



Osteopathic Board of Pediatrics (AOBP) is also required. Every one with this advanced education will have a certificate and it will be on the licensure board site.

Ineligible Provider Types: In contrast with the Medicare eligible provider definition, the following provider types will not be eligible for the Oklahoma SoonerCare EHR Incentive Payment Program:

- Podiatrist – Provider type 14
- Chiropractor – Provider type 15
- Optometrist – Provider type 18

Also ineligible by exclusion in the Final Rule are behavioral health practitioners and long-term care facilities that do not otherwise meet the definition of an EP or an EH (see §495.4 General definitions for Medicare eligibility; and §495.304 Medicaid Provider Scope and Eligibility).

4.5.1.4 Methodology for EP Patient Volume

OHCA has adopted the Final Rule CMS patient volume definition for the SoonerCare EHR Incentive Program. The following statements encapsulate the CMS Final Rule definition regarding patient volume:

- "... all EPs and the vast majority of hospitals will need to meet certain patient volume thresholds in order to be eligible for incentive payments. (The only exception to this rule is for children's hospitals, which have no patient volume threshold requirement)...
- ...for the SoonerCare member volume, these thresholds are calculated using as the numerator the individual hospital's or EP's total number of SoonerCare member encounters in any representative continuous 90-day period in the preceding calendar year and the denominator is all patient encounters for the same individual professional or hospital over the same 90-day period."
- EPs practicing predominantly in an FQHC or RHC will be evaluated according to their "needy individual" patient volume. To be identified as a "needy individual," patients must meet one of following criteria: (1) Received medical assistance from SoonerCare or the Children's Health Insurance Program; (2) Were furnished uncompensated care by the provider; or (3) Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.



Table 8 SoonerCare Patient Volumes

Eligible Hospital (EH) Type	Patient Volume over 90-day Period
Acute Care Hospital	10%
Children’s Hospital	No percentage requirement
Eligible Professional (EP) Type	Patient Volume over 90-day Period
Physicians (M.D., D.O.)	<ul style="list-style-type: none"> ○ 30% SoonerCare ○ For Medical EPs practicing predominantly in FQHC/RHC – 30% Needy Individuals
Dentists	
Certified Nurse Midwives	
Nurse Practitioners	
PAs in FQHC/RHC led by a PA	
Pediatricians	<ul style="list-style-type: none"> ○ 30% SoonerCare ○ If Pediatrician patient volume = 20-29%, the provider may qualify for 2/3 of incentive payment

4.5.1.5 Verifying EP Patient Volume

Claims data from OHCA’s DW will be used to verify the reasonableness of patient volume attested to by EPs. EPs will be asked to provide separate patient volume numbers from each of the different locations their NPI is associated with. This will help in two ways: 1) Practice owners/managers at one location will not be able to complete the EP’s attestation for all practices and therefore, will not be able to complete the attestation and assign payment to their location without the EP’s knowledge and 2) The patient volume numbers will be easier to validate at the location level than in the aggregate.

4.5.1.6 Assuring Providers Are Not Hospital-Based

OHCA will ask providers to attest that they are not hospital-based. In addition, professional claims for the reporting period will be analyzed, with the provider’s NPI in the rendering provider field, to look at the place of service for their claims. Since the definition of “hospital based” now includes inpatient or ER setting, OHCA plans to use only Place of Service Codes 21-Inpatient Hospital and 23-ER as a basis for “hospital-based” services. Analysis will be made of professional and institutional claims (and dental claims, for dental providers) to verify where their SoonerCare member time is spent. If the predominant place of service is at the inpatient hospital or ER, OHCA will consider the provider to be hospital-based.



4.5.1.7 Verifying Acute Care Hospital Patient Volume

Acute care hospitals would be asked to enter their SoonerCare and total discharges for the prior federal fiscal year. Acute care and children's hospitals' SoonerCare and total discharges are listed on the hospitals' cost reports. OHCA will take these numbers from the cost reports in order to verify the information entered by the hospitals. IHS hospitals do not submit cost reports to OHCA; IHS hospitals will be asked to submit supporting documentation that contains this information.

4.5.1.8 Ensure Providers are Licensed, Not Sanctioned

MITA Reference: Enroll Provider (PM 01) and Disembroid Provider (PM 02)

OHCA's existing process for checking provider licensure and sanctioning will be employed for the SoonerCare EHR Incentive Program as well. All providers are manually checked for sanctions before being enrolled in SoonerCare. Once a month, CMS sends a file that is run against the provider file to check for any new sanctions. CMS also sends letters when new providers to the State are sanctioned. OHCA staff use multiple local resources to identify new sanctions. All these sources will be reviewed prior to completing any provider's enrollment in the SoonerCare EHR Incentive Program.

While I/T/U providers are required to be licensed, they are not required to have a valid Oklahoma license. As part of the EPE contracting process, OHCA verifies with the appropriate State licensing entity that the I/T/U provider has a valid license.

4.5.1.9 Provider Attestation Process and Validation

This section will include a description of the Attestation language and the Provider documentation that will be needed to support the meaningful use of certified EHR requirements that support the meaningful use, and that they have adopted, implemented or upgraded certified EHR technology during the reporting period. This section will also include the methodology to verify the meaningful use information. This section will also include the process to verify the overall content of provider attestation.

The MMIS currently supports an EPE module that allows providers to manage their enrollment and associated data electronically. This provider web portal will be modified to include the required elements of the SoonerCare EHR Incentive Program enrollment and attestation.

When providers register for the SoonerCare EHR Incentive Program, they will be asked to attest that they are not hospital based. OHCA will analyze claims for the reporting period with the provider's NPI in the rendering provider field, and look at the place of service for their claims. If the predominant place of service is at the inpatient hospital or ER, the provider will be considered hospital-based. OHCA will initially deny eligibility and advise the provider to ask for eligibility reconsideration if he/she can provide proof to the contrary.

OHCA has defined the attestation criteria for providers applying for an incentive payment to include each of the program eligibility criteria in the first year. In subsequent years as the providers will need to demonstrate their ability to "meaningfully" apply the capabilities of their EHR systems, OHCA will need to develop additional methods of verification.



4.5.1.10 Participation in National Level Registry (NLR)

This section will describe the business process and technology planned to support participation in the National Level Registry (NLR). This section will include the information that will be added to the registry as well as the information that will be queried in order to certify the provider's enrollment in the Provider Incentive Program.

OHCA assumes that the NLR will be available to support the registration of SoonerCare providers wishing to participate in the SoonerCare EHR Incentive Program. Oklahoma providers will select one NPI number with which to register in the NLR and one TIN. OHCA further assumes that the NLR will transmit or make available transactions indicating that the provider had registered.

In the event that the NLR is not available at the inception of the implementation of the SoonerCare EHR Incentive Program, OHCA will compare the registration requests received prior to NLR availability to the data in the NLR when it becomes available. If there are discrepancies, OHCA will utilize its existing internal process to validate the provider submission and recoup the EHR Incentive payment if necessary.

OHCA will develop an electronic bi-directional interface with the NLR. Specification details for this interface will be described in the IAPD supporting the SoonerCare EHR Incentive Program system changes.

OHCA has volunteered to be one of the states that will beta test the NLR interface.

4.5.2 Eligible Providers

This section will identify hospitals and providers eligible to enroll in the Oklahoma Provider Incentive Program.

OHCA will qualify providers as defined in the Final Rule **Medicare and Medicaid Programs; Electronic Health Record Incentive Program**. As specified under section 1903(t)(2)(A) of the Act, SoonerCare participating providers who wish to receive a Medicaid incentive payment must meet the definition of a "Medicaid Eligible Professional" or "Medicaid Eligible Hospital." The EP definition (1903(t)(3)(B) of the Act) lists five types of Medicaid professionals: Physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants practicing in an FQHC or RHC that is so led by a physician assistant. OHCA also engaged I/T/U and determined that I/T/U providers that met the eligibility criteria could also participate in the program.

EPs and EHs enrolling in SoonerCare EHR Provider Incentive Program must have a practice physically located within Oklahoma.

4.5.3 Provider Registration Process

This section will include a paragraph on provider registration process for enrollment into the Provider Incentive Program. Requirements will include completion of the Attestation Statement certifying the Medicaid patient percentage thresholds have been met.

4.5.3.1 Provider Taxpayer Identification Number (TIN)

This section will include the processes and validation to ensure that each eligible EP or hospital will provide a TIN for the purposes of tracking the incentive payment.

MITA Reference: Manage Provider Information (PM06)



OHCA currently requires that all providers submit a valid TIN as a condition of SoonerCare provider enrollment. Each EP or EH will be enrolled as an OHCA SoonerCare provider and will therefore, without change in process or system modification, meet the requirement to supply a TIN.

The TIN will be used to identify the providers on IRS Form 1099 and allow IRS reporting based on the appropriate TIN where providers have received an EHR Incentive payment from OHCA. Current business and system processes support the use of TIN to identify provider payments.

TINs are validated with the IRS annually. When OHCA submits a 1099 file to the IRS, the IRS will respond to OHCA Finance Department with a letter including a list of incorrect TINs. OHCA Finance will send this list to Provider Enrollment to follow up by contacting the provider for the correct information. If the provider does not respond, OHCA Finance places the provider on payment hold until the correct TIN is submitted.

OHCA assumes that the NLR will accept SoonerCare EHR Incentive Program update transactions correcting TIN data; OHCA will send corrections upon receipt of the corrected TINs from providers.

Assignment of Payment

It is understood that the National Plan and Provider Enumeration System (NPPES) registration system will require all providers to assign payment at the national level. The NLR Registration transaction to the State will include not only the EP's Personal TIN, but also the Payee TIN. OHCA plans to assign the payment at the state level, as the national level has no way to validate the payee TIN/EP TIN combination. The Oklahoma SoonerCare EHR Incentive Payment Registration and Attestation function will list the valid individual and group NPIs, names, State provider IDs, and TINs associated with the EP who is registering at the state level. The EP will have the opportunity to choose which of these valid entities, to assign his/her EHR Incentive payment to. If the entity who the EP wants to receive the payment is not listed, a phone number for the Provider Enrollment Unit will be listed on the screen that the EP can call and discuss it. The valid choices will be the groups the provider is associated with, and if the provider is a billing provider, then the individual will also be listed. If the provider is not a billing provider, the Provider Enrollment Unit will need to make some modifications in the MMIS system before the provider's information will show up in the list. This is due to the design of the MMIS system; it will not automatically create an electronic payment to a provider who is not a biller.

4.6 Processing Payments to Providers

This section includes the plan for making payments to providers and a list of tasks that must be completed during the implementation phase to calculate and process provider payments. Appendix E contains the Table of Qualifying Patient Volume.

MITA Reference: Prepare Provider EFT Check – (OM10)

MMIS expenditure entries will be automatically created when OHCA staff indicate in the MMIS system that all supporting documentation has been submitted by the EP/EH and that all of the requirements for payment have been satisfied. The incentive payments are considered supplemental payments. A specific funding code is applied to provider incentive payments.



Funds are dispersed as specified by the State Medicaid Enterprise business rules. Payments are routed as specified by the “pay to” instruction from the CMS NLR most recent registration transaction, to the EFT account on file for the Payee TIN. OHCA staff updates the Payment History Information data store, the Perform Accounting Functions, and State Financial Management business processes with transaction accounting detail.

Providers determined to be eligible for SoonerCare EHR Incentive Program payments will be identified and payments made on a monthly basis (e.g., all providers identified as eligible providers in January 2011 would receive their Year 1 payments in February 2011)

Providers determined to be ineligible for the SoonerCare EHR Incentive Program payments will be notified via mail of the decision, the reason(s) for the decision, as well as the OHCA process for reconsideration.

