentive payments would directly reflect the CBRC cost reporting structure. The groups are defined to include all DHS owned and operated clinics and hospital outpatient departments, including the listed CRBC sites and any satellite clinics billed under the listed NPIs. Each proposed CBRC Group would include either one or multiple NPIs, and all CBRC Groups would share a single TIN. See Attachment A for the names of the CBRC Groups, and the names, addresses, and NPIs of the proposed CBRC Groups and their component clinic sites. We believe these proposed groups best reflect the County's financial, organizational, and operational structure for the following reasons.

First, each of the 11 CBRC Groups files a separate Medi-Cal CBRC Report. Accordingly, this proposed definition of a CBRC Group would enable the County to provide appropriate documentation for the calculation of Medicaid patient volume that could be sustained upon audit.

Second, the CBRC Groups are consistent with the County's organizational structure. The use of multiple groups for DHS is necessary, in part, because of the size of the patient population served by the County and the size of the County's health care service area. The clinics that comprise each CBRC Group are geographically proximate to each other, and EPs often practice at multiple clinics in the same region. Therefore, many of the clinical and administrative services relevant to the EPs, such as credentialing, creating work schedules, and providing clinical oversight for the quality of healthcare services, take place at the level of CBRC cost reporting, *i.e.*, both at the level of the HOPDs and the clinic groups – all of which are represented in the Medi-Cal CBRC Cost Reports.

Third, this proposal also reflects the planned implementation of EHR in the County. DHS' preliminary plan is to phase in the implementation of EHR systems for EPs by CBRC Group. This means that the implementation will take place sequentially for each of the proposed CBRC Groups.

Fourth, this proposal results in qualifying only those clinic sites that would qualify independently. Although we propose to report the Medicaid patient volume data at the CBRC Cost Report level, we have confirmed that each of the CBRC sites in 10 of the 11 proposed CBRC Groups would independently satisfy the 30 percent Medicaid patient volume threshold. (The potential exception is proposed CBRC Group 11, the juvenile hall CBRC Group, which may not satisfy the Medicaid patient volume threshold.) Nevertheless, based on the availability of auditable data to support the patient volume calculations, the clinical and financial organization of the County's clinics, and DHS' EHR implementation plans, we believe that use of the proposed CBRC Groups is the most logical way of defining a "group" for DHS.

Finally, DHS' proposed definition of a "group" satisfies conditions set forth under federal regulations that allow group practices to calculate patient volume at the group practice/clinic level,[7] provided they meet the State's criteria for operational and clinical oversight lines of authority and use of the encounters of providers under the designated group to establish the group's volume.

CALCULATION OF MEDICAID PATIENT VOLUME BASED ON CBRC GROUPS

[7] 42 C.F.R. § 495.306(h).

Under the DHS proposal, the Medicaid patient volume will be calculated based on the total Medicaid encounters for the most recent year for which both the annual Medi-Cal CBRC Cost Reports and the Workbooks submitted under Paragraph 14 of the Section 1115 demonstration project that was approved in 2005 (often referred to as the "Paragraph 14 Workbooks" or the "P-14 Workbooks") have been filed.[8] As required by the State Medicaid Health Information Technology Plan, the Medicaid patient volume calculation will be based on the Medicaid visits of all providers of professional services in the CBRC Groups that are captured through the CBRC payment mechanism, including physicians, physician assistants, nurse practitioners, dentists, certified nurse midwives, and optometrists. For purposes of this proposal, a visit is equivalent to an encounter.

The Medicaid patient volume percentage for each CBRC Group will be calculated as follows. The numerator will be the total of the Medi-Cal CBRC visits, Medi-Cal managed care visits, Safety Net Care Pool ("SNCP") visits, Coverage Initiative and Low Income Health Program ("LIHP") visits[9], and Medi-Cal Fee-for-Service ("FFS") visits.[10] The denominator will be the total visits. The numerator will be divided by the denominator, and the result will be the Medicaid patient volume percentage.[11] The sources of data will be described below.

[8] The references in this Section to forms, schedules, columns and line numbers correspond to the Medi-Cal CBRC Cost Reports and P-14 Workbooks for the July 1, 2010 to June 30, 2011 cost reporting year. In the event that the CBRC Cost Reports or P-14 Workbooks are revised in subsequent years of the demonstration project, and/or there are changes in the forms, schedules, columns and lines, data comparable to that identified herein shall be used.

[9] The Coverage Initiative enrollees were transitioned into the Low Income Health Program as of November 1, 2010.

[10] The SNCP, Coverage Initiative, and LIHP visits are funded in part by Medicaid funds through California's Section 1115 demonstration projects, and therefore are considered Medicaid encounters for purposes of the Medi-Cal EHR incentive program.

[11] This method for calculating the Medicaid patient volume excludes certain visits that may permissibly be counted as Medicaid encounters for this EHR incentive program (i.e., Child Health and Disability Prevention Program, Family PACT, PACE Program, and, for CBRC groups that are not HOPDs, dual eligibles) from the numerator; however, these visits are included in the denominator. It is unnecessary to include these visits in the numerator because DHS' Medicaid patient volume percentage will far exceed the minimum threshold. Therefore, DHS proposes to use the total Medicaid visits as reported in the existing, audited Medi-Cal CBRC Cost Reports and P-14 Workbooks as its Medicaid encounters, even though such an approach results in an underrepresentation of its Medicaid patient volume, in order to ensure accurate and consistent reporting of encounters across Medicaid programs.

Medi-Cal and Total Visit Counts

The Medi-Cal and total visit counts that will be used for this calculation are reported on the following lines of the Medi-Cal CBRC Cost Reports for each of the 11 proposed groups. There are currently two different CBRC Cost Report forms: one for hospital CBRCs, and one for other CBRCs.

Table 1: Medi-Cal CBRC Cost Report: Source of Medi-Cal and Total Visit Data

No.	Name	CBRC Form	Medi-Cal Visits	Total Visits
1	LAC+USC Medical Center	1	Column 6, Lines 90 and 90.02 [8]	Column 2, Lines 90, 90.01, and 90.02
2	Northeast Cluster	2	Line 6	Line 4
3	Harbor-UCLA Medical Center	1	Column 6, Lines 90 and 90.02	Column 2, Lines 90 and 90.02
4	Coastal Network	2	Line 6	Line 4
5	Southwest Network	2	Line 6	Line 4
6	Martin Luther King Jr.- MACC	2	Line 6	Line 4
7	Rancho Los Amigos National Rehabilitation Center	1	Column 6, Lines 90 and 90.02	Column 2, Lines 90 and 90.02
8	Olive View - UCLA Medical Center	1	Column 6, Lines 90 and 90.02	Column 2, Lines 90 and 90.02
9	San Fernando Cluster[9]	2	Line 6	Line 4
10	Antelope Valley Cluster	2	Line 6	Line 4
11	Juvenile Court Health Services	2	Line 6	Line 4

[8] The number of Medi-Cal visits reported on the CBRC Cost Report under-represents the total number of Medi-Cal visits because it does not include the specialty mental health visits at the outpatient psychiatric clinic, which are not paid under the CBRC reimbursement system. However, the Medi-Cal visits at the outpatient psychiatric clinic are reported on the P-14 Workbook (Schedule 1.2, Column 4c 4g, Line 09001) and will be added to Lines 90 and 90.2 to arrive at a total Medi-Cal visit count.

[9] Glendale Health Center is jointly operated by DHS and the County Department of Public Health. Because it provides predominantly public health services, it is not treated as a CBRC, and its Medi-Cal DHS visits and total DHS visits are not reflected in any of the CBRC Cost Reports. As a result, the County will provide a supplemental worksheet identifying the total visits, Medi-Cal DHS visits, and

Medi-Cal Managed Care DHS visits at Glendale Health Center, and these visits will be added to the applicable visits for the San Fernando Cluster. The DHS SNCP visits, DHS Coverage Initiative visits, and DHS LIHP visits for Glendale Health Center will be reported on a separate line from the San Fernando Valley Cluster visits on Schedule 4 of the P-14 Workbook.

Please see Attachment B for examples of the hospital and non-hospital CBRC forms described above that were used for FY 2010-2011 cost reporting.

