Medicaid Health Information Technology Plan (MHP)

FINAL PLAN
October 21, 2010
Revised
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Developed by Health Management Associates, Inc.
For Texas Health and Human Services Commission
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1. EXECUTIVE SUMMARY

One of HITECH’s most important features is its clarity of purpose. Congress apparently sees HIT — computers, software, Internet connection, telemedicine — not as an end in itself but as a means of improving the quality of health care, the health of populations, and the efficiency of health care systems.¹

The Texas Health and Human Services Commission (HHSC) Medicaid Health Information Technology Plan (MHP) is the Texas state plan to implement Section 4201 of Health Information Technology for Economic and Clinical Health Act (HITECH) with the American Recovery and Reinvestment Act of 2009 (ARRA). HITECH established a program for eligible Medicare and Medicaid professionals and hospitals to receive incentive payments for the adoption and meaningful use of electronic health records (EHRs) to improve health outcomes, care quality and cost efficiency.

In May 2010, the Texas HHSC engaged Health Management Associates to assist with development of its Medicaid Heath IT Plan (MHP) and Implementation Advance Planning Document (I-APD) for approval by the Centers for Medicare and Medicaid Services (CMS) so that HHSC can implement this new program in 2011. The MHP is drafted to respond to each of the questions in the Centers for Medicare and Medicaid Services (CMS) State Medicaid Health Information Technology Plan (SMHP) template, which will hopefully facilitate CMS’s review and approval of this plan. The purpose of the MHP is to provide HHSC and CMS with a common understanding of the activities that HHSC will be engaged in over the next 5 years to implement Section 4201 Medicaid provisions of ARRA.

To help facilitate broader understanding of this process for key stakeholders and providers, HHSC has already engaged in planning Provider Outreach and Education, and has included information about these plans as another section in the MHP. The team responsible for this section has continuing responsibilities for implementing the provider communication strategy and ensuring ongoing communication is clear, concise and provides complete understanding of the process. Thus, the primary intended audience for the MHP is CMS and our state partners, and the plan describes the ongoing strategy for provider and other key stakeholder communications.

As a result, the Texas Medicaid Health IT Plan includes the following six sections:

- **As Is Health Information Technology (HIT) Landscape** – describing the current state of HIT activities throughout the state,

- **To Be Health IT Landscape** – describing HHSC’s vision for the meaningful use of HIT to improve HHSC’s capabilities as a “Value Purchaser” of health care services and

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¹ David Blumenthal, M.D., M.P.P., “Stimulating the Adoption of Health Information Technology,” NEJM, April 9, 2010
improve health care providers capabilities to improve the quality of health care, the health of populations, and the efficiency of health care systems,

- **EHR Incentive Program** – providing a detailed description of the steps that HHSC will undertake with its contractors and key stakeholders to successfully implement the EHR Incentive Program,
- **Audit Strategy** – outlining the critical steps for program integrity of the EHR Incentive program,
- **Outreach and Education** – relating the process for informing, involving and supporting eligible providers and key stakeholders in the program,
- **Health IT Roadmap** – describing the plans for provider adoption and meaningful use of EHRs.

The plan has been developed in a rapidly changing environment. The last year has witnessed seismic shifts in public policy, including the Children’s Health Insurance Program Reauthorization Act (CHIPRA), ARRA and the Patient Protection and Affordability Care Act (ACA); all of which require health IT to support improvements in health outcomes, care quality and cost efficiency. Simultaneously, strategic and operational plans are being developed for state-level health information exchange (HIE) capabilities, health IT regional extension centers (RECs) and health IT workforce training.

This MHP represents a point in time landscape of health IT, which forms the basis of the health IT roadmap. The plan will be regularly updated to provide a pathway for the Health and Human Services (HHHS) Enterprise (five agencies with HHSC oversight) to collaborate with its key partners – other public and private entities, health care providers and individuals and their families who receive health care coverage through Texas Medicaid – to improve the quality of health care, the health of populations and the efficiency of health care systems.