4.6.1 Provider Registration and Payment Request

This section will include a paragraph on OHCA triggers for making incentive payments to providers, including payment schedule.

Providers (EPs and EHs) contacting OHCA regarding the SoonerCare EHR Incentive Program payment process will be directed to the OCHA secure provider web site for detailed information on participation in the SoonerCare EHR Incentive Program in Oklahoma. Providers will be instructed to register in the NLR before requesting payment from OHCA.

OHCA is leveraging capability to have providers electronically engage with OHCA. OHCA is modifying the design and requirements to match NLR and ONC certification web service and screen designs are available upon request.

Providers (EPs, EHs, and CAHs) are directed to the EPE site to begin SoonerCare EHR Incentive Program registration. OHCA will validate the SoonerCare provider enrollment and the NLR record, affirming that the provider has selected Oklahoma SoonerCare participation. The provider is then directed to the Oklahoma secure EPE Attestation page where he/she will enter his/her NLR Registration number. The Attestation process will search for the NLR Registration number in the NLR table. The Attestation process will automatically compare the provider type, NPI, and payee TIN to the information from the NLR. If these do not match, the user will receive an error message on the screen with an OHCA phone number to call for assistance. The Attestation process will compute the current participation year based on the most recent NLR Registration record participation year and the number of participation/payment years recorded in the Oklahoma MMIS.

Table 9 Eligible Professional Attestations

During EHR Year 1 reporting period, the EP attests:	During EHR Years 2 through 6 reporting period, the EP attests:
The EP is a board certified Pediatrician, if applicable	The EP is a board certified Pediatrician, if applicable
The Physician Assistant attest that he/she is working in an FQHC or RHC so led by: a) a PA as the primary provider in the clinic, b) a PA as the clinical or medical director at a site of practice, or c) a PA as an owner of an RH.	The Physician Assistant attest that he/she is working in an FQHC or RHC so led by: a) a PA as the primary provider in the clinic, b) a PA as the clinical or medical director at a site of practice, or c) a PA as an owner of an RHC.



During EHR Year 1 reporting period, the EP attests:	During EHR Years 2 through 6 reporting period, the EP attests:
The EP attests that he/she practices predominantly in an FQHC or RHC, if applicable	The EP attests that he/she practices predominantly in an FQHC or RHC, if applicable
The EP is not Hospital based professional who furnishes 90% or more of his/her professional services in an inpatient hospital or emergency room setting, if he/she does not practice predominantly in an FQHC or RHC	The EP is not Hospital based professional who furnishes 90% or more of his/her professional services in an inpatient hospital or emergency room setting, if he/she does not practice predominantly in an FQHC or RHC
The EP is not concurrently receiving an incentive payment from another state, or under another SoonerCare ID number or Medicare program	The EP is not concurrently receiving an incentive payment from another state, or under another SoonerCare ID number or Medicare program.
The EP has adopted, implemented or upgraded (A/I/U) a certified EHR	The EP used certified EHR technology
The EHR product used is certified and EP entered a product certification number	The EHR product used is certified and EP entered a product certification number
The EP has reported the number of FTE jobs created by implementing this certified EHR product	The EP has reported the number of FTE jobs created by implementing this certified EHR product
The EP has reported the amount of cash payments made directly attributable to him/her for the certified EHR (not including payments from state or local governments, in-kind contributions, etc.)	The EP has reported the amount of cash payments made directly attributable to him/her for the certified EHR (not including payments from state or local governments, in-kind contributions, etc.)
The EP has confirmed That at least \$3,750 of the EHR technology is the responsibility of him/her or his/her employer, group, clinic, hospital affiliation, or in-kind contributions or grants	The EP has confirmed That at least \$1,500 of the EHR technology is the responsibility of him/her or his/her employer, group, clinic, hospital affiliation, or in-kind contributions or grants
The EP has confirmed assignment of his/her payment to another TIN and agrees to this assignment, if applicable	The EP has confirmed assignment of his/her payment to another TIN and agrees to this assignment, if applicable
The EP's percentage of SoonerCare encounters or Needy Individual (for EP's practicing predominantly in an FQHC/RHC) patient volume is equal to or greater than the allowed percentage of their specialty (See Appendix E)	The EP's percentage of SoonerCare encounters or Needy Individual (for EP's practicing predominantly in an FQHC/RHC) patient volume is equal to or greater than the allowed percentage of their specialty (See Appendix E)
The EP has specified the patient volume date range of at least 90 days	The EP has specified the patient volume date range of at least 90 days
	The EP has specified the EHR reporting period and provided the result of each applicable measure for all patients seen during the EHR reporting period for which a selected measure is applicable
	The EP has satisfied the required objectives and associated measures under §495.6(d) and §495.6(e), except §495.6(d)(10) "Report ambulatory clinical quality measures to the State"
	The EP attests to meeting the meaningful use criteria associated with his/her year of



During EHR Year 1 reporting period, the EP attests:	During EHR Years 2 through 6 reporting period, the EP attests:
	participation and applicable stage per the rule
	If applicable, the EP attests that the clinical quality measures not reported do not apply to any patients treated by the EP
The EP attests that all information is true and accurate per wording in the rule	The EP attests that all information is true and accurate per wording in the rule
The EP's electronic signature on the attestation is valid for the SoonerCare EHR Incentive Program payment request	The EP's electronic signature on the attestation is valid for the SoonerCare EHR Incentive Program payment request

For all calendar years, an EP who practices in multiple physical locations, not all of which have certified EHR technology available, the EP will demonstrate meaningful use using only the locations where the EP has certified EHR technology available.

In order to qualify for payment, the EP must meet the definition of §495.4 meaningful EHR user.

Table 10 Eligible Hospitals and CAHs Attestations

Eligible Hospitals or CAHs eligible only for the Oklahoma SoonerCare EHR Incentive Payment Program, attesting to Adopt, Implement, or Upgrade in their first participation year attests that:	During 2011 reporting period, the eligible hospitals or CAHs attesting to Meaningful Use attests that:	During 2012 and subsequent reporting periods, the eligible hospitals or CAHs attesting to Meaningful Use attests that:
The EH or CAH adopted, implemented or upgraded (A/I/U) a certified EHR	The EH or CAH used certified EHR technology	The EH or CAH used certified EHR technology.
	The EHR product used is certified and EH or CAH entered product certification number, vendor, product, and version	The EHR product used is certified and EH or CAH entered product certification number, vendor, product, and version
The EH or CAH has reported the number of FTE jobs created by implementing this certified EHR product	The EH or CAH has reported the number of FTE jobs created by implementing this certified EHR product	The EH or CAH has reported the number of FTE jobs created by implementing this certified EHR product
	The EH or CAH satisfied the required objectives and associated measures under §495.6(f) and §495.6(g).	The EH or CAH has satisfied the required objectives and associated measures under §495.6(f) and §495.6(g), except §495.6(f)(9) "Report hospital clinical quality measures to the State"
		The EH or CAH attests that the information submitted with respect to clinical quality



Eligible Hospitals or CAHs eligible only for the Oklahoma SoonerCare EHR Incentive Payment Program, attesting to Adopt, Implement, or Upgrade in their first participation year attests that:	During 2011 reporting period, the eligible hospitals or CAHs attesting to Meaningful Use attests that:	During 2012 and subsequent reporting periods, the eligible hospitals or CAHs attesting to Meaningful Use attests that:
		measures was generated as output from an identified certified EHR technology
		The EH or CAH attests that the information was submitted to the knowledge and belief of the official submitting on behalf of the eligible hospital or CAH
		The EH or CAH attests that the information submitted includes information on all patients to whom the measure applies
		For EHs or CAHs that do not report one or more measures, the EH or CAH attests that the clinical quality measures not reported do not apply to any patients treated by the EH or CAH during the reporting period
		The EH or CAH attests numerators, denominators, and exclusions for each clinical quality measure result reported, providing separate information for each clinical quality measure including the numerators, denominators, and exclusions for all patients irrespective of third party payer or lack thereof; for Medicaid patients.
		The EH or CAH attests the beginning and end dates for which the numerators, denominators, and exclusions apply
	The EH or CAH specified the EHR reporting period and provided the result of each applicable measure for all patients admitted to the inpatient or emergency department (POS 21 or 23) of the hospital during the EHR reporting period for which a	The EH or CAH specified the EHR reporting period and provided the result of each applicable measure for all patients admitted to the inpatient or emergency department (POS 21 or 23) of the hospital during the EHR reporting period for which a selected measure is



Eligible Hospitals or CAHs eligible only for the Oklahoma SoonerCare EHR Incentive Payment Program, attesting to Adopt, Implement, or Upgrade in their first participation year attests that:	During 2011 reporting period, the eligible hospitals or CAHs attesting to Meaningful Use attests that:	During 2012 and subsequent reporting periods, the eligible hospitals or CAHs attesting to Meaningful Use attests that:
	selected measure is applicable	applicable
The EH or CAH attests that all information is true and accurate per wording in the rule	The EH or CAH attests that all information is true and accurate per wording in the rule	The EH or CAH attests that all information is true and accurate per wording in the rule
The EH or CAH electronic signature on the attestation is valid for the SoonerCare EHR Incentive Program payment request	The EH or CAH electronic signature on the attestation is valid for the SoonerCare EHR Incentive Program payment request	The EH or CAH electronic signature on the attestation is valid for the SoonerCare EHR Incentive Program payment request

Provider attestation information will be reviewed by OHCA to determine provider eligibility. The EHR system certification number entered on the attestation has been verified prior to payment being made. (OHCA is working with CMS and ONC to automate this process.) Providers determined to be eligible will receive incentive payment for that year. Providers will have to re-attest each year to meaningful use for each year’s participation in SoonerCare Provider Incentive Program prior to receipt of an incentive payment.

OHCA will confirm the provider’s eligibility for the current year’s payment via the MMIS Provider subsystem. OHCA will approve the provider incentive payment via the MMIS Financial subsystem.

The eligible EP and eligible hospital or CAH must maintain documentation supporting their demonstration of meaningful use for six years.

4.6.2 Provider Payment Calculations

4.6.2.1 Eligible Professionals (EP) Payment Calculation

This section will discuss how providers will be required to make requests for payments for reimbursement from the Medicaid program and how payments will be calculated.

OHCA will validate Provider “net” average allowable costs. Allowable costs for each provider must be adjusted in order to subtract any cash payment that is made to SoonerCare EPs and is directly attributable to payment for certified EHR technology or support services of such technology. Payments from State or local governments, in-kind contributions and grants do not reduce the average allowable costs. The resulting figure is the “net” average allowable cost, that is, average allowable cost minus payments from other sources (other than State or local governments).

OHCA will calculate 85 percent of a “net” allowable cost not to exceed a maximum in the first year of \$21,250. Per §495.310, an EP may not begin receiving payments later than calendar year 2016. For subsequent years, OHCA will calculate 85 percent of a net allowable cost, not to exceed a maximum of \$8,500. Payment after the first year may continue for a maximum of five



years. SoonerCare EPs may receive payments on a non-consecutive, annual basis. No payments may be made after calendar year 2021. In no case shall a SoonerCare EP participate for longer than six years or receive payment in excess of the maximum \$63,750.

EPs that meet the State definition of Pediatrician and carry between 20 percent to 29 percent Medicaid patient volume will have their payment reduced by one-third. The Pediatrician will not receive more than \$14,167 in the first year and not more than \$5,667 for subsequent years. The total allowable for six years will not exceed \$42,500. All other requirements noted above for an EP remain the same.

4.6.2.2 Eligible Hospital (EH) Payment Calculation

This section will include the hospital payment calculation including the data elements, and resources of payment.