Medi-Cal Managed Care, SNCP, Coverage Initiative and LIHP, and Medi-Cal FFS Visits

The number of Medi-Cal managed care, SNCP, Coverage Initiative and LIHP, and Medi-Cal FFS visits will be taken from the P-14 Workbooks filed by the County. Although the County submits only four P-14 Workbooks, the visits are separately identified for each CBRC Group. Attachment A also identifies the P-14 Workbook on which these additional visits are reported. The visits from the columns and lines in the table on the following pages will be added to the numerator.

Table 2: P-14 Workbook: Source of Medi-Cal Managed Care, SNCP, Coverage Initiative and LIHP, and Medi-Cal FFS Visit Data

No.	Name	P-14 Workbook Schedule	Medi-Cal Managed Care Visits	SNCP Visits[10]	Coverage Initiative Visits[11]	LIHP Visits[12]	Medi-Cal FFS Psych. Visits
1	LAC+USC Medical Center	Schedule 1.2	Column 3c/3g, Line 09000; Column 4/c/4g, Line 09001 for psych. visits	Column 7c/7g, Line 09000	Column 8c-1/8g-1, Line 09000	Column 8c, 9c, 9g, 9k, Line 09000	Column 11a Line 09001
2	Northeast Cluster	LAC+USC Medical Center, Schedule 4	N/A	Non-Hospital and Contracted Hospital Costs Related to the Uninsured, Columns for applicable period, Line for County OP Clinics (non-FQHC)	Non-Hospital and Contracted Hospital Costs Related to the 2005 Waiver Coverage Initiative (CI), Columns for applicable period, Line for County OP Clinics (non-FQHC)	Non-Hospital and Contracted Hospital Costs Related to the 2010 Health Care Coverage Initiative (HCCI), Columns for applicable period, Line for County OP Clinics (non-FQHC)	N/A

No.	Name	P-14 Workbook Schedule	Medi-Cal Managed Care Visits	SNCP Visits[10]	Coverage Initiative Visits[11]	LIHP Visits[12]	Medi-Cal FFS Psych. Visits
3	Harbor-UCLA Medical Center	Schedule 1.2	Column 3c/3g, Line 09000	Column 7c/7g, Line 09000	Column 8c-1/8g-1, Line 09000	Column 8c, 9c, 9g, 9k, Line 09000	N/A
4	Coastal Network	Harbor-UCLA Medical Center, Schedule 4	N/A	Non-Hospital and Contracted Hospital Costs Related to the Uninsured, Columns for applicable period, Line for County OP Clinics (non-FQHC) – Coastal CHC/HC	Non-Hospital and Contracted Hospital Costs Related to the 2005 Waiver Coverage Initiative (CI), Columns for applicable period, Line for County OP Clinics (non-FQHC) – Coastal CHC/HC	Non-Hospital and Contracted Hospital Costs Related to the 2010 Health Care Coverage Initiative (HCCI), Columns for applicable period, Line for County OP Clinics (non-FQHC) – Coastal CHC/HC	N/A
5	Southwest Network	Harbor-UCLA Medical Center, Schedule 4	N/A	Non-Hospital and Contracted Hospital Costs Related to the Uninsured, Columns for applicable period, Line for County OP Clinics (non-FQHC) – Southwest (SW) CHC/HC	Non-Hospital and Contracted Hospital Costs Related to the 2005 Waiver Coverage Initiative (CI), Columns for applicable period, Line for County OP Clinics (non-FQHC) –Southwest (SW) CHC/HC	Non-Hospital and Contracted Hospital Costs Related to the 2010 Health Care Coverage Initiative (HCCI), Columns for applicable period, Line for County OP Clinics (non-FQHC) – Southwest (SW) CHC/HC	N/A
6	Martin Luther King Jr.- MACC	Harbor-UCLA Medical Center, Schedule 4	N/A	Non-Hospital and Contracted Hospital Costs Related to the Uninsured, Columns for applicable period, Line for County OP Clinics (non-FQHC) – MLK MACC	Non-Hospital and Contracted Hospital Costs Related to the 2005 Waiver Coverage Initiative (CI), Columns for applicable period, Line for County OP Clinics (non-FQHC) – MLK MACC	Non-Hospital and Contracted Hospital Costs Related to the 2010 Health Care Coverage Initiative (HCCI), Columns , for applicable period, Line for County OP Clinics (non-FQHC) – MLK MACC	N/A
7	Rancho Los Amigos National	Schedule 1.2	Column 3c/3g, Line 09000	Column 7c/7g, Line 09000	Columns 8c-1/8g-1, Line 09000	Column 8c, 9c, 9g, 9k, Line 09000	N/A

No.	Name	P-14 Workbook Schedule	Medi-Cal Managed Care Visits	SNCP Visits[10]	Coverage Initiative Visits[11]	LIHP Visits[12]	Medi-Cal FFS Psych. Visits
	Rehabilitation Center						
8	Olive View - UCLA Medical Center	Schedule 1.2	Column 3c/3g, Line 09000	Column 7c/7g, Line 09000	Column 8c-1/8g-1, Line 09000	Column 8c, 9c, 9g, 9k, Line 09000	N/A
9	San Fernando Cluster[13]	Olive View - UCLA Medical Center, Schedule 4	N/A	Non-Hospital and Contracted Hospital Costs Related to the Uninsured, Columns for applicable period, Line for County OP Clinics (non-FQHC) – San Fernando Valley (SFV) CHC/HC, Glendale (GL) - HC	Non-Hospital and Contracted Hospital Costs Related to the 2005 Waiver Coverage Initiative (CI), Columns for applicable period, Line for County OP Clinics (non-FQHC) – San Fernando Valley (SFV) CHC/HC, Glendale (GL) - HC	Non-Hospital and Contracted Hospital Costs Related to the 2010 Health Care Coverage Initiative (HCCI), Columns for applicable period,, Line for County OP Clinics (non-FQHC) – San Fernando Valley (SFV) CHC/HC, Glendale (GL) - HC	N/A
10	Antelope Valley Cluster	Olive View - UCLA Medical Center, Schedule 4	N/A	Non-Hospital and Contracted Hospital Costs Related to the Uninsured, Columns for applicable period, Line for County OP Clinics (non-FQHC) – Antelope Valley (AV) Health System	Non-Hospital and Contracted Hospital Costs Related to the 2005 Waiver Coverage Initiative (CI), Columns , for applicable period, Line for County OP Clinics (non-FQHC) – Antelope Valley (AV) Health System	Non-Hospital and Contracted Hospital Costs Related to the 2010 Health Care Coverage Initiative (HCCI), Columns for applicable period, Line for County OP Clinics (non-FQHC) – Antelope Valley (AV) Health System	N/A
11	Juvenile Court Health Services[14]	None	None	None	None	None	None

[10] The number of SNCP visits will be reduced by 13.95%, which represents the percentage of total provider expenditures attributable to non-emergency care provided to non-qualified aliens, as established in Para. 40(a) of the Special Terms and Conditions of the California Bridge to Reform Demonstration.

[11] The Coverage Initiative was in effective from July 1, 2010 through October 31, 2010. Thus, the data in this column reflects visits for four months.

[12] Effective November 1, 2010, the Coverage Initiative was replaced by two separate LIHP programs – the HCCI and the MCE program. Thus, the data in the columns for the HCCI and MCE program reflects visits for eight months (11/1/2010 – 7/31/2011) for Fiscal Year ("FY") 2011. In future FYs, the data for the HCCI and MCE programs will each be reported for the full 12-month period.

[13] See note 8 above regarding visit information for Glendale Health Center.

[14] None of the costs or visits for the Juvenile Hall CBRC Group are reported on any of the P-14 Workbooks filed by the County.

CONCLUSION

In summary, we request that DHCS approve this proposal to define groups for DHS consistent with the 11 Medi-Cal CBRC Cost Reports and to calculate Medicaid patient volume based on these 11 CBRC Groups. Given the size, number of patients served, and unique reimbursement structure of DHS, we believe that this definition of a "group" is most appropriate for DHS and best reflects its financial, organizational, and operational structure, as well as being consistent with the criteria established by DHCS for an exception to the definition of a group.