The MHP describes the State’s newly developed policies and processes to implement the Medicaid incentive program, including a description of how HHSC intends to: identify eligible providers, make payments to eligible providers, ensure adequate programmatic oversight of the incentive payments, and educate and encourage providers to adopt certified EHR technology. This MHP outlines the first steps in a multi-phase approach that develops over time and will, by necessity, include simultaneous planning and implementation activities. A second version of the MHP was updated and submitted in February 2011 in response to CMS’s conditional approval and comments. This plan expands upon the planning process for Year 1 activities that will commence in 2011. Annual updates will be submitted thereafter to describe the progress to date and to request approval for new implementation strategies.

2. **BACKGROUND**

2.1 **Legislation**

On February 17, 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law, and established the framework for financial incentives to stimulate growth and
improve the health of the nation’s economy and health care system. ARRA defined specific roles and incentives for the U.S. Department of Health and Human Services (HHS) and its partner – State Medicaid Agencies – in improving the nation’s health and health care through the meaningful use of electronic health record (EHR) technologies.2

The Texas Legislature created the Texas Health Services Authority (THSA) in 2007 through House Bill 1066. The THSA is a public-private partnership, legally structured as a nonprofit corporation, to promote and coordinate the development of electronic health information exchange (HIE) in Texas.

The Texas Legislature also passed H.B. 1218 in 2009, which sets the stage for Texas Medicaid to align its HIE efforts with national and statewide efforts. A Medicaid HIE Systems Advisory Committee established under H.B. 1218 advises the Texas HHSC on Medicaid activities related to health IT. A key objective of the Committee is to ensure Medicaid/CHIP HIE is “interoperable” with broader statewide health information exchange. In addition to the establishment of the Advisory Committee, H.B. 1218 authorized pilot programs and initiatives to further the advancement of electronic health records (EHRs) in the state.

A more detailed description of the federal laws and rules, the general guidance from CMS and the Texas state laws related to EHR can be found in Appendix A.

2.2 Medicaid Health IT Planning Approach

The HHSC initiated the Medicaid EHR Incentive Program to promote the goal of improving health care quality and reducing costs by exchanging health information through the use of certified EHR technologies. Upon approval of its Planning-Advance Planning Document (P-APD) request, Texas Medicaid began the planning process by developing the Medicaid Health IT Plan and the Implementation-Advance Planning Document (I-APD). Appendix B contains a full description of the planning process, including coordination with all five agencies across the HHS Enterprise.

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3. THE TEXAS MEDICAID “AS-IS” HEALTH IT LANDSCAPE

The purpose of the As-Is health IT landscape section is to provide an overview of the current state of projects and activities that support the adoption and meaningful use of EHRs. This section also addresses the existing environment of health IT infrastructure and the level to which it currently supports the private and secure exchange of electronic health information to improve health outcomes and care quality.

3.1 State Organizations Authorized to Facilitate HIE and EHR Adoption

The State of Texas has undertaken a number of activities to facilitate HIE and EHR adoption. HHSC, which oversees the Texas Medicaid program, established the Office of e-Health Coordination (OeHC) last year. This office works closely with the Texas Health Services Authority, described below.

3.1.1 Texas Medicaid/CHIP Division

The Medicaid/CHIP Division is the lead agency for the Texas Medicaid Health IT Plan and Medicaid EHR Incentive program under Title IV of ARRA, for which the agency received $4.8 million for planning purposes. Medicaid established a Health IT unit to manage health IT initiatives and provide policy advice on HIE and EHR issues that affect Texas Medicaid, including providers and clients. The Health IT unit is responsible for implementing the Medicaid EHR Incentive program and for planning and coordinating health IT services and programs within the Medicaid and CHIP division.

The Medicaid Electronic HIE Advisory Committee, established in state statute under H.B. 1218, advises HHSC regarding the development and implementation of the Medicaid electronic health information exchange system to improve the quality, safety and efficiency of health care services provided through Medicaid and CHIP.