The SoonerCare EHR Incentive Program hospital aggregate incentive amount calculation will be a one-time, up front calculation using the equation outlined in the Final Rule, as follows:

(Overall EHR Amount) times (Medicaid Share) where Overall EHR Amount Equals {Sum over 4 year of [(Base Amount plus Discharge Related Amount Applicable for Each Year) times Transition Factor Applicable for Each Year]} times Medicaid Share Equals {(Medicaid inpatient-bed-days plus Medicaid managed care inpatient-bed-days) divided by [(total inpatient-bed days) times (estimated total charges minus charity care charges) divided by (estimated total charges)]}

OHCA will leverage the disproportionate share hospital payment screens and functionality to create a similar approach for hospital provider payments to be calculated.

Oklahoma intends to pay the aggregate hospital incentive payment amount over a period of three annual payments, contingent on the hospital's annual attestations and registrations for the annual Oklahoma SoonerCare payments. The reason for this approach is that most of Oklahoma's numerous rural hospitals operate on a very thin margin and will need the money as soon as possible to offset their EHR system costs.

In the first year, if all conditions for payment are met, 50 percent of the aggregate amount will be paid to the EH. In the second year, if all conditions for payment are met, 40 percent of the aggregate amount will be paid to the EH. In the third year, if all conditions for payment are met, 10 percent of the aggregate amount will be paid to the EH. No SoonerCare EHs may begin receiving payments after 2016 and no payments may be made after calendar year 2021. Prior to 2015 payments can be made to an eligible hospital on a non-consecutive annual basis.

4.6.2.3 Payments to Eligible Providers through Managed Care Plans

This section will include a description of the process to assure that there are fiscal arrangements with providers to disburse incentive payments through Medicaid managed care plans does not exceed 105 percent of the capitation rate per 42CFR Part 438.6, as well as a methodology for verifying such information.

This requirement does not apply because OHCA programs do not have contracts with managed care entities.

4.6.3 Provider Payment Monitoring

*This section will include the processes and **verification methods** in place to assure that:*



- *No amounts higher than 100% of FFP will be claimed for reimbursement of expenditures for State payments to Medicaid eligible providers for the EHR incentive payment*
- *Payments are made directly to a Medicaid EP or Hospital or to an employer or facility to which such a provider has assigned payment) without any deduction or rebate.*
- *All assignments to an entity promoting the adoption of certified EHR are voluntary for the Medicaid EP*
- *Entities promoting the adoption of EHR technology do not retain more than 5% of payments not related to or required for the operation of the technology*
- *Medicaid EP or eligible hospitals do not collect EHR payments from multiple states*
- *Process to ensure that existing fiscal relationships with providers to disburse incentive payments through Medicaid managed care plans does not result in payments that exceed 105% of the capitation rate*
- *Method to monitor the compliance of providers beginning the program with different requirements dependent upon the year*
- *Process to ensure that the Medicaid EHR incentive program payments are made for no more than six years and that no eligible provider or hospital begins receiving payments after 2016*
- *Description of the process and method used to calculate the net average allowable costs and verification that the payments do not exceed 85% of the net average allowable cost*
- *Description of the process, data and method used to calculate the hospital payment incentives*
- *Description of the process to provide for timely and accurate payment of incentive payments, including the time frame specified by the State to meet the timely payment requirement*

MITA Reference: Audit Claim/Encounter (OM07)

In order to ensure that no amounts higher than 100 percent of FFP will be claimed for reimbursement, payments to SoonerCare EHR Incentive Program eligible providers will be reported on a separate line on the CMS 64 (MAR 1060/1062 reports) report. This report will be reviewed for accuracy and deficiencies.

Payments will be made directly to a SoonerCare EP or Hospital or to an employer or facility to which the provider has assigned payment.

The State has no current plans to designate any entities for promoting the adoption of certified EHR technology.

System controls will be implemented and tested in the MMIS Financial subsystem to ensure appropriate payments and reporting. OHCA assumes that states will participate in the registration and payment reporting to the NLR. OHCA will interrogate the NLR based on unique provider NPI and TIN, prior to completing the payment process to ensure that SoonerCare EP or EH do not collect EHR payments from multiple states. This process will also ensure that EPs have not previously received Medicare payment for the same Program Year.

Providers will be required to attest to the year of their participation that they have not requested to participate in the Medicare (for EHRs) or any other State Provider Incentive Program. Communications with the CMS NLR will be used to validate this information prior to making the incentive payment.



Provider participation in the SoonerCare EHR Incentive Program will be tracked in the Oklahoma MMIS. The Provider's status relative to Program eligibility will be assessed with each annual payment request. The eligibility determination will include the interrogation of the NLR to assess previous payments based on unique provider NPI and TIN. OHCA will maintain in each MMIS participating Provider record the year in which payments are requested and the SoonerCare EHR Incentive Program requirements relative to the year of the request. Each eligible provider will be limited to a maximum of six payments. New provider SoonerCare EHR Incentive Program participation requests will not be allowed after December 31, 2016.

In addition, OHCA will submit program participation data to CMS including data for the number, type and practice location(s) of providers who qualified for an incentive payment on the basis of having adopted, implemented, or upgraded certified EHR technology or who qualified for an incentive payment on the basis of having meaningfully used such technology as well as aggregate de-identified data on meaningful use.

4.6.4 Provider National Provider Identifier (NPI)

This section will include the processes and verification methods in place to assure that eligible EPs or hospitals will receive an NPI.

MITA Reference: Enroll Provider (PM01)

OCHA currently requires that all providers submit a valid NPI as a condition of SoonerCare provider enrollment. Each EP or EH will be enrolled as an OHCA SoonerCare provider and will therefore, without any change in process or system modification, meet the requirement to receive an NPI. OHCA performs a manual NPPES search to validate NPIs during the enrollment process.

4.6.5 Role of Contractors in the SoonerCare EHR Incentive Program Implementation

OHCA leverages the services of a contractor to provide Fiscal Agent Services. OHCA State staff will be responsible for the oversight and administration of the SoonerCare EHR Incentive Program. Hewlett Packard Inc. (HP), acting as the State's Fiscal agent, operates the State's Call Center supporting provider inquiries, operates the MMIS supporting provider payments and recording attestations, and participates in the development of system solutions supporting the SoonerCare EHR Incentive Program. OCHA will develop policies and procedure manuals to guide the actions of HP in participating in the SoonerCare EHR Incentive Program.

Additional contractor staff may be brought on board during the implementation stage to augment OHCA staff as needed.

4.7 Reporting Requirements

This section will include a discussion on OHCA Provider Incentive Program Reporting needs. The Provider Incentive Program payment data will need to be captured, standard reports developed for identification of providers for outreach, tracking payments, adjustments and refunds, as well as state and federal reporting requirements met.

Reporting requirement modifications to the MMIS and DW are described in more detail in Section 5.1.2.3.3.



4.8 Coordination with Medicare to Prevent Duplicate Payments

This section will include the plan for coordination of enrollment of eligible providers and hospitals to ensure no duplicate payments are made for providers participating in both Medicare and Medicaid.

OHCA assumes that the NLR will be available to support the registration of SoonerCare providers wishing to participate in the SoonerCare EHR Incentive Program. OHCA will evaluate transactions from the NLR to determine if providers eligible for both Medicaid and Medicare payments have already received Medicare payments.

In the event that the NLR is not available at the inception of the Oklahoma implementation of the SoonerCare EHR Incentive Program, OHCA will compare the registration requests received prior to NLR availability to the data in the NLR once available. If there are discrepancies, OHCA will utilize its existing internal process to validate the provider submission and recoup the Incentive payment if necessary.

OHCA will develop an electronic bi-directional interface with the NLR. Specification details for this interface will be described in the IAPD supporting the SoonerCare EHR Incentive Program system changes.

4.9 Program Integrity (PI) Monitoring

This section will discuss Program Integrity goals and objectives related to Medicaid Incentive Program and task necessary to develop monitoring process during the implementation phase.

MITA Reference: Identify Candidate Case (PI01)

OHCA will conduct annual audits of the provider incentive payments. Audits will be conducted via statistical sampling. Volume, scope, methods, and procedures will be based on risk assessments and materiality consistent with the OHCA PI and Planning Division Audit/Review Process.

Guidance in the Audit/Review Process Handbook outlines the steps below to define Audit Scope.

Assessment and Analysis

The audit assessment and analysis phase includes steps necessary to assemble information that will enable the audit team to make decisions concerning the nature, timing, and extent of detailed audit work. The review includes a timely gathering and analysis of information so that potential audit areas can be identified and plans made to review and test management controls over these areas.

Focus Objectives

Focusing on objectives is a function of the internal control assessment and risk analysis, which can be done systematically through the process of a survey.

Risk Analysis and Internal Control Assessment

The purpose of the audit survey is to identify areas of potential audit risk and design audit work to minimize the risk. The audit team should target its resources in areas with the most risk. This requires that the audit team gain an understanding of the internal control structure. With this understanding, the team should identify the controls that are relevant to the objectives of the



audit. The team should then assess the relative control risk for each control. There are several approaches to making a risk analysis and internal control assessment. Regardless of the method followed, the team must consider all factors relevant to the audit objective. These factors include materiality, significance of legal and regulatory requirements, and the visibility and nature of the government programs.

Refine Objectives

Through a careful process of analyzing risk and assessing internal controls, the team must ensure that the audit objectives cover the areas of highest risk consistent with resource limitations. The team should refine the overall objective(s) established in the preliminary planning phase when necessary.

4.9.1 Incentive Payment Recoupment

This section describes the process in place to ensure that any monies that have been paid inappropriately will be recouped and FFP will be repaid.

MITA Reference: PG15 – Perform Accounting Functions

In the event OHCA determines monies have been paid inappropriately, a current Recoupment process will be leveraged to recover the funds. An AR record will be created associated with the appropriate provider and the payment identified as an overpayment. Payments amounts may need to be collected and would be refunded to CMA via the appropriate CMS 64 adjustment. The existing practice allows OHCA to work out an acceptable repayment period dependent upon the provider circumstances and amount of the AR.

AR can be manually established in the MMIS through the AR entry window. From this window, an AR record can be setup against a Provider. The user has the ability to turn the manual recoupment indicator on or off. If the manual recoupment indicator is turned on, then the system will not recover money from any payments, and all recoupments must be applied manually through the AR Disposition window for that record. The user also has the ability to choose how the system will recoup money. The system will recover either a user specified percentage of each payment, or a user specified payment rate. Finally, the user can specify a weekly maximum recoupment amount for a Provider/Service location from the Provider AR Recoupment limit window. If a recoupment limit record exists, the system will not recoup any money once the weekly recoupment limit has been recovered.

These funds will be identified as SoonerCare EHR Incentive Program reversals and as such will reduce the amount of the Quarterly Provider Incentive Payment Federal Fund draw.

4.9.2 Fraud and Abuse Prevention

This section describes the process in place to address federal laws and regulations designed to prevent fraud, waste, and abuse.

MITA Reference: PI01 – Identify Candidate Case

The OHCA PI unit supports the investigation of potential misuse, by providers and clients, of the SoonerCare program and other programs administered by OHCA. PI staff analyzes historical data and develop profiles of health care delivery, and report those participants or providers whose patterns of care or utilization deviate from established normal patterns of health care delivery.



This function serves as a management tool to allow OHCA to evaluate the delivery and utilization of medical care, on a case-by-case basis, to safeguard the quality of care, and to guard against fraudulent or misuse of the Oklahoma SoonerCare Program, by either providers or members.

Two new reports will be required to support the SoonerCare EHR Incentive Program that includes reporting from expenditure data instead of claims data. These reports will consolidate payments by provider groups or clinics, and an activity for all providers participating in the program.

OHCA plans additional annual audit activities to support the validation of provider attestations and provider data submissions to ensure compliance with the federal program.