APPENDIX 25: AMERICAN ACADEMY OF FAMILY PHYSICIANS PRACTICE PROFILE STUDY

Average number of family physician visits per week and average number of patients in various settings, June 2008

	Office Visits	Hospital Visits	Nursing Home Visits	House Calls	Patients Supervised Under Home Health Care	Nursing Home Patients Supervised	Hospice Patients Supervised	Patients with Free or Discounted Care
Total	84.9	8.1	2.3	0.6	7.5	9.6	2.1	9.5
Census Division								
New England	77.3	3.7	1.4	. 1.0	9.7	5.4	1.0	10.4
Middle Atlantic	90.4	9.1	3.0	0.5	1.0	15.1	1.3	6.9
East North Central	84.8	8.2	2.7	0.9	6.4	10.3	1.4	7.2
West North Central	82.3	10.7	2.8	0.2	7.9	13.7	2.5	7.0
South Atlantic	90.3	7.8	3.3	0.8	7.3	11.1	3.1	11.0
East South Central	116.5	14.2	3.5	0.6	13.7	10.4	5.1	9.4
West South Central	92.9	9.3	2.6	0.8	10.9	11.7	2.9	12.8
Mountain	63.9	6.4	1.1	.0.3	6.1	5.0	1.4	9.7
Pacific	74.9	3.9	1.9	0.4	3.2	7.1	1.1	10.4
Location								
Urban	82.4	6.4	1.9	0.6	6.8	8.2	1.9	9.0
Rural	92.9	13.4	3.7	0.6	9.8	13.9	2.7	11.0
Completion of FP Residency								
FP Residency Graduate	83.9	8.1	2.3	0.6	7.5	9.7	2.1	9.6
Not FP Residency Graduate	101.5	8.9	2.2	0.3	7.7	7.6	2.4	7.9

**Based on survey responses of 1,054 active members of the American Academy of Family Physicians, including those with no visits in any setting.*

Source: American Academy of Family Physicians, Practice Profile I Survey, June 2008

APPENDIX 26: METHODOLOGY FOR IDENTIFYING PANEL MEMBERS

INGENIX

Department of Health Care Services

Scope Document/Data Request Form

Date: May 4, 2011
From: Daria Rostovtseva
To: Dr. Larry Dickey
Copies: Steve Yegge, Raul Ramirez, Steve Grimshaw, Karen Duong

IR #: 6396
Subject: Individual Managed Care providers with a panel of 300+ patients in 2010

Background

The Office of Health Information Technology (OHIT) would like to estimate the proportion of individual Managed Care providers who may be prequalified for the EHR incentive payment program.

Scope

Ingenix will prepare a report on the distribution of the estimated panel size per provider in 2010, by provider type. The proportion of providers with panels of 300 or more patients will be calculated.

Proposed Selection Criteria

Program codes 02 and 04 will be included (02 – Managed Care plans, 04 - COHS).

Claims and encounters with the following aid codes will be excluded: 0R, 0T, 2V, 4V, 53, 65, 7M, 7N, 7P, 7R, 71, 73, and 81.

Claim types identifying pharmacy and institutional charges, such as room & board, will be excluded (fi_claim_type_cd= '01','02','03' and claim_type_cd='2','3').

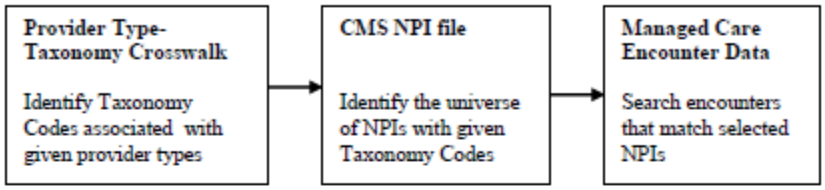
Patient panel will be estimated as the number of unique patients seen by the provider in 2010. Unique providers are identified by NPI and Service Location Number. Unique patients are identified by patient CIN. Year of service is determined by the Service-From date on the claim header.

We will use the matched provider number to capture all Managed Care records associated with the provider. All providers with valid NPIs will be included, regardless of whether the provider is found in the PMF.

Patients will be attributed to providers according to the following logic. If the rendering provider field is populated and the number can be linked to a valid NPI, the patient will be attributed to this NPI. Otherwise, the encounter will be attributed to the billing provider NPI.

Provider types 005 (nurse midwife), 007 (nurse practitioner), 020 (optometrists) 026 (physicians), 099 (dentists) will be included. Note that provider type is unknown for

providers not present in the PMF. However, taxonomy codes are available for all providers with valid NPIs from the CMS NPI file. To capture all providers of these types, we will utilize the Provider Type-Taxonomy crosswalk available in the MIS/DSS data warehouse to identify the universe of NPIs that match these criteria. The diagram below shows, in a simplified way, the steps involved in this process:



Report Format

Report will be delivered in the form of a PDF document. There will be no PHI in the report.

Proposed Report Generation and Delivery Schedule

The work proposal below assumes that the report is generated using the criteria established in this document.

Date Due	Task	Responsibility
5/6/2011	Scope approved	Ingenix/OHIT
5/16/2011	Report delivered	Ingenix
TBD	Changes requested by OHIT, report revised as necessary	Ingenix/OHIT

Data Issues

There are two significant data issue in this analysis:

- Quality of Managed Care provider information. Prior research found that provider information populated on Managed Care encounter data lacks quality, particularly on program code 02 records. Rendering provider field is frequently not populated or mapped. Both billing and rendering provider fields are often populated with numbers that cannot be matched to the available provider information.

- Data lag. Managed Care data has substantial time lags and is sometimes inconsistently submitted by health plans.

APPENDIX 27: MU REQUIREMENTS

PROGRAM YEAR 2011-2012

In Program Year 2011 and 2012, all providers attesting to MU will attest to Stage 1.

2011/12 STAGE 1 MU FOR EPS

MU Section	Requirement
Core Measures	**Complete all 15**
	(1) CPOE
	(2) Drug-Drug Drug-Allergy
	(3) Problem List
	(4) E-Prescribing
	(5) Medication Lists
	(6) Medication Allergy Lists
	(7) Record Demographics
	(8) Vital Signs
	(9) Smoking Status
	(10) Report Ambulatory CQMs
	(11) Clinical Decision Support
	(12) Patient Electronic Copy
	(13) Patient Clinical Summaries
	(14) Exchange Clinical Information
	(15) Protect Health Information
Menu Measures	**Complete 5 out of 10. One must be a Public Health Measure**
	Public Health Measures:
	(1) Syndromic Surveillance
	(2) Immunization registry
	Additional Menu Measures:
	(3) Electronic Patient Access
	(4) Drug Formulary Checks
	(5) Clinical Lab Results
	(6) Condition List
	(7) Patient Reminders
	(8) Patient Education Resources
	(9) Medication Reconciliation
	(10) Summary of Care Record
CQM Core Measures	**Complete all 3. For any measure where the denominator is zero, a CQM Alternate Measure must be completed.**
	(1) NQF 0013

	(2) NQF 0028/PQRI 114	
	(3) NQF 0421/PQRI 128	
CQM Alternate Core Measures	**Complete one for each CQM Core Measure with a denominator of zero.**	
	(1) NQF 0024	
	(2) NQF 0041/PQRI 110	
	(3) NQF 0038	
CQM Additional Measures	**Complete 3 of 38.**	
	(1) NQF 0001/PQRI 64	(20) NQF 0062/PQRI 119
	(2) NQF 0002/PQRI 66	(21) NQF 0064/PQRI 2
	(3) NQF 0004	(22) NQF 0067/PQRI 6
	(4) NQF 0012	(23) NQF 0068/PQRI 204
	(5) NQF 0014	(24) NQF 0070/PQRI 7
	(6) NQF 0018	(25) NQF 0073/PQRI 201
	(7) NQF 0027/PQRI 115	(26) NQF 0074/PQRI 197
	(8) NQF 0031/PQRI 112	(27) NQF 0075
	(9) NQF 0032	(28) NQF 0081/PQRI 5
	(10) NQF 0033	(29) NQF 0083/PQRI 8
	(11) NQF 0034/PQRI 113	(30) NQF 0084/PQRI 200
	(12) NQF 0036	(31) NQF 0086/PQRI 12
	(13) NQF 0043/PQRI 111	(32) NQF 0088/PQRI 18
	(14) NQF 0047/PQRI 53	(33) NQF 0089/PQRI 19
	(15) NQF 0052	(34) NQF 0105/PQRI 9
	(16) NQF 0055/PQRI 117	(35) NQF 0385/PQRI 72
	(17) NQF 0056/PQRI 163	(36) NQF 0387/PQRI 71
	(18) NQF 0059/PQRI 1	(37) NQF 0389/PQRI 102
	(19) NQF 0061/PQRI 3	(38) NQF 0575/PQRI 66