3.1.2 Office of e-Health Coordination

The Office of e-Health Coordination (OeHC) was established within the HHSC Office of Health Services (OHS) under the direction of the Deputy Executive Commissioner for Health Services. The OeHC serves as the coordination point for Texas to ensure that health IT initiatives relating to HHS programs are coordinated across the HHS Enterprise.³

OeHC serves as the single point of contact for health information policy and state funding opportunities under Title XIII of ARRA for the HHS Enterprise. The OeHC Director is the State HIT Coordinator, an ex-officio member of the THSA board, and staffs the HHS Health Information Steering Committee. The Steering Committee, chaired by the OHS, includes representatives designated by the commissioners of each HHS agency and major programs.

within HHSC, including administrative and legal services, to provide strategic direction about projects or policy concerns regarding health information.

3.1.3 Texas Health Services Authority (THSA)

The THSA is a public-private partnership established in 2007 to promote and coordinate the development of electronic HIE in Texas. A 13-member Board of Directors appointed by the Governor of Texas, with the advice and consent of the Texas Senate, governs the THSA. The Department of State Health Services (DSHS) has two ex-officio members of the THSA board.

HHSC submitted the Texas application to the Office of the National Coordinator for Health Information Technology (ONC) for funding of the State HIE Cooperative Agreement Program to support the state in developing its Strategic and Operational Plans in 2010 and statewide HIE capacity. Texas was awarded $28.8 million in federal funds over four years. HHSC is contracting with the THSA to manage a collaborative stakeholder process and develop the strategic and operational plans as required under the cooperative agreement. The remainder of the grant will be expended in the implementation phase from the fall of 2010 to 2013.

3.2 Status of Medicaid HIE and EHR Activities

3.2.1 Medicaid Management Information System

The Medicaid Management Information System (MMIS) is the primary information technology system serving the Medicaid program. It is operated by a fiscal agent under contract with the HHSC. The MMIS is composed of seven subsystems, including: recipient, provider, reference, third party liability, claims processing, surveillance and utilization review, management and administration reporting and third party liability. The MMIS is the “backbone” of the state’s Medicaid system, which services nearly 3 million Texans—close to 13 percent of the state’s population or one in eight Texans—and accounts for 25 percent of the state’s budget.\(^4\)

The first five subsystems track eligible recipients, certify providers, detail benefit rules, coordinate benefits, adjudicate claims, and reimburse providers for medical assistance. Through the surveillance and utilization review and management and administrative reporting subsystems, HHSC receives access to data that have been normalized, compiled and reported to prevent fraud, waste and abuse or provide management reporting. The MMIS also includes the Claims and Encounters Data Warehouse which serves as a storage, archive and a Decision Support System (DSS) for all Medicaid and Children’s Health Insurance Program (CHIP) claims and encounters.

The current MMIS contract runs through August 31, 2012, with three (3) one year options to extend. HHSC has recently released an RFP to secure the services of a vendor to assist with the development of the business and technical requirements to re-procure a new MMIS by 2011,

and to implement a new MMIS and fiscal agent contract by 2013. The major components of the existing MMIS system include but are not limited to those described in Appendix C.

The re-procurement of the MMIS presents a tremendous opportunity to advance the use of health IT to improve health outcomes, care quality and cost efficiency. This will require alignment of technology requirements and services to address these critical business needs.

HHSC also contracts for management of Pharmacy Claims and Rebate Administration (PCRA). The contract includes the processing of pharmacy claims, collection of associated data and management of rebates. As part of the current fiscal agent contract, the PCRA system is being replaced. The new PCRA system will include an interface to a national e-prescribing network. This connection will allow prescribers with a certified EHR to access medication history for Medicaid clients and Medicaid formulary and pharmacy benefit information during the electronic prescribing process.

3.2.2 Coordination of MHP with MITA Transition Plans

The MITA State Self-Assessment identified significant barriers for effective provider management in Medicaid, including:

- Manual processes for communicating with providers;
- Updating provider information through a mix of manual and automated processes from multiple repositories in multiple program areas;
- Overall high level of compartmentalization across HHS operating agencies that results in non-standard forms and data definitions;
- Redundant business processes and applications across multiple agencies that are not integrated; and
- Messaging that is not coordinated across agencies.5

The Assessment found that the seven individual business processes related to provider communications are at MITA maturity level Stage 1. Efforts are underway to push Medicaid business processes toward higher levels of MITA maturity based on the MITA Roadmap’s five-year timeline.