This section will include a description of the methods OHCA will employ to investigate suspected fraud and abuse. Please identify what audit elements will be addressed through prepayment controls or other methods and which audit elements will be addressed post-payment. This section also will include a description of the actions OHCA will take when fraud and abuse is detected.

MITA Reference: PI02 – Manage Candidate Case

The OHCA does not investigate fraud; all cases of suspected fraud are referred to the Medicaid Fraud Control Unit (MFCU). MFCU has direct access to all data and information as well as the staff assigned to the OHCA audit. Oklahoma's MFCU is located in the Office of the Attorney General and is responsible for investigating and ensuring the prosecution of Medicaid fraud by providers.

When a preliminary investigation of a provider leads PI staff to believe that fraud or abuse may have occurred, the case is referred in writing to MFCU. Unless requested by MFCU to stop the review, PI staff will complete a full investigation to allow for the timely initiation of internal administrative action, i.e., recovery of overpayments, suspension of payments, termination of provider contracts, etc. Depending on the parties involved, the agency may also contact OKDHS Office of the Inspector General (OIG), appropriate licensing boards, other State agencies and appropriate units within the agency such as Quality Assurance.

Pre-payment controls will include the verification of provider NPI and TIN, provider type, NLR status and both Federal and local sanctions. Post-payment controls will include annual provider audits of provider incentive payments. Audits will be conducted via statistical sampling. Volume, scope, methods, and procedures will be based on risk assessments and materiality.

All EPs, eligible hospitals, and CAHs must maintain documentation supporting their demonstration of meaningful use for six years

4.9.3 Provider Appeals

This section will include a description of the process for a provider to appeal incentive payments, provider eligibility determination, efforts to adopt meaningful use and a methodology to verify the appeals.

MITA Reference: PM05 – Manage Provider Grievance and Appeals

OHCA will have a process in place for a provider to appeal incentive payments, provider eligibility determination, and efforts to adopt meaningful use in the SoonerCare EHR Incentive Program.



The OHCA will provide the appeals process pursuant to its rules, at Oklahoma Administrative Code (OAC) 317:2-1, regarding Grievance Procedures and Process. The appeals process will include a paper review and/or hearing with an OHCA administrative law judge. The writing of the administrative rule is not yet complete, but will be completed and adopted prior to the implementation of the SoonerCare EHR Incentive Program.

4.10 Coordination with OFMQHIT

This section will include a plan for coordination of outreach and education activities to Medicaid providers with Oklahoma Foundation for Medical Care (OFMC) to ensure efficient contact and follow up to eligible providers regarding enrollment and when assistance is requested.

The HITECH Act for the Health Information Technology Extension Program, which consists of the RECs and a national Health Information Technology Research Center (HITRC), has established a federally funded program to assist eligible providers within their practice locations as they select, successfully implement, and begin to meaningfully use certified EHR technology to improve the quality and value of health care.

The OFMQ, with support from a broad coalition of more than 30 Oklahoma professional organizations, has been designated as the HIT REC for Oklahoma and named OFMQHIT. The center offers technical assistance, guidance, and information on best practices to support and accelerate health care providers' efforts to become meaningful users of EHRs. Formal Steering Committee meetings have not yet begun, but it is anticipated that a regular schedule of meetings for information sharing, shared decision-making, and coordination of activities will begin in the summer of 2010.

OHCA's role is to ensure that providers know that incentive payments are available to eligible providers and hospitals who adopt and meaningfully use certified EHR technology and how to access those incentive payments. The OFMQHIT role is to ensure that appropriate technical assistance is available to the providers to select, implement, and meaningfully use that technology and to effectively integrate the technology within the workplace. The two agencies work in a coordinated manner to ensure the overall success of the program, providing links to each other's web sites, sharing information, and jointly meeting and providing information to providers.

Because of this connection, OHCA anticipates a close working relationship with the OFMQHIT, based upon the assumption that each organization has a critical role to play in the successful implementation of the EHR program. For example, scan data collected by the OHCA will be shared with the OFMQHIT. The path and timing of the complementary roles and plans provide information to the providers about the EHR program, explain the value and benefits of the program, assist the providers with purchase and implementation of a certified system, assist providers with meaningful use of the system, and make incentive payments to the providers to assist with the cost of purchase and implementation of an EHR system.

OHCA's Director of Provider Services serves on the steering committee of the OFMQHIT and is the liaison between the OHCA and the OFMQHIT. This OHCA representative provides the OFMQHIT with information on SoonerCare providers upon request, and will continue to keep the OFMQHIT informed and up-to-date on the SoonerCare EHR Incentive Program that OHCA is currently implementing. In turn, the OFMQHIT has kept the OHCA informed of its activities, meetings, efforts, and plans to provide technical assistance to SoonerCare providers. Although



there are no dependencies between the two agencies, there has been agreement to include the OFMQHIT web link in information sharing via the "Fast Facts" documents and the OHCA web site. In addition, the Provider Services Unit of OHCA will provide callers with OFMQHIT information as a help source for EHR.

OHCA HMP staff is also working closely with the OFMQHIT staff to coordinate programs in order to avoid duplication of services. The SoonerCare HMP contains a Practice Facilitation component, whereby practice facilitators work with primary care practices to enhance quality and improve office efficiencies. A chronic disease patient registry is implemented within the practice. To avoid primary care offices being overwhelmed with technical assistance by the OFMQHIT and OHCA, staffs in both entities are closely coordinating to determine the appropriate timing of our respective interventions with providers.

The OFMQHIT has been actively involved in the development and implementation of provider surveys to identify the As Is status of IT in health care provider offices and hospitals in Oklahoma. Their goal is to provide assistance to 1,060 health care providers over the next two years, and they currently have letters of interest from 460 providers. The OFMQHIT will also be a presenter at the semi-annual provider training sessions held by the OHCA for health care providers in the spring and fall of each year. Another stated goal of the OFMQHIT is to assist health care providers with getting "volume pricing" of certified EHR systems.

Following adoption of the certified EHR technology, the OHCA and the OFMQHIT will continue to work in a coordinated manner with health care providers to ensure the ongoing successful use of the selected IT. These follow-up services will help providers resolve issues, answer questions, become more efficient in the use of IT, and ensure that IT and HIE becomes a part of the culture of health care provision in Oklahoma.

In the follow-up process of the EHR survey of EPs and EHRs, the following question is asked:

"The HITECH Act included provisions to establish Health Information Technology Regional Extension Centers (HIT RECs) to provide direct technical assistance to practitioners in their defined geographic region for EHR implementation and use (visit <http://www.ofmq.com/hitrec> for additional information). Would you like assistance from the Health Information Technology REC? A) Yes B) Possibly C) No." If an EH or EP answers yes or possibly, that contact information will be forwarded to the OFMQHIT.

Additionally, Provider Services Unit staff mention at all provider training, contact, or outreach events that the OFMQHIT is available to assist providers.

Finally, the OHCA has three letters of support for the SoonerCare EHR Incentive Program from the OHA, Oklahoma State University (OSU) Center for Health Sciences, and OFMQHIT, posted on the OHCA web site (attached as *Appendix F* of this document).

4.11 OHCA SoonerCare EHR Incentive Program Administration

This section will include a description of the responsibilities within OHCA to administer the EHR Provider Incentive Program.

4.11.1 Federal Financial Participation (FFP)

This section will include a description of the process that draws the federal funds for program administration and the controls in place to ensure that no amounts higher than 90% of FFP will be claimed for administrative expenses.



This section will include a description of the process to assure that all Federal funding both for the 100 percent incentive payments, as well as the 90 percent HIT Administrative match are accounted for separately for the HITECH provisions and not reported in a commingled manner with the enhanced MMIS FFP.

This section will include a description of the methodology to ensure that only appropriate funding sources are used to make Medicaid EHR payments.

This section will include a description of the process to assure that Medicaid provider payments are paid directly to the provider (or an employer or facility to which the provider has assigned payments) without any deduction or rebate.

OHCA will authorize the full amount of each Incentive payment due to the provider through the MMIS system. EPs will be offered a choice of direct or assigned payments. In the case where the provider is a member of a group and chooses to assign the incentive payment to the group, these payments will be made to a group consistent with existing MMIS capabilities. In the case where the provider who is a member of a group chooses to retain the incentive payment, the payment will be made directly to the provider through an existing process in the MMIS.

This section will include a description of the process to assure that SoonerCare payments to an entity promoting the adoption of certified EHR technology, as designated by the State and approved by the US DHHS Secretary, are made only if participation in such a payment arrangement is voluntary by the EP and that no more than five percent of such payments is retained for costs unrelated to EHR technology adoption.

OHCA will use the existing capabilities to make the SoonerCare EHR Incentive Program payments. An automated process will be leveraged to retain the voluntary payments to a state and federal designated entities promoting the adoption of Certified EHR technology. The providers will be offered the option to participate in the voluntary retention at the time they request their annual incentive payment.

4.12 Clinical Quality Data

This section describes the process in place to capture the clinical quality data from each eligible EP or hospital and a method for verification, including the reporting of clinical quality measures.

Multiple methods for capturing clinical quality data from eligible providers and hospitals are being considered. The current electronic data interchange (EDI) process could be amended by populating fields that are not currently utilized with pertinent data. Also of note, OHCA's IT department is currently working on methods by which data will be exchanged with the HANs. This method could be replicated if it suits OHCA needs regarding capture of this newly required data. The SoonerCare prior authorization workflow process was established as a means to marry multiple incoming data types for the purposes of reviewing prior authorization requests. A process such as this could be modeled if it resolves the issue whereby two different data sets are required to live in two separate environments. The secure provider site, likely destined to be a provider portal, is another means by which data can be brought into OHCA's various systems. This can be modified from the current functionality to suit increased needs related to clinical quality data reporting by providers receiving incentives.

The methods for capturing provider reporting of clinical quality data is undetermined at this time. OHCA will update this SMHP when the information is available.



4.13 OHCA EHR Outcome Evaluation

This section will describe the process in place and the methods to verify program outcomes consistent with the EHR rule. This includes ensuring improvements in health outcomes, clinical quality or efficiency. These include:

- *Ensure improvements in health outcomes, clinical quality or efficiency*
- *Description of how the needs of underserved and vulnerable populations will be addressed through this program including:*
 - *Person centered goals and objectives and shared decision-making*
 - *Coordination of care across service providers, funding sources, settings and patient conditions*
 - *Accessibility to people with disabilities and older Americans*
 - *Self-direction including budget development and expenditure tracking*
 - *Institutional discharge planning and diversion activities that are tied to community based service availability*

Outcomes are evaluated and influenced within several OCHA program and administrative areas, which will be augmented to utilize data from and assess the outcomes related to the SoonerCare EHR Incentive Program. These perspectives are described below.

4.13.1 EHR Quality Assurance/Quality Improvement Outcome

MITA Reference: Develop and Manage Performance Measures and Reporting (PG16)

The Quality Assurance/Quality Improvement (QA/QI) department currently uses claims data stored in the Decision Support System (DSS) in the performance of administrative measures of Healthcare Effectiveness Data and Information Set (HEDIS) studies, provider profiles, and compliance audits. The contracted QIO also use stored claims data. Claims data is used to evaluate all aspects of utilization. Predictive modeling software looks at the current data for forecasting for SoonerCare members, identifying and stratifying high-risk members, guideline gaps, and medication compliance; for SoonerCare providers the software will profile cost and utilization, in addition to reporting on performance, risk, and compliance summation on adherence to evidence-based medical guidelines. QA/QI reviews clinical data when conducting provider quality/compliance reviews during onsite audits. The QIO reviews clinical data during retrospective (inpatient) reviews when conducting HEDIS audits that require medical record review and while evaluating physician records referred for quality of care.