2011/12 STAGE 1 FOR EH

MU Section	Requirement
Core Measures	**Complete all 14**
	1) CPOE
	2) Drug-Drug/Drug Allergy
	3) Problem List
	4) Medication List
	5) Medication Allergy List
	6) Record Demographics
	7) Vital Signs

	8) Smoking Status 9) Report Hospital CQMs 10) Clinical Decision Support 11) Patient Health Information 12) Patient Discharge Instructions 13) Exchange Clinical Information 14) Protect Health Information
Menu Measures	**Complete 5 out of 10. One must be a Public Health Measure**
	Public Health Measures: (1) Immunization registry (2) Reportable Lab Results to Public Health Agencies (3) Syndromic Surveillance Data Submission *Additional Menu Measures:* (4) Drug Formulary Checks (5) Advance Directives (6) Clinical Lab Test Results (7) Patient Lists (8) Patient-Specific Education Resources (9) Medication Reconciliation (10) Transition of Care Summary
CQM Additional Measures	**Complete all 15**
	1) NQF 0495 – Emergency Department (ED)-1 2) NQF 0497 – Emergency Department (ED)-2 3) NQF 0435 – Stroke-2 4) NQF 0436 – Stroke-3 5) NQF 0437 – Stroke-4 6) NQF 0438 – Stroke-5 7) NQF 0439 – Stroke-6 8) NQF 0440 – Stroke-8 9) NQF 0441 – Stroke-10 10) NQF 0371 – VTE-1 11) NQF 0372 – VTE-2 12) NQF 0373 – VTE-3 13) NQF 0374 – VTE-4 14) NQF 0375 – VTE-5 15) NQF 0376 – VTE-6

PROGRAM YEAR 2013

Although the Final Rule indicates that providers will progress to Stage 2 after completing two years of Stage 1, in 2013 Stage 2 requirements were not yet defined. As such, all providers attesting to MU in Program Year 2013 will attest to the Stage 1 requirements specified below.

2013 STAGE 1 MU FOR EPS

MU Section	Requirement
Core Measures	**Complete all 13**
	(1) CPOE
	(2) Drug-Drug Drug-Allergy
	(3) Problem List
	(4) E-Prescribing
	(5) Medication Lists
	(6) Medication Allergy Lists
	(7) Record Demographics
	(8) Vital Signs
	(9) Smoking Status
	(10) Clinical Decision Support
	(11) Patient Electronic Copy
	(12) Patient Clinical Summaries
	(13) Protect Health Information
Menu Measures	**Complete 5 out of 10. One must be a Public Health Measure**
	Public Health Measures:
	(1) Syndromic Surveillance
	(2) Immunization registry
	Additional Menu Measures:
	(3) Electronic Patient Access
	(4) Drug Formulary Checks
	(5) Clinical Lab Results
	(6) Condition List
	(7) Patient Reminders
	(8) Patient Education Resources
	(9) Medication Reconciliation
	(10) Summary of Care Record
CQM Core Measures	**Complete all 3. For any measure where the denominator is zero, a CQM Alternate Measure must be completed.**
	(1) NQF 0013

	(2) NQF 0028/PQRI 114	
	(3) NQF 0421/PQRI 128	
CQM Alternate Core Measures	**Complete one for each CQM Core Measure with a denominator of zero.**	
	(1) NQF 0024	
	(2) NQF 0041/PQRI 110	
	(3) NQF 0038	
CQM Additional Measures	**Complete 3 of 38.**	
	(1) NQF 0001/PQRI 64	(20) NQF 0062/PQRI 119
	(2) NQF 0002/PQRI 66	(21) NQF 0064/PQRI 2
	(3) NQF 0004	(22) NQF 0067/PQRI 6
	(4) NQF 0012	(23) NQF 0068/PQRI 204
	(5) NQF 0014	(24) NQF 0070/PQRI 7
	(6) NQF 0018	(25) NQF 0073/PQRI 201
	(7) NQF 0027/PQRI 115	(26) NQF 0074/PQRI 197
	(8) NQF 0031/PQRI 112	(27) NQF 0075
	(9) NQF 0032	(28) NQF 0081/PQRI 5
	(10) NQF 0033	(29) NQF 0083/PQRI 8
	(11) NQF 0034/PQRI 113	(30) NQF 0084/PQRI 200
	(12) NQF 0036	(31) NQF 0086/PQRI 12
	(13) NQF 0043/PQRI 111	(32) NQF 0088/PQRI 18
	(14) NQF 0047/PQRI 53	(33) NQF 0089/PQRI 19
	(15) NQF 0052	(34) NQF 0105/PQRI 9
	(16) NQF 0055/PQRI 117	(35) NQF 0385/PQRI 72
	(17) NQF 0056/PQRI 163	(36) NQF 0387/PQRI 71
	(18) NQF 0059/PQRI 1	(37) NQF 0389/PQRI 102
	(19) NQF 0061/PQRI 3	(38) NQF 0575/PQRI 66

2013 STAGE 1 MU FOR EHS

MU Section	Requirement
Core Measures	**Complete all 12**
	1) CPOE
	2) Drug-Drug/Drug Allergy
	3) Problem List
	4) Medication List
	5) Medication Allergy List
	6) Record Demographics

	7) Vital Signs 8) Smoking Status 9) Clinical Decision Support 10) Patient Health Information 11) Patient Discharge Instructions 12) Protect Health Information
Menu Measures	**Complete 5 out of 10. One must be a Public Health Measure**
	Public Health Measures: (1) Immunization registry (2) Reportable Lab Results to Public Health Agencies (3) Syndromic Surveillance Data Submission *Additional Menu Measures:* (4) Drug Formulary Checks (5) Advance Directives (6) Clinical Lab Test Results (7) Patient Lists (8) Patient-Specific Education Resources (9) Medication Reconciliation (10) Transition of Care Summary
CQM Additional Measures	**Complete all 15**
	1) NQF 0495 – Emergency Department (ED)-1 2) NQF 0497 – Emergency Department (ED)-2 3) NQF 0435 – Stroke-2 4) NQF 0436 – Stroke-3 5) NQF 0437 – Stroke-4 6) NQF 0438 – Stroke-5 7) NQF 0439 – Stroke-6 8) NQF 0440 – Stroke-8 9) NQF 0441 – Stroke-10 10) NQF 0371 – VTE-1 11) NQF 0372 – VTE-2 12) NQF 0373 – VTE-3 13) NQF 0374 – VTE-4 14) NQF 0375 – VTE-5 15) NQF 0376 – VTE-6

PROGRAM YEAR 2014

Stage 2 MU became available for the first time in Program Year 2014. Although the Final Rule specifies that those who have completed two years of Stage 1 will progress to Stage 2, in 2014 CMS issued a Flexibility Rule that allowed providers who were scheduled to begin Stage 2 in 2014 to satisfy the objectives of the earlier Stage 1 criteria instead, depending on the CEHRT edition used. To be eligible to use the Flex Rule, providers must have been unable to fully implement 2014 Edition Certified Electronic Health Record Technology (CEHRT) for Program Year 2014 due to delays in 2014 CEHRT availability The table below specifies the attestation options available based on the CEHRT used.