Potential enhanced uses of clinical EHR data would expand OHCA capabilities. The QA/QI department could conduct in-depth quality studies utilizing both administrative (claims) and hybrid (medical record review) measurement via access to medical data housed in records, i.e., lab results, ACOG information, validated Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) exam documentation, immunization registry information, etc. In conducting PCMH/HAN audits, the verification of referral, coordination, and care transition between providers via the EHR can be accomplished. When evaluating the physician quality issues the QIO will be able to evaluate labs, x-rays, and other aspects of physician records to evaluate quality of care delivered, care coordination, and prescribing practices. Essentially, access to clinical data would allow review of medical record information without need for paper record



submission; predictive modeling data and forecasting would be in real time with increased accuracy.

4.13.2 EHR Child Health Outcome Evaluation

Much of children's health care is focused on prevention and early intervention through the provision of "well child visits," immunizations, and screenings. In order to address potential problems early, PCPs are asked to provide these tests, screens, and treatments at various times according to a periodicity schedule. Currently, the only information that is available is that a visit occurred that meets the description of the code. Optimally, the components of the visit that are suggested in the periodicity schedule need to be captured in a database. For example, body mass index screening is suggested for all children beginning at age two, but since that is not a separate billable service, it is not known outside the practice whether that screening was done, and if done the results. This results in a lack of individual clinical information available for follow-up by the healthcare system, and also severely limits the availability of population-based data needed for developing services, interventions, and programs to address the health needs of children.

In discussion with colleagues, a vision exists of a unified health record that collects and maintains information on all preventive health tests, screens and treatments that have been performed that would be accessible by any healthcare, childcare, education or social service professional approved by the parent/guardian. In a sense, it is a registry much like OSIS is today, but it is for all childhood preventive care, not just immunizations. Besides serving as a repository of the individual child information in order to improve the efficiency of care and also improve the timely delivery of care, this would also have the impact of allowing other professionals who care for the child have confidence in the child's status as to these important tests, screens and treatments.

In addition, the data for populations of children could be analyzed to find those who are delinquent in preventive care across multiple areas and would allow for targeted outreach. The ability of an EHR to interoperate with a Preventive Registry for Children would result in program, service, and clinical practice system improvements that could greatly enhance health outcomes for children.

4.13.3 EHR Performance and Reporting Outcome Evaluation

MITA Reference: Develop and Manage Performance Measures and Reporting (PG16)

The Performance and Reporting Unit (PRU) at OHCA has, as one of its primary functions, to ensure that all stakeholders have accurate, reliable, and relevant information to evaluate the performance of OHCA. The PRU ensures stakeholders have this information by tracking and reporting performance measures. The lack of capability to report health outcomes for our population and compare it to local, statewide, and national performance has been detrimental to our ability to report a complete picture of OHCA's performance.

Most clinical data is captured one of two ways, (1) through MMIS claims processing, or (2) by researching national data from organizations such as the Census Bureau and the CDC and Prevention. Oklahoma-specific information and particularly SoonerCare specific data is rarely available and in many cases is from data collected years earlier and/or is estimated or projected.



As EHR/HIE technology use becomes widespread, PRU anticipates having access to current (if not real-time) clinical information, some of which is not commonly available at the present time. More importantly, complex outcomes based on combinations of data elements, such as demographics, diagnosis, treatment regimens, medication, etc., will become available with little or no more effort on the medical professional/community's part than maintaining an electronic version of currently kept medical records.

This presents enormous opportunities for practitioners to take state-level aggregate information and apply it to their practice and patients. With this information, OHCA can make focused policy and reimbursement rate decisions based not only on cost information, but also on clinical data that supports quality services, benefits and improvement. Nationally, policy and funding decisions can be based on comprehensive information and targeted to meet national objectives, regional concerns and responsive to the needs of all Americans. Data-based decisions can be easily supported and better understood by the average citizen as a consumer, provider, and/or taxpayer.

4.13.4 EHR Health Management Program (HMP) (Chronic Disease) Outcome Evaluation

Although the SoonerCare HMP serves a small portion of the SoonerCare population (up to 5,000 members), it is one of the more costly populations (the top 5 percent at-risk members with chronic disease). The goal of the SoonerCare HMP nurse case management program is to empower patients with self-management skills and education to assist the most at risk patients to become prepared and proactive. The availability of real-time patient-specific data gathered by care providers through an EHR/EMR will be invaluable for helping patients manage their own care. It will allow for more comprehensive care plans, an increased ability to monitor compliance and ultimately, the elimination of duplication of services.

The HMP also serves providers by offering practice facilitation services. The goal of this service is to work with providers to build empowered teams who are focused on quality of care. Providers are given access to a patient registry which aids in the provision of efficient and high-quality care. By maintaining this registry, providers gain real-time access to performance data as well as patient specific and population level indicators of care gaps. The patient registry at this time is compatible with EHRs/EMRs with certain data standards (i.e., HL7) as more EHRs/EMRs are adopted by practitioners, and interfaces with the registry are gained, the availability of quality measurement and actionable information for the provider will enhance the overall quality of care achieved.

4.13.5 EHR Pharmacy Outcome Evaluation

When electronic prescribing data is interfaced with the MMIS, prescribers, pharmacists, and the agency will be able to better serve the members. The pharmacists and the agency would know which drugs had been prescribed to the patient and not picked up, or prescribed and paid for with cash. Prescribers would know that the reason the patient's blood pressure has not changed is that the prescription that was ordered for them was not picked up! This would save wasteful dosage adjustments and provider time.

Prescription drug therapy could be optimized for SoonerCare members if certain pieces of clinical information were stored and cross-referenced in the MMIS for claims processing.



Effectiveness monitoring would become seamless for some disease states, as laboratory or physical assessment values could be referenced along with medication history.

Diagnostic information, even as simple as an ICD-9 diagnosis code, could be used to automate prior authorization processes. Many drugs that are placed in one prior authorization program are placed due to "off-label" prescribing. When the system is able to cross-reference diagnosis codes and/or procedure codes, manual prior authorizations would not be needed.

Drug allergies that are stored in an EHR system would also be helpful for providers who are new to members, on call, or otherwise not able to access historic records.

By aligning some pay-for-performance incentives with formulary adherence, drug costs can be minimized and prescribers can be rewarded for choosing a generic or preferred brand.

4.13.6 EHR Use – Care Management Outcome Evaluation

Improvements are anticipated in health outcomes, clinical quality, and efficiency in multiple physical and behavioral health care management environments with increased usage and interoperability of EHRs. Best practices and trends in direct care and care coordination efforts can be identified by expanding reporting capabilities and evaluating outcomes data. Potential and actual cost impact can be calculated to guide further program development. Utilization review endeavors can be enhanced from both pre-payment and post-payment perspectives. Through developments in data exchange, provider access to data will further enhance care coordination opportunities, eliminate duplication of service and foster identification of appropriate levels of care. Similarly OHCA can more effectively identify serious quality of care issues, gaps in care, member compliance issues and member behavior trends in areas such as ER utilization.

Through enhanced data availability, improvements are expected in our ability to coordinate internal and external care management efforts between SoonerCare behavioral healthcare managers, general services care managers, chronic care case managers and a variety of State agencies offering similar or complimentary services. This includes statewide collaborative and initiatives as well as SoonerCare related programs, such as HANs and other large provider groups or PCMHs.

Current operational efforts focus many resources on various care management endeavors related to populations with unique needs. OHCA has structured programs to address behavioral health issues of both adults and children. Care management programs address high-risk obstetrics (OB), ER over-utilization, breast and cervical cancer, transplants, medically fragile, chronic diseases, and other special circumstances. By enhancing providers' access to EHRs, and widening the availability of that data to appropriate parties through HIEs, the care coordination opportunities become increasingly advantageous.

4.14 State Alternative Methods

This section will identify any State alternative methods proposed under the rule.

In the initial stage of the SoonerCare EHR Incentive Program, OHCA will generally adhere to the methods outlined in the Final Rule. However, issues raised and discussions that occurred in the process of developing this SMHP and determining how the program would be implemented



has led OHCA to decide that further consideration of potential alternatives and discussions with external stakeholders are needed to further explore possible alternatives for certain aspects of the program in the future.

4.14.1 Meaningful Use Criteria

This section will identify any changes Oklahoma plans to make to the MU definition as permissible per rule making. If any changes are planned provide details about how the OHCA assessed the issue of additional provider reporting and financial burden.

Public agencies are very interested in health information and OHCA understands that the medical community also wants to see the health of Oklahomans improve. Meeting the proposed Meaningful Use criteria impacts many stakeholders and in a variety of ways. The benefit of obtaining information must be weighed against the cost of collecting and reporting it. OHCA recognizes that defining Meaningful Use is not an isolated decision to be made unilaterally and prefers participating in a statewide process to collect stakeholder input. This will provide a broad perspective of what is important to all players who would benefit from HIT.

OHCA is in the process of forming a Meaningful Use Task Force which will be comprised of multiple stakeholders from across the State. This task force will work with OHCA in an advisory capacity to research and recommend any potential changes to the federal meaningful use language. The task force will take into account multiple agency interests related to matters of public health.

4.14.1.1 Additional Meaningful Use Objectives

This section will discuss objectives for any planned additional meaningful criteria and health outcomes measures to be reported.

OHCA will adopt the meaningful use objectives for Stage 1 required in the Final Rule. With guidance from the OHCA, the Meaningful Use Task Force will lead a public hearing of stakeholders to obtain feedback and recommendations pertaining to potential enhancements to the meaningful use definition for stages two and three. From this information, the Task Force would make recommendations to the agency to assist in collecting the right data and creating a public information service to the providers and citizens of Oklahoma.

4.14.1.2 Patient Volume Calculation

This section will discuss the methodology used to calculate an EP's patient volume for the program

OHCA will adopt the patient volume calculation as stated in the Final Rule. However, initial results from the environmental scan show that many health professionals in the State may not qualify on the basis of the proposed patient volume requirements. Therefore, OHCA may reconsider this definition in an attempt to increase the number of providers that would be eligible by patient volume for the SoonerCare EHR Incentive Program.

Enrollment into the SoonerCare EHR Incentive Program is limited to providers with practice locations in Oklahoma. Providers will need to submit a detailed list of **all** patients seen in representative 90 days, regardless of payer, during the enrollment process.

4.14.1.3 Early Program Incentive Payment

This section will discuss any plans by OK to implement early provider incentive payments



OHCA has determined it is not feasible to implement early provider incentive payments. The SoonerCare EHR Incentive Program is anticipated to begin in January 2011.

4.15 Dependence upon Federal Initiatives

This section will include assumptions where the path and timing of Federal initiatives and plans have dependencies based upon regarding the role of CMS (e.g., the development and support of the National Level Repository), ONC or other Federal organizations.

The current federal HIT initiatives, such as the State HIE Cooperative Agreement, the RECs, and broadband initiatives, were designed to set the foundation and provide an environment that would support adoption of EHRs and deployment of state and regional exchanges networks. OHCA is dependent on the success of these initiatives to provide the infrastructure that makes it feasible for individual providers to easily adopt and effectively utilize EHRs and electronic exchange to support and enhance patient care and essential business operations. OHCA is also dependent on the success of other federal initiatives, such as the Beacon Communities and HRSA grants, that support HIT innovation and testing projects that will provide lessons learned, best practices, and specific examples of how EHRs and electronic exchange can benefit both providers and patients.

OHCA is dependent upon CMS for the review and approval of this SMHP as well as the IAPD that will be submitted to request federal funding for the SoonerCare EHR Incentive Program MMIS system changes. OHCA also relies on CMS to create the NLR to provide operational support for provider participation in the program. OHCA is also anticipating additional CMS educational and technical support to assist states with implementation of the program so that monies can be deployed and meaningful use achieved on a broad basis as quickly as possible.