Providers attesting to AIU
You must use 2014 CEHRT

Providers scheduled to report to Stage 1 Meaningful Use	
If you used:	**These are your reporting options:**
2011 CEHRT	2013 Stage 1 Objectives and CQMs
Combo 2011 & 2014 CEHRT	2013 Stage 1 Objectives and CQMs, or 2014 Stage 1 Objectives and CQMs
2014 CEHRT	2014 Stage 1 Objectives and CQMs

Providers scheduled to report to Stage 2 Meaningful Use	
If you used:	**These are your reporting options:**
2011 CEHRT	2013 Stage 1 Objectives and CQMs
Combo 2011 & 2014 CEHRT	2013 Stage 1 Objectives and CQMs, or 2014 Stage 1 Objectives and CQMs, or 2014 Stage 2 Objectives and CQMs
2014 CEHRT	2014 Stage 1 Objectives and CQMs*, or 2014 Stage 2 Objectives and CQMs

*Note, this scenario is only available if the provider was unable to meet the threshold for the Stage 2 Summary of Care objective because the recipients of the transmissions or referrals were impacted by issues related to 2014 EHR Technology availability delays and therefore could not implement the technology required to receive the summary of care documents.

2014 STAGE 1 MU FOR EPS

MU Section	Requirement
Core Objectives	**Complete all 13**
	(1) CPOE
	(2) Drug-Drug Drug-Allergy
	(3) Problem List
	(4) E-Prescribing
	(5) Medication Lists
	(6) Medication Allergy Lists
	(7) Record Demographics
	(8) Vital Signs
	(9) Smoking Status
	(10) Clinical Decision Support
	(11) Patient Electronic Copy
	(12) Patient Clinical Summaries
	(13) Protect Health Information
Menu Objectives	**Meet 5 of 9 objectives or meet or exclude all 9 objectives. One selection must be a Public Health Measure. Exclusions do not count towards the required 5 except as specified above.**
	Public Health Measures:
	(1) Syndromic Surveillance
	(2) Immunization registry
	Additional Menu Measures:
	(3) Drug Formulary Checks
	(4) Clinical Lab Results
	(5) Condition List
	(6) Patient Reminders
	(7) Patient Education Resources
	(8) Medication Reconciliation
	(9) Summary of Care Record
CQMs	**Complete 9 of 64 from among at least 3 of 6 domains.**
	Patient and Family Engagement Domain
	1 CMS157
	2 CMS66
	3 CMS56
	4 CMS90
	Patient Safety Domain

5 CMS156
6 CMS139
7 CMS68
8 CMS132
9 CMS177
10 CMS179

Care Coordination Domain

11 CMS50

Population and Public Health Domain

12 CMS155
13 CMS138
14 CMS153
15 CMS117
16 CMS147
17 CMS2
18 CMS69
19 CMS82
20 CMS22

Efficient Use of Healthcare Resources Domain

21 CMS146
22 CMS166
23 CMS154
24 CMS129

Clinical Process/Effectiveness Domain

25 CMS137
26 CMS165
27 CMS125
28 CMS124
29 CMS130
30 CMS126
31 CMS127
32 CMS131
33 CMS123
34 CMS122
35 CMS148
36 CMS134
37 CMS163
38 CMS164
39 CMS145
40 CMS182

41 CMS135
42 CMS144
43 CMS143
44 CMS167
45 CMS142
46 CMS161
47 CMS128
48 CMS136
49 CMS169
50 CMS141
51 CMS140
52 CMS62
53 CMS52
54 CMS77
55 CMS133
56 CMS158
57 CMS159
58 CMS160
59 CMS75
60 CMS74
61 CMS61
62 CMS64
63 CMS149
64 CMS65

2014 STAGE 2 MU FOR EPS

MU Section	Requirement
Core Objectives	**Complete all 17**
	(1) CPOE
	(2) e-Prescribing
	(3) Demographics
	(4) Vital Signs
	(5) Smoking Status
	(6) Clinical Decision Support
	(7) Lab Test Results
	(8) Patient Lists
	(9) Patient Reminders
	(10) Online Health Information
	(11) Patient Clinical Summaries

	(12) Patient Education Resources
	(13) Medication Reconciliation
	(14) Summary of Care Record
	(15) Immunization Registries
	(16) Protect Health Information
	(17) Electronic Messaging
Menu Objectives	**Complete 3 of 6 measures. If the provider has an exclusion from 4 or more objectives they must meet all remaining measures.**
	(1) Imaging Results
	(2) Family Health History
	(3) Syndromic Surveillance
	(4) Cancer Reporting
	(5) Registry Reporting
	(6) Electronic Notes
CQMs	**Complete 9 of 64 from among at least 3 of 6 domains.**
	Patient and Family Engagement Domain
1	CMS157
2	CMS66
3	CMS56
4	CMS90
	Patient Safety Domain
5	CMS156
6	CMS139
7	CMS68
8	CMS132
9	CMS177
10	CMS179
	Care Coordination Domain
11	CMS50
	Population and Public Health Domain
12	CMS155
13	CMS138
14	CMS153
15	CMS117
16	CMS147
17	CMS2
18	CMS69
19	CMS82
20	CMS22

Efficient Use of Healthcare Resources Domain

21 CMS146
22 CMS166
23 CMS154
24 CMS129

Clinical Process/Effectiveness Domain

25 CMS137
26 CMS165
27 CMS125
28 CMS124
29 CMS130
30 CMS126
31 CMS127
32 CMS131
33 CMS123
34 CMS122
35 CMS148
36 CMS134
37 CMS163
38 CMS164
39 CMS145
40 CMS182
41 CMS135
42 CMS144
43 CMS143
44 CMS167
45 CMS142
46 CMS161
47 CMS128
48 CMS136
49 CMS169
50 CMS141
51 CMS140
52 CMS62
53 CMS52
54 CMS77
55 CMS133
56 CMS158
57 CMS159
58 CMS160

59 CMS75
60 CMS74
61 CMS61
62 CMS64
63 CMS149
64 CMS65

2014 STAGE 1 MU FOR EHS

MU Section	Requirement
Core Objectives	**Complete all 11**
	1) CPOE
	2) Drug-Drug/Drug Allergy
	3) Problem List
	4) Medication List
	5) Medication Allergy List
	6) Record Demographics
	7) Vital Signs
	8) Smoking Status
	9) Clinical Decision Support
	10 Patient Discharge Instructions
	11) Protect Health Information
Menu Objectives	**Complete 5 out of 10. One must be a Public Health Measure**
	Public Health Measures:
	(1) Immunization registry
	(2) Reportable Lab Results to Public Health Agencies
	(3) Syndromic Surveillance Data Submission
	Additional Menu Measures:
	(4) Drug Formulary Checks
	(5) Advance Directives
	(6) Clinical Lab Test Results
	(7) Patient Lists
	(8) Patient-Specific Education Resources
	(9) Medication Reconciliation
	(10) Transition of Care Summary
CQMs	**Complete all 16 of 29 from among at least 3 of 6 domains.**
	Patient and Family Engagement Domain
1	CMS55
2	CMS111
3	CMS107

4 CMS110
5 CMS26

Patient Safety Domain

6 CMS108
7 CMS190
8 CMS114
9 CMS171
10 CMS178
11 CMS185

Care Coordination Domain

12 CMS102
13 CMS32

Population and Public Health Domain

none available

Efficient Use of Healthcare Resources Domain

14 CMS188
15 CMS172

Clinical Process/Effectiveness Domain

16 CMS104
17 CMS71
18 CMS91
19 CMS72
20 CMS105
21 CMS73
22 CMS109
23 CMS100
24 CMS113
25 CMS60
26 CMS53
27 CMS30
28 CMS9
29 CMS31

2014 STAGE 2 MU FOR EHS

MU Section	Requirement
Core Objectives	**Complete all 16**
	1) CPOE
	2) Demographics
	3) Vital Signs

		4) Smoking Status
		5) Clinical Decision Support
		6) Lab - Test Results
		7) Patient Lists
		8) Patient Electronic Access
		9) Patient Education Resources
		10 Medication Reconciliation
		11) Summary of Care Record
		12) Immunization Registries
		13) Public Health Reporting
		14) Syndromic Surveillance
		15) Protect health Information
		16) Electronic Medication Administration record (eMAR)
Menu Objectives	**Complete 3 out of 6.**	
		1) Advance Directives
		2) Imaging Results
		3) Family Health History
		4) e-Prescribing (eRX)
		5) Electronic Notes
		6) Lab Results to Ambulatory Providers
CQMs	**Complete all 16 of 29 from among at least 3 of 6 domains.**	
		Patient and Family Engagement Domain
	1	CMS55
	2	CMS111
	3	CMS107
	4	CMS110
	5	CMS26
		Patient Safety Domain
	6	CMS108
	7	CMS190
	8	CMS114
	9	CMS171
	10	CMS178
	11	CMS185
		Care Coordination Domain
	12	CMS102
	13	CMS32
		Population and Public Health Domain
		none available
		Efficient Use of Healthcare Resources Domain