OHCA is dependent upon CMS and the ONC for the distribution of the Final Rule regarding the Provider Incentive Program and Meaningful Use criteria. OHCA is dependent upon ONC for the certification requirements and certification of EHR systems so that Oklahoma SoonerCare providers can adopt, implement, or upgrade to appropriate certified EHR systems.



5 HIT ROADMAP

5.1 Oklahoma Vision for Moving from “As Is” to “To Be” HIT Landscape

This section will include an overview of how OHCA will move from the current “As Is” HIT environment to achieve the “To Be” vision for health information exchange.

This section will include a graphical as well as narrative pathway that clearly shows where OHCA is starting from today, expects to be five years from now, and how OHCA plans to get there.

The RFP, submitted to CMS Regional Office for review on April 1, 2010, identified requirements that must be met to begin administration of the SoonerCare EHR Incentive Program.

OHCA recently provided to CMS the MITA Roadmap and Transition Plan developed for the MMIS Re-procurement activities. The Roadmap is provided in the figure below. This work can be leveraged and integrated into the statewide HIT Landscape to promote statewide cost-effective and efficient use of HIT, where feasible. The MITA Roadmap will be updated to add the HIE/HIT projects arising from the SMHP planning activities. OHCA has identified the MMIS changes needed to solution the immediate need to implement the SoonerCare EHR Incentive Program within the EPE and MMIS systems. OHCA is deferring some of its longer-term planning and benchmark development for HIT/HIE since the SHIECAP Strategic and Operational Plans are not complete at this time. OHCA dialog with the HIIAB, Broadband grantee and Beacon Communities grantee is also underway. When details of these projects are fully understood, including a timeline for projects, this SMHP will be updated and a separate IAPD to request funding will be submitted.

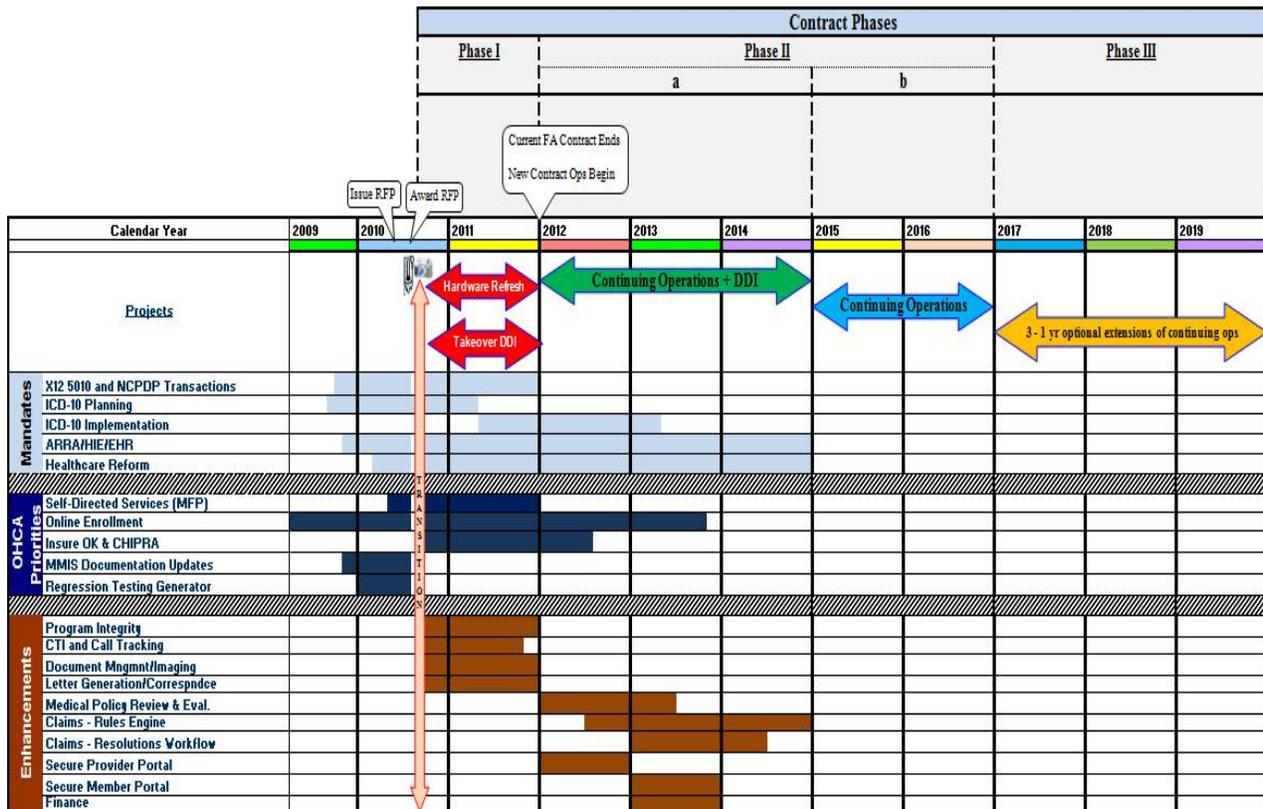


Figure 18 MITA Roadmap

What are OHCA expectations re: provider EHR technology adoption over time? What are OHCA annual benchmarks by provider type?

Describe the annual benchmarks for each OHCA goals that will serve as clearly measurable indicators of progress along the scenario.

5.1.1 OHCA Programs “To Be” Vision

This section will describe OHCA’s strategic pathway to move from the current “As Is” HIT Landscape to the desired “To Be” HIT Vision.

OHCA work groups began initial strategic planning activities by identifying a vision, goals, and objectives for the SoonerCare EHR Incentive Program as it related to their work groups. The CQA work group because of their clinical focus took the lead in developing the concept of operations for identifying how SoonerCare program and members would benefit from clinical data that will become available over time. OHCA goals were aligned with the national goals to encourage adoption and meaningful use of certified EHR technology and promote healthcare quality and information exchange.



OHCA goals include:

- Promote the exchange of individually identifiable health information between SoonerCare providers for care coordination of SoonerCare members. The program is most interested in exchange of the following types of clinical data:
 - Prescription drug information
 - Office visit encounters
 - Laboratory diagnostic tests to fill treatment gaps
 - Personal Health Screening and Records for population research
 - Linking individuals to the ODMH system to coordinate care between medical treatment with mental health treatment
- Promote an electronic exchange of clinical data to automate and improve timeliness of precertification of services upon request
- Improve quality of healthcare through patient health outcomes research
- Reduce health care costs through elimination of duplicate diagnostic testing and reduced medical errors
- Empower patients to take charge of their health status
- Promote efficient healthcare delivery through automate exchange of information when and where it is needed at the point of care
- Ensure secure transfer of health information to meet HIPAA and ARRA privacy and security requirements

SHIECAP goals include:

- Exchange of clinical information to multiple healthcare providers while keeping personal health data safe and secure
- Make time critical data available to providers in an ER, office, and hospital setting
- Reduce redundant testing by making lab results available
- Reduce patient hassle factors
- Improve coordination of preventive services
- Improve clinical quality of care and at the same time contain rising healthcare cost by reducing redundant testing

OHCA's vision includes MMIS and related IT systems exposure of services through an interface to OKHIE. Initially, there will be three types of services as shown in the table below.



Table 11 Category of Services

Category 1: OHCA services exposed to Payers to aid in administration of health care programs			
Service	Consumer	How	When
Electronic validation of Health Plan coverage for COBs	Top 5 Oklahoma Payers capability to access OHCA Programs client eligibility	OHCA service exposed to SHIECAP Statewide HIE through standard format and data set such as 270/271	
Category 2: OHCA access to clinical data from EHRs			
Service	Consumer	How	When
MU - Enable a user to electronically record, store, retrieve, and manage, at a minimum, the following order types: 1. Medications 2. Laboratory 3. Radiology/imaging 4. Provider referrals	OHCA Medical Review Staff	OHCA Clinical Data Subsystem	Stage 1
Category 3: OHCA administrative Services necessary to operate the SoonerCare EHR Incentive Program			
Service	Consumer	How	When
Electronic match to NLR	OHCA CMS	OHCA access to NLR to download data to DW match against MMIS payment data	
EFT of Incentive Payment	OHCA	Leverage MMIS financials to track and report PIP payments	

To demonstrate meaningful use requirements and report measures, the certified EHR products adopted, updated, and implemented by clinicians will need to be able to capture data elements report measures identified for Stage 1, Stage 2, and Stage 3. The clinician must be able to review EHRs from other clinicians, download information into an EHR (e.g., lab results), and push EHR data from their systems to others if coordination of care goals are to be met. How this will occur in Oklahoma will be defined as the details of the OKHIE Strategic and Operational Plans become available. During implementation, OHCA will determine what information will be included in an EHR, what data standards will be used until national meaningful use standards are finalized, and how Medicaid and ARRA funds can be leveraged to support a sustainable HIE infrastructure.

During the implementation phase, OHCA will continue to have dialog and collaborate with SHIECAP, HIIAB, and other stakeholders to define how the OHCA and SHIECAP visions can become reality.

5.1.2 OHCA Role in the SoonerCare EHR Incentive Program

This section will describe OHCA's role in administration of the Provider Incentive Program.

MITA Reference: Draw and Report FFP (PG18) and Manage FFP for Services (PG19)



For purposes of the SoonerCare EHR Incentive Program, OHCA by necessity must identify and track EPs and EHs attestations of meaningful use, SoonerCare threshold, NLR registration information, payments to providers, and receipt of meaningful use measures. Additionally, OHCA must audit and verify payments are correct and accurately calculated, recoupment activities occur for any duplicate payments, and FFP drawdown is audited for appropriateness of monies received from the Federal government for provider payments and administrative services. This will require modifications to the MMIS and EPE systems development of program operation policies and administrative procedures to support these functions. During the implementation phase, OHCA must develop the policies and procedures necessary for accountability under ARRA. OHCA is charged with encouraging and assisting SoonerCare providers in adoption and conversion to certified EHR/EMR. Outreach to the providers is ongoing and OHCA is collaborating and coordinating these efforts with the OFMQHIT. OHCA is also studying any changes necessary to the current ePrescribe program and POS system to assist providers in using e-prescribing.

5.1.2.1 OHCA Oversight of Program Payments

This section will describe how the state plans to oversee the 100% provider incentive payments.

The oversight of payments has four distinct components, payment eligibility, calculation, payment reporting and audit. These are all current functions of SoonerCare and the EHR incentive payments will be incorporated into them. In addition to SoonerCare controls and processes, the NLR will be relied upon to assist the State in assuring providers are not receiving payments from Medicare or other states.

In order to ensure that no amounts higher than 100 percent of FFP will be claimed for reimbursement, incentive payments made to SoonerCare eligible providers will be reported on a separate line on the CMS 64 (MAR 1060/1062 reports) report. This report will be reviewed for accuracy and deficiencies.

Payments will be made directly to a SoonerCare EP or Hospital or to an employer or facility to which the provider has assigned payment. System controls will be implemented and tested in the MMIS Financial subsystem to ensure that entities promoting the adoption of EHR technology will not retain more than 5 percent of payments not related to or required for the operation of the technology. OHCA will participate in registration and payment reporting to the NLR. OHCA will interrogate the NLR based on Provider unique NPI and TIN, prior to completing the payment process to ensure that SoonerCare EP or EHs do not collect EHR payments from multiple states. This process will also ensure that EP's have not previously received Medicare payment for the same Program Year.

Provider participation in the incentive payment program will be tracked in the Oklahoma MMIS. The Provider's status relative to Program eligibility will be assessed with each annual payment request. The eligibility determination will include the interrogation of the NLR to assess previous payments based on unique provider NPI and TIN. OHCA will maintain in the MMIS Provider record for each provider, the year in which payments are requested and the Incentive Payment Program requirements relative to the year of the request. Each eligible provider will be limited to a maximum of six payments. New provider Incentive Payment Program participation requests will not be allowed after December 31, 2016.