14 CMS188
15 CMS172

Clinical Process/Effectiveness Domain

16 CMS104
17 CMS71
18 CMS91
19 CMS72
20 CMS105
21 CMS73
22 CMS109
23 CMS100
24 CMS113
25 CMS60
26 CMS53
27 CMS30
28 CMS9
29 CMS31

PROGRAM YEAR 2015-2016

In 2015, CMS issued a Final Rule that eliminated Stage 1 and updated Stage 2 objectives to include alternate exclusions for providers who were previously scheduled to be in Stage 1. Due to SLR limitations, DHCS received approval from CMS to present providers who were previously scheduled to be in Stage 1 with two separate MU paths: in one path, all alternate exclusions were automatically accepted, while in the second path providers were presented with Stage 2 objectives only. All other providers (those scheduled to be in Stage 2) were automatically routed to Stage 2 objectives.

2015-16 STAGE 2 MU FOR EPS

MU Section	Requirement
Core Objectives	**Complete all 10***
	(1) Protect Patient health Information
	(2) Clinical Decision Support
	(3) CPOE
	(4) e-Prescribing
	(5) Health Information Exchange*
	(6) Patient Specific Education*
	(7) Medication reconciliation*
	(8) Patient Electronic Access
	(9) Secure Messaging*
	(10) Public Health Reporting
* In 2015, providers scheduled to be in Stage 1 can opt to not complete all marked with (*).	
CQMs	**Complete 9 of 64 from among at least 3 of 6 domains.**
	Patient and Family Engagement Domain
	1 CMS157
	2 CMS66
	3 CMS56
	4 CMS90
	Patient Safety Domain
	5 CMS156
	6 CMS139
	7 CMS68
	8 CMS132
	9 CMS177
	10 CMS179
	Care Coordination Domain
	11 CMS50
	Population and Public Health Domain

12 CMS155
13 CMS138
14 CMS153
15 CMS117
16 CMS147
17 CMS2
18 CMS69
19 CMS82
20 CMS22

Efficient Use of Healthcare Resources Domain

21 CMS146
22 CMS166
23 CMS154
24 CMS129

Clinical Process/Effectiveness Domain

25 CMS137
26 CMS165
27 CMS125
28 CMS124
29 CMS130
30 CMS126
31 CMS127
32 CMS131
33 CMS123
34 CMS122
35 CMS148
36 CMS134
37 CMS163
38 CMS164
39 CMS145
40 CMS182
41 CMS135
42 CMS144
43 CMS143
44 CMS167
45 CMS142
46 CMS161
47 CMS128
48 CMS136
49 CMS169

50 CMS141
51 CMS140
52 CMS62
53 CMS52
54 CMS77
55 CMS133
56 CMS158
57 CMS159
58 CMS160
59 CMS75
60 CMS74
61 CMS61
62 CMS64
63 CMS149
64 CMS65

2015-16 STAGE 2 MU FOR EHS

MU Section	Requirement
Core Objectives	**Complete all 9***
	(1) Protect Patient health Information
	(2) Clinical Decision Support
	(3) CPOE
	(4) e-Prescribing**
	(5) Health Information Exchange*
	(6) Patient Specific Education*
	(7) Medication reconciliation*
	(8) Patient Electronic Access
	(9) Public Health Reporting
* In 2015, hospitals scheduled to be in Stage 1 can opt to not complete all marked with (*).	
** In 2015 and 2016, hospitals scheduled to be in Stage 1 can opt to not complete all marked with (**).	
CQMs	**Complete all 16 of 29 from among at least 3 of 6 domains.**
	Patient and Family Engagement Domain
	1 CMS55
	2 CMS111
	3 CMS107
	4 CMS110
	5 CMS26
	Patient Safety Domain

6 CMS108
7 CMS190
8 CMS114
9 CMS171
10 CMS178
11 CMS185

Care Coordination Domain

12 CMS102
13 CMS32

Population and Public Health Domain

none available

Efficient Use of Healthcare Resources Domain

14 CMS188
15 CMS172

Clinical Process/Effectiveness Domain

16 CMS104
17 CMS71
18 CMS91
19 CMS72
20 CMS105
21 CMS73
22 CMS109
23 CMS100
24 CMS113
25 CMS60
26 CMS53
27 CMS30
28 CMS9
29 CMS31

PROGRAM YEAR 2017

At the start of 2017, alternate exclusions are no longer an option and all providers were required to complete Stage 2. Later in 2017, the CQM requirement was changed for EPs to reporting 6 of 56 CQMs without regard to domains. For hospitals, the number of CQMs was reduced to 16 and hospitals were required to complete all. In 2017, providers also have the option of attesting to Stage 3 (see Program Year 2018 section below for Stage 3 requirements).

2017 INITIAL STAGE 2 MU FOR EPS

MU Section	Requirement
Core Objectives	**Complete all 10**
	(1) Protect Patient Health Information
	(2) Clinical Decision Support
	(3) CPOE
	(4) e-Prescribing
	(5) Health Information Exchange
	(6) Patient Specific Education
	(7) Medication reconciliation
	(8) Patient Electronic Access
	(9) Secure Messaging
	(10) Public Health Reporting
CQMs	**Complete 6 of 53 available CQMs.**

1 CMS157
2 CMS66
3 CMS56
4 CMS90
5 CMS156
6 CMS139
7 CMS68
8 CMS132
9 CMS177
10 CMS50
11 CMS155
12 CMS138
13 CMS153
14 CMS117
15 CMS147

16 CMS2
17 CMS69
18 CMS82
19 CMS22
20 CMS146
21 CMS166
22 CMS154
23 CMS137
24 CMS165
25 CMS124
26 CMS130
27 CMS126
28 CMS127
29 CMS131
30 CMS123
31 CMS122
32 CMS134
33 CMS164
34 CMS145
35 CMS135
36 CMS144
37 CMS143
38 CMS167
39 CMS161
40 CMS128
41 CMS136
42 CMS169
43 CMS52
44 CMS133
45 CMS158
46 CMS159
47 CMS160
48 CMS75
48 CMS74
50 CMS61
51 CMS64
52 CMS149
53 CMS65

2017 INITIAL STAGE 2 MU FOR EHS

MU Section	Requirement	
Core Objectives	Complete all 9	
	(1)	Protect Patient health Information
	(2)	Clinical Decision Support
	(3)	CPOE
	(4)	e-Prescribing
	(5)	Health Information Exchange
	(6)	Patient Specific Education
	(7)	Medication reconciliation
	(8)	Patient Electronic Access
	(9)	Public Health Reporting
CQMs	Complete all 16	
1	CMS 9	NQF 0480 PC-05
2	CMS 31	NQF 1354 EHDI-1a
3	CMS 32	NQF 0496 ED-3
4	CMS 53	NQF 0163 AMI-8a
5	CMS 55	NQF 0495 ED-1
6	CMS 71	NQF 0436 STK-03
7	CMS 72	NQF 0438 STK-05
8	CMS 102	NQF 0441 STK - 10
9	CMS 104	NQF 0435 STK-02
10	CMS 105	NQF 0439 STK-06
11	CMS 26	No NQF CAC-3
12	CMS 108	NQF 0371 VTE-1
13	CMS 111	NQF 0497 ED-2
14	CMS 113	NQF 0469 PC-01
15	CMS 190	NQF 0372 VTE-2
16	CMS 107	No NQF STK-08

PROGRAM YEAR 2018

In 2018, Stage 2 or Stage 3 is required for all providers. Stage 3 is optional.