In addition, OHCA will submit program participation data to CMS including data for the number, type and practice location(s) of providers who qualified for an incentive payment on the basis of having adopted, implemented, or upgraded certified EHR technology or who qualified for an incentive payment on the basis of having meaningfully used such technology as well as aggregate de-identified data on meaningful use.

OHCA assumes that the NLR will be available to support the registration of SoonerCare providers wishing to participate in the EHR Provider Incentive Payment Program. OHCA will evaluate transactions from the NLR to determine if providers ineligible for both Medicaid and Medicare payments have already received Medicare payments.

In the event that the NLR is not available at the inception of the Oklahoma implementation of the Provider Incentive Payment Program, OHCA will compare the registration requests received prior to NLR availability to the data in the NLR. If there are discrepancies, OHCA will utilize its existing internal process to validate the provider submission and recoup the provider Incentive payment if necessary.

In the event OHCA determines monies have been paid inappropriately, a current Recoupment process will be leveraged to recover the funds. An Accounts Receivable (AR) record will be created associated with the appropriate provider. Payments owed to the provider will be reduced to collect the AR. The existing practice allows OHCA to work out an acceptable repayment period dependent upon the provider circumstances and amount of the AR.

Two new reports will be required to support the SoonerCare EHR Incentive Program that includes reporting from expenditure data instead of claims data. These reports will consolidate payments by provider groups or clinics, and an activity for all providers participating in the program.

The OHCA PI unit supports the investigation of potential misuse, by providers and clients, of the SoonerCare program and other programs administered by OHCA. PI staff will add review of provider incentive payments to current audit plans.

5.1.2.2 OHCA HIT Plan Coordination with MITA Transition

This section includes a description of how intrastate systems, including the Medicaid Management Information System (MMIS) and other automated mechanized claims processing and information retrieval systems: Have been considered in developing an HIT solution, and a plan that incorporates the design, development, and implementation phases for interoperability of such State systems with a description of how any planned systems enhancements support overall State and Medicaid goals, plus a description of the data-sharing components of the HIT solution.

OHCA is one of only seven stand-alone Medicaid agencies in the country. OHCA was formed by legislation and is the primary entity in the State of Oklahoma charged with controlling costs of state-purchased health care. It currently handles federal funding for SoonerCare and SCHIP programs and is experienced in handling all required federal reporting for those programs, as well those reports requested ad hoc by federal and state auditors. In addition, there is organizational knowledge as a Transformation Grant recipient and prepares regular progress reports and evaluations of the grant activities. The SoonerCare program covers over 650,000 lives with a variety of service delivery models, including Oklahoma's public/private premium assistance program, Insure Oklahoma (IO). As the Medicaid agency, it has dedicated medical, care management, quality assurance, planning, and IT divisions, as well as provider and member services operational divisions. Members of appropriate divisions participate in multi-



disciplinary teams to plan, manage, and implement projects. Statewide or regional projects include external stakeholders and other State agencies on project steering committees. Oklahoma's SoonerCare program puts special emphasis on collaboration within the community of members, providers, and partner agencies to meet the many needs of Oklahomans. The State-designated entity will diligently work as a collaborator with the OKHIE team to further the health information interoperability needs of Oklahoma.

This section contains a brief description of how the state coordinated their HIT Plan with their MITA transition plan.

The OHCA recently completed an RFP for MMIS and Fiscal Agent Re-Procurement, which was published on June 3, 2010. In preparation for this re-procurement, OHCA completed a MITA SS-A, and then focused on gaps identified by business users where newer technologies, automation, and higher MITA maturity level capabilities are needed to fulfill the "To Be" vision of the business users. A MITA Roadmap and Transition Plan was developed as an integral part of the MITA SS-A and submitted to CMS Regional Office. The OHCA business users and Information Services staffs reviewed the Final Rule for administration of the Provider Incentive Program and collection of Meaningful Use measures from eligible providers, and then developed the MMIS requirements for HIE/HIT section of the RFP to include known MMIS changes necessary to administer the SoonerCare EHR Incentive Program such as: issue payments to providers; audit attestation, SoonerCare thresholds; provider registration; check sanctions and licensing databases, etc.). The MITA Roadmap and Transition plan developed included these HIT/HIE projects and dates were aligned with regulatory requirements and OHCA desire to implement the SoonerCare EHR Incentive Program by January 2011.

The As Is Environmental Scan identified areas of manually entered data including data for HIE. Enhancements to the MMIS under the procurement include implementation of a claims rules engine and work flow functionality and work flow capabilities are in place for handling of prior authorization documentation and the online enrollment. These MMIS changes will reduce paper and manual processing within the agency and result in an increase to MITA maturity level 2.

A comprehensive list of HIT/HIE projects is not available at this time because the SHIECAP Strategic and Operational Plans are not yet complete. Thus, OHCA is deferring completion of this section of the SMHP. The MITA Transition Plan and Roadmap has been updated with known projects to fulfill immediate needs for SoonerCare EHR Incentive Program. It is anticipated that additional projects will be added after further collaboration and SHIECAP and statewide plans are available.

The technology division manages multiple large IT and consultant contracts as part of the MMIS and is skilled at the procurement process. Oklahoma's MMIS is known for its innovation and ability to adapt quickly to new processes. The Oklahoma MMIS was the first MMIS to implement Internet-based claim, eligibility and other administrative transactions all in real-time operation. The SoonerCare program is one of the first in the nation to implement the medical home model into its SoonerCare delivery system.

The OHCA is the State's Medicaid agency and the largest payer in the State. OHCA processes a monthly average of 3.1 million claims, of which 96 percent are submitted as electronic transactions or entered directly via the Internet. Claims are processed real time and are paid weekly. The following table reflects the average electronic transaction volume for OHCA per month.



Table 12 Average Electronic Volume for OHCA per month

Electronic Transactions Per Month Transaction Type	Electronic Data Interchange (EDI)	Web Direct Data Entry
Eligibility Transactions	1,000,000	300,000
Claim Inquiry	15,000	100,000
Claim Submission	3,168,000	400,000

5.1.2.3 HIT Solution Considerations

The ARRA has mandated incentive payments to certain eligible SoonerCare providers to encourage the adoption and meaningful use of certified EHRs technology by 2014, resulting in changes to the SoonerCare program and a need for changes to the MMIS. The first initiative to be completed is capturing, distributing, tracking, and monitoring the incentive payments. Changes to the EPE are required to accommodate provider enrollment and registration and interface activities to the NLR as well as verification of eligibility.

A second phase of the overall HIE initiative is to provide the capability to exchange EHR data between private and public insurers, facilities, other State agencies, and clinicians, and to allow members access to their own EHR data. This includes having the ability to accept EHR data into the system and provide EHR when necessary.

The ARRA/HIE/EHR enhancement function must accept the following inputs: MMIS subsystem data including but limited to DW/SURS, claims, provider, and member; clinical data; lab results data; electronic attachments; prescriptions; and ARRA incentive payment amounts.

The ARRA/HIE/EHR enhancement function must accommodate the following capabilities:

1. Provide the capability to track, issue, and report on provider incentive payments in the MMIS, including identification of designated providers in provider database, system calculation of payments, capability for voiding, auditing, tracking, and reporting requirements, and changes to CMS 64, etc.
2. Provide capabilities within MMIS and DSS/DW to collect, store, retrieve, and report on EHR data including clinical data, lab results data, x-rays, scans, etc.

The ARRA/HIE/EHR enhancement function must provide the following outputs:

1. Reports as defined by the state and federal government for the reporting of gaps, issues, monitoring, and tracking of incentive funds.
2. Provider incentive payments for EHRs
3. EHR data to authorized requestor

The ARRA/HIE/EHR enhancement function must accept an interface with the following: NHIN, Private Insurer EHR systems, other State agency EHR systems, Facility EHR systems, and Clinician EHR systems.



5.1.2.3.1 Information Technology (IT), Fiscal, and Communication Systems Supporting the SoonerCare EHR Incentive Program

This section identifies the IT, fiscal, and communication systems that will be used to implement the EHR Incentive program.

OHCA plans to use its existing EPE web-based system to collect provider registration information, including attestations regarding SoonerCare Threshold and meaningful use measures data.

The MMIS Financial Subsystem will support the submission, validation, and distribution of incentive payments; along with the supporting financial reports. The MMIS and DW will be used to automate the process of receipt and to store prior authorization information. The standard Sterling Commerce products will be used to exchange NRL information with CMS.

5.1.2.3.2 Interoperability with HIT Solutions

This section addresses planning to incorporate the design, development, and implementation phases for interoperability of such State systems with a description of how any planned systems enhancements support overall State and Medicaid goals.

OHCA is currently in discussion with the HIIAB entities, broadband grantee, Beacon Communities grantee, and SHIECAP. The response to this question will be deferred until planning activities are complete and projects and timeline are available.

A description of the data-sharing components of the HIT solution.

The response to this question will be deferred until planning activities are complete and projects and timeline are available.

A description of the role of the MMIS in current HIT/HIE environment.

The response to this question will be deferred until planning activities are complete and projects and timeline are available.

5.1.2.3.3 Anticipated MMIS Modifications

This section will include OHCA anticipated modification to the existing systems (e.g., MMIS) to support the Provider Incentive Program.

The Oklahoma MMIS system will require certain changes to support the administration of the SoonerCare EHR Incentive Program. These changes are described at a high-level below and will be further defined in a subsequent IAPD requesting financial support for the changes. OHCA plans to submit the IAPD by June 30, 2010 in conjunction with this SMHP for CMS review and approval. OHCA anticipates that these changes will be completed by January 2011 to support the SoonerCare EHR Incentive Program.

Financial Subsystem Changes: Estimate approximately 1,000 hours

- Create a new fund code and financial category of service to support state and federal reporting
- Create new operational monitoring reports, DW, and financial systems
- Update 1099 reporting as needed, for providers receiving incentive payments
- Support voluntary withhold up to 5 percent of payments to state-designated entities
- Develop Automated Interface to check the CMS NLR during payment processing, verifying that the provider has not been paid for the current year by another state or



Medicare; and verifying that the provider has not exceeded payment limits as defined in the Final Rule

- Develop Automated Interface with CMS NLR to update payment and recoupment information from the Oklahoma MMIS system
- Develop a new panel to calculate payment amount for a specific provider, if payment cannot be calculated by the system automatically
- Develop a new function for mass activations of expenditures by category of service

Management and Administrative Reporting (MAR) Subsystem Changes are estimated at approximately 300 hours

- Create a new MAR category of service for state and federal reporting
- Modify the existing MAR 1060/1062 reports to accommodate the incentive payment program
- If required by CMS, the MSIS file will be modified to accommodate the incentive payment program

Provider subsystem modifications:

- Develop a new panel for staff to indicate approval of a specific incentive payment to a provider

EPE module of Provider secure web site:

- Receive and store transactions to the Oklahoma MMIS system from the CMS NLR
- Develop a new function/ set of screens for providers and hospitals to register locally and submit their attestation for the prior year, including the following:
 - a. For EPs only:
 - i. Provider type
 - ii. Predominantly practicing in FQHC/RHC/Indian clinic
 - iii. Not receiving payment from another state or Medicare
 - iv. Net average allowable cost
 - v. Not hospital-based (inpatient or emergency setting)
 - vi. If provider is a Physician Assistant in FQHC/RHC, center is led by a Physician Assistant
 - vii. Select which group or individual will receive payment
 - b. For EHs only:
 - i. Average length of stay
 - ii. Not receiving payment from another state
 - iii. Number of discharges in reporting period
 - iv. Number of SoonerCare bed days in reporting period
 - v. Number of total bed days in reporting period



- vi. Average length of stay
- vii. Ratio of non-charity care revenue to total revenue
- c. For EPs and EHs:
 - i. Adopt/Implement/Upgrade (1st year) or Meaningful Use (all years)
 - ii. If meaningful use, each component for applicable stage of meaningful use
 - iii. Reporting period beginning/ending dates
 - iv. Have a certified EHR
 - v. Not receiving incentive payments under another provider ID
 - vi. ARRA jobs created information
 - vii. EHR Technology Promotion Payment voluntary withhold
 - viii. Designated entity
 - ix. Amount
 - x. Checkbox for, "This is to certify..." statement
 - xi. Electronic signature

COLD Document Archival system:

- Store supporting documentation related to the attestation, faxed or scanned in by providers:
 - i. Patient volume numerator and denominator
 - ii. Proof of Adoption/ Implementation/ Upgrade
 - iii. Vendor EHR Certification document, including meaningful use stage
 - iv. System cost document for Eligible Providers

HL7 Messaging – Add functionality to receive and interpret HL7 messaging structures.

5.1.2.4 Benchmarks

This section will identify clear, quantifiable benchmarks – minimally on an annual basis – that will allow OHCA and CMS to gauge progress toward achieving the "To-Be" vision. Include annual benchmarks for audit and oversight activities.

Statewide plans are just beginning to be developed with much research to be done. OHCA will track results in the following areas and declare milestones as information becomes available.

Overarching quantifiable benchmarks:

As baseline data is identified for the incentive program and the State develops its strategic and operational HIE plans, timelines and target details will be added to better gauge OHCA performance. Proposed benchmarks for Medicaid Incentive Program Providers would include:

- Percent increase in number of EPs participating in the SoonerCare EHR Incentive Program
- Percent increase in number of EHs participating in the SoonerCare EHR Incentive Program



- Percent increase in number of providers accessing health information from external sources
- Number of providers achieving meaningful use reported by year of participation
- Percent increase in number of providers participating in OKHIE once established

Long-term Goal – To stimulate a safe and cost effective SoonerCare health care delivery system by ensuring OHCA is prepared to participate in Oklahoma’s statewide HIE and collaborating with state and federal stakeholders to promote the adoption and use of HIT and exchange in Oklahoma.

Objective: To collaborate with state agencies that utilize health data to ensure state health data systems are prepared for the HIE. Benchmarks will be developed as clear actions are identified by the HIIAB.

Interim benchmarks:

- Benchmark # 1: Serve on the HIIAB
- Benchmark # 2: Develop HIIAB Strategic Plan
- Benchmark # 3: Develop HIIAB procedures to exchange data

OHCA chairs and participates in the HIIAB, which was developed to identify and implement the actions necessary to ensure State agencies are prepared to participate in the OKHIE. The board is made up of representatives from each of the State’s agencies having health-related data. The purpose is to collaborate and develop the infrastructure, data contracts and cohesiveness necessary to exchange data with each other as well as outside authorized users.

The board has decided to research creation of a health information network infrastructure among the agencies to connect to the OKHIE. Work groups are being formed now to discuss appropriate procedures that will be necessary to share State health data collected in the following areas: lab results, immunizations and insurance coverage. A similar approach will be taken for information received at the State level.

Objective: To actively participate in state HIE/HIT planning, development and participation to ensure OHCA and our providers and members will be appropriately served.

Proposed benchmarks:

- Benchmark # 1: Assist in the development of the HIE Strategic and Operation Plan
- Benchmark # 2: Percent increase in number of providers participating in VANs
- Benchmark # 3: Percent increase in number of providers participating in RHIOs

OHCA has played a key role in the effort to create an Oklahoma HIE. OHCA coordinated the research and development of the Oklahoma SHIECAP grant, initiated the creation of the HIE Task Force and serves on many of the work groups responsible for advancement of the project. Once the OKHIE Task Force reached a consensus on the governance of the exchange, OHCA developed the language for the legislative bill submitted for consideration. Oklahoma passed legislation during the 2010 session to create a public trust to oversee the OKHIE. With this law



in place, the Task Force can turn its attention to creating the standards and requirements necessary to support the legal, secure, and structured exchange of health information.

OHCA will continue to work with the local VANs and RHIOs to ensure that community-based resources are prepared to participate in an HIE environment.

Objective: To promote and encourage SoonerCare providers' participation in statewide efforts to adopt and utilize EHR technology and the State's HIE.

Proposed benchmarks:

- Benchmark # 1: Develop and implement a formal procedure to foster active communication between OFMQHIT and SoonerCare providers/organizations
- Benchmark # 2: Promote to SoonerCare providers the benefits of HIE and the availability of the OFMQHIT
- Benchmark # 3: Develop, implement, and operate the SoonerCare EHR Incentive Program
- Benchmark # 4: To increase the number of SoonerCare providers capable of electronically exchanging health information
- Benchmark # 5: To increase the number of SoonerCare providers utilizing certified (per federal requirements) EHR systems
- Benchmark # 6: To increase the number of SoonerCare providers meaningfully using (per federal and state requirements) EHR systems

Objective: To accurately and timely pay qualifying providers

Proposed benchmarks:

- Benchmark # 1: To incorporate into current audit processes review of SoonerCare EHR Incentive Program eligibility and payment accuracy
- Benchmark # 2: To develop materiality and risk-based assessment procedures to identify samples of providers receiving EHR incentive payments

OHCA considers the SoonerCare EHR Incentive Program a “window of opportunity” to support federal and state efforts to develop HIE in Oklahoma. OFMQHIT is charged with assisting providers to obtain and meaningfully use EHR in their practices. Because of the potential to duplicate efforts, OHCA and OFMQHIT have been working closely to ensure coordination, leveraging the strengths of both organizations. In the process, OHCA has chosen the above benchmarks. As the incentive program is implemented and more concrete information is available, targets such as dates, resources and amounts will be added to better gauge our performance.

5.2 OHCA Participation in Health Information Exchange (HIE)

5.2.1 Participation in Federal National Health Information Network (NHIN)

This section will include a description of OHCA participation in NHIN, including vision objectives and the projected date(s) to begin data exchanges. “The Nationwide Health Information Network (NHIN) is a set of standards, services and policies that enable secure health information exchange over the Internet. The NHIN will provide a foundation for the exchange of health IT across diverse



entities, within communities and across the country, helping to achieve the goals of the HITECH Act. This critical part of the national health IT agenda will enable health information to follow the consumer, be available for clinical decision-making, and support appropriate use of healthcare information beyond direct patient care so as to improve population health.³

OHCA is working collaboratively with SHIECAP to provide capability for interoperability and exchange of health information between EPs, hospitals, FQHCs/RHCs, IHS and Tribes, other SoonerCare enrolled providers, State Health and Human Services Agencies responsible for delivery of health care services, and third-party payers throughout Oklahoma, SHIECAP is currently in the planning phase and, as envisioned, SHIECAP will maintain direct access to NHIN. Health information requests will be transported to NHIN through the statewide HIE using national standards (i.e., ASC X12; HL7) and services to promote care coordination for SoonerCare members. An example of such an exposed service would be a PCP sending a referral to care summary to a local specialist electronically. Standards for the NHIN will be approved by ONC's Health IT Policy Committee and its sub-work groups.

5.2.2 Participation in Statewide, Regional, and/or Local HIE Initiatives

This section will include a description of OHCA participation in Statewide, Regional and Local HIE initiatives, including vision objectives and the projected date(s) to begin data exchanges. OHCA is working collaboratively with many entities throughout Oklahoma to identify the interdependencies within the current Oklahoma HIT projects, as well as new ones that develop during strategic and operational planning of the OKHIE.

Collaboration under Senate Bill 757 enacted in 2008, has led to forming a statewide HIE group of state health and human services agencies, including: ODOC, Department of Mental Health, Vocational Rehabilitation, ODHS, and Department of Insurance. OHCA chairs group meetings and in the future all these entities will be involved in the governance committee. Exchange of data takes place in batch for billing and administrative reasons. OHCA also maintains the secure web site for authorized SoonerCare providers to access dental claim history for purposes of care coordination. A monthly file of immunization history is made available through the OSDH. A primary barrier to these efforts is the recognized limitation on match (only 60%) on consumer identification. OHCA in collaboration with ODOC, Department of Mental Health, Vocational Rehabilitation, ODHS, OSDH, and Department of Insurance will research causes and develop an approach for correcting the issue.

OHCA is also working collaboratively with SHIECAP, OFMQ, OFMQHIT, Broadband grantees, and Beacon Communities grantee to identify other collaborative efforts and initiatives providers are involved in to identify economies and efficiencies that may be achieved through shared State IT assets. The outcome of these collaborations is not fully known at this time. The SMHP will be updated as further details become available.

This section also includes:

- *A description of how each State will promote secure data exchange, where permissible under the Health Insurance Portability and Accountability Act (HIPAA) and other requirements included in the Recovery Act*
- *A description of how each State will promote the use of data and technical standards to enhance data consistency and data sharing through common data-access mechanisms*
- *A description of how each State will support integration of clinical and administrative data.*

³ National Information Network Overview as published at the Office of National Coordinator web site at: <http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&cached=true&objID=1142>



- *A description about whether OHCA is planning to leverage existing data sources to monitor meaningful use (e.g., HIEs, pharmacy hubs, immunization registries, public health surveillance databases, etc.)*
- *A description of state activities currently underway or in the planning phase to facilitate HIE/EHR adoption. What roles does OHCA play in these planning activities? Who else is currently involved? [For example, how is the REC assisting Medicaid eligible providers to implement EHR systems and achieve meaningful use?*
- *A description of OHCA's relationship to the State HIT Coordinator and the activities planned under the ONC funded HIE cooperative agreement and the Regional Extension Centers and local extension centers would help support the administration of the EHR Incentive Program*
- *A description of other activities currently underway that will likely influence the direction of the EHR Incentive Program over the next five years*

5.2.2.1 Vision Objectives and Projected Date(s) to Begin

This section will include objectives for collection, exchange and meaningful use of clinical data captured through use of certified EHR technology and the projected date to begin data exchange transform OKMMIS to desired MITA maturity level and a list of any EHR Commercial-off-the-Shelf (COTS) product to....

Multiple methods for capturing clinical quality data from EPs and EHRs are being considered. The EDI process could be amended by populating fields which are not currently utilized with pertinent clinical quality data. Also of note, OHCA IT department is currently working on methods by which data will be exchanged with the HANS. This method could be replicated if it suits our needs regarding capture of this newly required data. OHCA's Prior Authorization (PA) workflow process was established as a means to match multiple incoming data types for the purposes of reviewing prior authorization requests. A process such as this could be modeled to resolve the issue whereby two different data sets are required to reside in two separate environments. The secure provider site, likely destined to be a provider portal, is another means by which data can be brought into the various OHCA systems. This can be modified from the current functionality to suit increased needs related to clinical quality data reporting by providers receiving incentives.

Use of Meaningful Use Clinical Data

Initially, OHCA will only be collecting meaningful use measures from a small subset of eligible providers, which will be of limited utility. However, over time the coverage and amount of data submitted will increase, and with that will come increasing opportunities for utilizing the data in a variety of ways.

Early on, OHCA will have access to the meaningful use measures only. While somewhat limited, this data will have value in monitoring progress in EHR adoption and meaningful use achievement over the various stages both at the individual provider level as well as in aggregate for the SoonerCare contractor population. It will also provide some quality data that has previously been unavailable to OHCA that will be further studied to determine specific uses for SoonerCare program purposes. Once the measures stabilize, they can also provide a new means of comparability across providers and provider groups to identify and examine quality successes as well as quality opportunities.

As the program evolves and providers progress in their adoption of EHR and achieving meaningful use, OHCA may eventually request submission of the source data behind the meaningful use measures, which would provide a greater capacity for analysis and therefore