2018 STAGE 3 MU FOR EPS

MU Section	Requirement
Core Objectives	Complete all 8

(1)	Protect Patient Health Information
(2)	e-Prescribing
(3)	Clinical Decision Support
(4)	CPOE
(5)	Electronic Access
(6)	Coordination of Care
(7)	Health Information Exchange
(8)	Public Health

CQMs	Complete 6 of 53

1	CMS157
2	CMS66
3	CMS56
4	CMS90
5	CMS156
6	CMS139
7	CMS68
8	CMS132
9	CMS177
10	CMS50
11	CMS155
12	CMS138
13	CMS153
14	CMS117
15	CMS147
16	CMS2
17	CMS69
18	CMS82
19	CMS22
20	CMS146
21	CMS166
22	CMS154
23	CMS137
24	CMS165
25	CMS124
26	CMS130
27	CMS126
28	CMS127
29	CMS131
30	CMS123

31	CMS122
32	CMS134
33	CMS164
34	CMS145
35	CMS135
36	CMS144
37	CMS143
38	CMS167
39	CMS161
40	CMS128
41	CMS136
42	CMS169
43	CMS52
44	CMS133
45	CMS158
46	CMS159
47	CMS160
48	CMS75
49	CMS74
50	CMS61
51	CMS64
52	CMS149
53	CMS65

2018 STAGE 3 MU FOR EHS

MU Section	Requirement	
Core Objectives	**Complete all 8**	
	(1)	Protect Patient health Information
	(2)	e-Prescribing
	(3)	Clinical Decision Support
	(4)	CPOE
	(5)	Electronic Access
	(6)	Coordination of Care
	(7)	Health Information Exchange
	(8)	Public Health
CQMs	**Complete all 16**	
1	CMS 9	NQF 0480 PC-05
2	CMS 31	NQF 1354 EHDI-1a

3	CMS 32	NQF 0496	ED-3
4	CMS 53	NQF 0163	AMI-8a
5	CMS 55	NQF 0495	ED-1
6	CMS 71	NQF 0436	STK-03
7	CMS 72	NQF 0438	STK-05
8	CMS 102	NQF 0441	STK - 10
9	CMS 104	NQF 0435	STK-02
10	CMS 105	NQF 0439	STK-06
11	CMS 26	No NQF	CAC-3
12	CMS 108	NQF 0371	VTE-1
13	CMS 111	NQF 0497	ED-2
14	CMS 113	NQF 0469	PC-01
15	CMS 190	NQF 0372	VTE-2
16	CMS 107	No NQF	STK-08

APPENDIX 28: LIST OF ACRONYMS

A&I	Audits and Investigations
AB	Assembly Bill
ACA	Affordable Care Act
ACPPE	Advanced Community Pharmacy Practice Experience
ACS	Affiliated Computer Services
ADT	Admission, Discharge, and Transfer
AHA	American Hospital Association
AHA	American Heart Association
AI/AN	American Indian/Alaskan Native
AIU	Adopt, Implement, Upgrade
APC	Use of Multiple Concurrent Antipsychotics in Children and Adolescents
API	Application Programming interface
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics
ARRA	American Recovery and Reinvestment Act of 2009
ASA	American Stroke Association
ASAM	American Society of Addiction Medicine

B

BAA	Business Associate Agreement
BEACH	Beacon Education, Analytic, and Collaboration Hub
BHIE	Behavioral Health Information Exchange
BMFEA	Bureau of Medi-Cal Fraud and Elder Abuse
BPM	Business Process Management
BTOP	Broadband Technology Opportunities Program

C

C-CDA	Consolidated-Clinical Document Architecture
CA-MMIS	California Medicaid Management Information System
CBAS	Community-Based Adult Services
CAH	Critical Access Hospitals
CAHIE	California Association of Health Information Exchanges
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CalHIPSO	California Health Information Partnership and Services Organization
CAIR	California Immunization Registry
CalDURSA	California Data use and Reciprocal Support Agreement
CalLIMS	California Laboratory Information Management System
CalOHII	California Office of Health Information Integrity
CalPERS	California Public Employee's Retirement System
CalPSAB	California Privacy and Security Advisory Board
CalREDIE	California Reportable Disease Information Exchange

CalRHIO	California Regional health Information Organization
CAPH	California Association of Public Hospitals
CAPMAN	Capitation Payment Management System
CBO	Community-based Organization
CBTF	California Broadband Task Force
CCC	Council of Community Clinics
CCD	Continuity of Care Document
CCHA	California Children's Hospital Association
CCI	Coordination Care Initiative
CCP	California Coverdell Program
CCR	California Cancer Registry
CCS	California Children's Services
CDA	California Dental Association
CDC	Centers for Disease Control and Prevention
CDPH	California Department of Public Health
CDSS	California Department of Social Services
CEHRT	Certified Electronic Health Record Technology
CENIC	Corporation for Education Network Initiatives in California
CHCF	California HealthCare Foundation
CHDP	Child Health and Disability Prevention Program
CHeQ	California Health e-Quality
CHHS	California Health and Human Services (Agency)
CHILI	California Health Information Law Index
CHIP	Children's Health Insurance Program
CHPL	Certified HIT Product List
CHSDA	Contract Health Services Delivery Areas
CHWA	California Health Workforce Alliance
CIS	Clinical Information System
CLIA	Clinical Laboratory Improvement Amendments
CLPPB	Childhood Lead Poisoning Prevention Branch
CMA	California Medical Association
CMR	Confidential Morbidity Reports
CMRI	California Medicaid Research Institute
CMS	Centers for Medicare and Medicaid Services
CMSO	Center for Medicaid & State Operations
CNM	Certified Nurse Midwife
CFR	Code of Federal Regulations
COREC	CalOptima Regional Extension Center
COTS	Commercial Off-the-Shelf
CPCA	California Primary Care Association
CPOE	Computerized Physician Order Entry
CPS	Child Protective Services
CQM	Clinical Quality Measure
CRC	Caregiver Resource Center
CRIHB	California Rural Indian Health Board
CS	Connectivity Services
CSI	Client & Service Information

CSR	California Stroke Registry
CSRHA	California State Rural Health Association
CTAP	California Technical Assistance Program
CTCP	California's Tobacco Control Program
CTEC	California Telemedicine and eHealth Center
CTEN	California Trusted Exchange Network
CTF	California Trust Framework
CTN	California Telehealth Network
CTRC	California Telehealth Resource Center
CURES	Controlled Substance Utilization Review and Evaluation System
CURES 2.0	California's Controlled Substance Utilization Review and Evaluation System
CWC	Child Welfare Council
CWS/CMS	Child Welfare Services/Case Management System
CYC	California Youth Connection

D

DARs	Desk Audit Reviews
DCDC	Division of Communicable Disease Control
DHCS	Department of Health Care Services
DLT	Distance Learning and Telemedicine
DMC-ODS	Drug Medi-Cal Organized Delivery System
DMH	Department of Mental Health
DPH	Designated Public Hospital
DO	Doctor of Osteopathic Medicine
DOD	Department of Defense
DOJ	Department of Justice
DTI	Dental Transformation Initiative

E

ECHO	Expanding Capacity for Health Outcomes Act
ECM	Enterprise Content Management
eCR	Electronic Case Reporting
eCQM	Electronic Clinical Quality Measure
EDR	Electronic Dental Record
EFT	Electronic Funds Transfer
EH	Eligible Hospital
EHR	Electronic Health Record
EITS	Enterprise Innovation Technology Services
eICR	Electronic Initial Case Report
ELR	Electronic Laboratory Reporting
ELINCS	EHR-Lab Interoperability and Connectivity Specification
ELPD	Entity Level Provider Directory
ELR	Electronic Lab Reporting
ELVIS	Elevated Lead Visual Information System
EMS	Emergency Medical Services

EMSA	Emergency Medical Services Authority
eMAR	Electronic Medication Administration record
EP	Eligible Provider
EPCS	Electronic Prescribing of Controlled Substances
EPMI	Enterprise Master Patient Index
ESAR-VHP	Emergency System for Advance registration of Volunteer Health Professionals
ETL	Extract, Transform, Load

F

FAB	Financial Audits Branch
FADS	Financial Audits Data System
FARs	Field Audit Reviews
FATS	Financial Audits Tracking System
FAQ	Frequently Asked Questions
FCC	Federal Communications Commission
FFS	Fee-For-Service
FFY	Federal Fiscal Year
FHL	Ventura County Foster Health Link
FI	Fiscal Intermediary
FICOD	Fiscal Intermediary Contracts Oversight Division
FTPS	File Transfer Protocol Software
FQHC	Federally Qualified Health Centers

G

GAGAS	Generally Accepted Governmental Auditing Standards
GDSP	Genetic Disease Screening Program
GHS	Girls Health Screen
GHJI	Girls Health and Justice Institute
GPRA	Government Performance and Requirements Act
GWTG	Get with the Guidelines

H

HCF	Healthcare Connect Fund
HCFA	Health Care Financing Administration
HCCN	Health Center Controlled Networks
HEDIS	Healthcare Effectiveness Data and Information Set
HFP	Healthy Families Program
HHS	Health and Human Services
HHP	Health Homes Program
HIE	Health Information Exchange
HIO	Health Information Organization
HIT	Health Information Technology
HITEC-LA	Health Information Technology Extension Center for Los Angeles County
HITECH	Health Information Technology for Economic and Clinical Health

HITEMS	Health Information Technology for Emergency Medical Services
HMOS	Health Maintenance Organizations
HRSA	Health Resources and Services Administration
HAS	Human Services Agency
HSAG	Health Services Advisory Group

I

I-APD	Implementation Advanced Planning Document
I-APD-U	Implementation Advanced Planning Document Update
IA	Interagency Agreement
IB	Investigations Branch
ICEC	Interstate Consent Engine Collaborative
IdAM	Identity Access Management
IDN	Integrated Delivery Networks
IEHP	Inland Empire Health Plan
IEHIE	Inland Empire Health Information Exchange
IHA	Integrated Healthcare Association
IHS	Indian Health Services
HIS-CAO	Indian Health Services- California Area Office
IHP-ODS	Indian Health Program Organized Delivery System
ILPD	Individual Level Provider Directory
IPA	Independent Practice Association
IPHI	Institute for Population Health Improvement
IZ	CAIR Immunization Registry

L

LACDMH	Los Angeles County Department of Mental Health
LEA	Local Educational Agencies
LEC	Local Extension Center
LFS	Lab Field Services
LGHC	Let's Get Healthy California
LHD	Local Health Departments
LOINC	Logical Observation Identifiers Names and Codes

M

MARS	Management & Administrative Reporting System
MCQMD	Managed Care Quality and Monitoring Division
MCP	Managed Care Plan
MD	Doctor of Medicine
MDL	Medical Diagnostics Labs
MEDS	Medi-Cal Eligibility Data System
MFR	Master File Room
MH/SU	Mental Health and/or Substance Use
MHSA	Mental Health Services Act of 2004

MHP	Mental Health Program
MIS/DSS	Management Information System/Decision Support System
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
MOA	Memorandum of Agreement
MPI	Master Patient/Person Index
MRB	Medical Review Branch
MSO	Management Service Organization
MSSP	Multipurpose Senior Services Program
M-TIP	MITA Transition and Implementation Plan
MU	Meaningful Use

N

NAMCS	National Ambulatory Medical Care Survey
NASMD	National Association of State Medicaid Directors
NATE	National Association for Trusted Exchange
NCHS	National Center for Health Statistics
NCPDP	National Council for Prescription Drug Programs
NCQA	National Committee for Quality Assurance
NDC	National Drug Codes
NHIN	Nationwide Health Information Network
NLR	National Level Repository
NSRHN	Northern Sierra Rural Health Network
NSSMPP	National Study of Small and Medium-Sized Physician Practices
NP	Nurse Practitioner
NSP	Newborn Screening Program
NTIA	National Telecommunications and Information Administration
NQS	National Quality Strategy for Quality Improvement in Health Care

O

OCPRHIO	Orange County Partnership Regional Health Information Organization
OD	Doctor of Optometry
OHB	Occupational Health Branch
OHP	Oral Health Program
OHIT	Office of Health Information Technology
OLPPP	Occupational Lead Poisoning Prevention Program
ONC	Office of the National Coordinator
OOH	Out-of-Home
OSHPD	Office of Statewide Health Planning and Development

P

P-APD	Planning Advanced Planning Document
P-APD-U	Planning Advanced Planning Document Update
PA	Physician Assistant

PACES	Post-Adjudicated Claim and Encounter System
PAVE	Provider Application and Validation for Enrollment
PCP	Primary Care Physicians
PED	Provider Enrollment Division
PETS	Provider Enrollment Tracking System
PD	Parkinson's disease
PHA	Public Health Agencies
PHR	Personal Health Record
PMF	Provider Master File
POLST	Physician Orders for Life-Sustaining Treatment
PPOS	Preferred Provider Organizations
PPS	Prospective Payment System
PL	Public Law
PRIME	Public Hospital Redesign and Incentives in Medi-Cal
pSCANNER	Patient-Centered Scalable National Network for Effectiveness Research
PULSE	Patient Unified Lookup System for Emergencies

Q

QIPS	Quality Improvement Projects
QRDA	Quality Reporting Document Architecture

R

RAND	Research and Development Corporation
RASSCLE	Response and Surveillance System for Childhood Lead Exposure
REC	Regional Extension Center
RFP	Request for Proposal
RHC	Rural Health Clinic
RPMS	Resource and Patient Management System
RTI	Research Triangle Institute

S

S-HIE	Social-Health Information Exchange
SaaS	Software as a Service
SACWIS	State Automated Child Welfare Information System
SAFR	Search, Alert, File, and Reconcile
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SCA	Service Component Architecture
SCHIE	Santa Cruz Health Information Exchange
SCHIP	State Children's Health Insurance Program
SCO	State Controller's Office
SDE	State Designated Entities
SDBC	San Diego Beacon Community
SDHC	San Diego Health Connect

SDRHIE	San Diego Regional Health Information Exchange
SFTP	Secure File Transfer Protocol
SHA	Staying Healthy Assessment
SHIG	State Health Information Guidance
SIM	State Innovation Model
SLR	State Level Registry
SPA	State Plan Amendment
SMD	State Medicaid Directors Letter
SMI	Serious Mental Illness
SMHP	State Medicaid Health Information Technology Plan
SOA	Service Oriented Architecture
SOAP	Simple Object Access Protocol
SOM	School of Medicine
SON	School of Nursing
SOP	School of Pharmacy
SQL	Structured Query Language
SR	Services Registry
SS-A	State Self-Assessment
SSW	Superior Systems Waiver
SSIS	SQL Server Integration Services
SUDs	Substance Use Disorders
SURS	Surveillance and Utilization Review Subsystems

T

TA	Technical Assistance
TAR	Treatment Authorization Request
TCP	The Children's Partnership
THP	Tribal Health Provider
TPL	Third Party Liability
TRC	Telehealth Resource Center

U

UCSF	University of California, San Francisco
UIHP	Urban Indian Health Programs

V

VA	Veterans Administration
VASDMC	Veterans Administration San Diego Medical Center
VDH	Virtual Dental Home
VHIE	Veteran Health Information Exchange
VLER	Virtual Lifetime Electronic Records
VistA	Veterans Health Information Systems and Technology Architecture

W

W&I Code	Welfare and Institutions Code
WHIN	Western Health Information Network
WIR	Wisconsin Immunizations Registry
WPC	Whole Person Care
WRHealthIT	Western Region Health IT Program
WSC	Western States Consortium

X

XML	Extensible Markup Language

APPENDIX 29: THE USUAL SUSPECTS

OHIT Staff, from left to right.

Front Row:	William White, Soua Vang, Nicole Buenaventura, Jenny Ly, Julia Jamie, Chelsea Harlow
Second Row:	Kristina Cooney, Tom Vang, Dr. Larry Dickey, Sandra Montiero, Elison Alcovendaz
Third Row:	Pamela Williams, Steve Yegge, Morgan Peschko, Raul Ramirez, Jason Van Court, Errin Horstkorta

We dedicate this SMHP to the memory of Steve Yegge (1949-2018). Steve was the Chief of Operations for the program from its very beginning. His wisdom and humor were invaluable to the program and to OHIT staff morale.