HHSC is coordinating the MHP with the following strategic projects of the MITA Roadmap, listed below:

- Medicaid HIE pilot with Regional Health Information Organizations (RHIOs).
- Medicaid e-Prescribing.
- Medicaid Eligibility Health Information Services (MEHIS) project. This new electronic eligibility system is expected to be operational in May 2011.6

• MMIS enhancements that include ICD-10 transition planning\(^7\), conversion to X12 5010\(^8\), and planning for the next generation of the MMIS.

3.2.3 Medicaid Health Information Exchange (HIE) Pilot

H.B. 1218 directed HHSC to establish an HIE pilot project with qualified RHIOs to determine the feasibility, costs, and benefits of exchanging secure, electronic health information between HHSC and the RHIOs.\(^9\) Texas Medicaid is coordinating the pilot with five organizations that met the criteria in the statute:

1. Integrated Care Collaborative (ICC)
2. Healthcare Access San Antonio (HASA)
3. Sandlot, LLC
4. Health Information Network of South Texas
5. Texas Health Resources (THR)

The pilot program is limited to the exchange of filled prescriptions based on claims data.

3.2.4 Medicaid E-Prescribing

Currently, less than 5 percent of prescriptions are electronic in Texas (ranked 30th according to Surescripts). Barriers to Medicaid e-prescribing include:\(^10\)

• Limited pharmacy acceptance among independents;
• State restrictions on Schedule II drugs that require handwritten prescriptions;
• Exceptions are still difficult to handle (e.g., patient changes the pharmacy uses after prescription is sent); and
• Medication history may be incomplete.

The Medicaid e-Rx program is designed to make Medicaid formularies and medication history available through the e-prescribing network. Medicaid officials expect e-prescribing rates to continue rising slowly, but predict that federal incentives will help to push the rate to 12 percent by 2012.\(^11\)

3.2.5 Medicaid Eligibility and Health Information Exchange System

The new Medicaid Eligibility and Health Information System (MEHIS) will replace the current paper Medicaid identification form with a permanent plastic card, automate eligibility

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\(^7\) The International Classification of Diseases- version 10 (ICD-10) will replace ICD-9 by October 1, 2013. ICD is a system for coding diseases as classified by the World Health Organization and used world-wide for morbidity and mortality statistics, reimbursement systems, and automated decision support.

\(^8\) X12 standard, Version 5010 is used for certain electronic health care transactions. It includes updated standards for claims, remittance advice, eligibility inquiries, referral authorization, and other administrative transactions. Compliance with the standard is expected by January 1, 2012.

\(^9\) Internal HHSC document, Medicaid Health Information Exchange Pilot Status, April 26, 2010.


verification, provide an electronic health record for all Medicaid clients, and establish a foundation for future health information exchange.

Some of the key features of the new system include:
- New plastic magnetic stripe Medicaid ID cards;
- Rapid client check-in with automated eligibility verification;
- Multiple configuration/access options for providers;
- Near real-time eligibility data;
- Automated program notifications for periodic services;
- Provider & client portals with access to program and health information;
- Client and provider help desks; and
- Web-based e-prescribing tool.

The new system offers clients access to Medicaid program and health information including recent office visits, claims-based diagnoses and procedures, immunizations, and medication history. HHSC plans to add access to additional data sources, such as laboratory data, as they become available. The target operational date for the statewide implementation is June 2011.

Medicaid will be working with the MEHIS vendor to offer a certified e-prescribing tool that can be used towards meaningful use. The current tool offered by the vendor, HP, is operational is Pennsylvania Medicaid and is not certified. Surescripts has recently been approved as an authorized testing and certification body for e-Prescribing modules. They will soon be accepting applications for this certification, and they will begin determining timelines for certifications after the application period has begun. The HP e-prescribing solution will be submitted to Surescripts once they begin accepting applications.

The new MEHIS system positions HHSC to respond to the emerging and anticipated health information technology initiatives that will foster improved continuity of care, increased communication with clients and providers, expanded data for healthcare analytics, and better health outcomes over time.

3.2.6 Enterprise Data Warehouse/Business Intelligence

The Enterprise Data Warehouse/Business Intelligence (EDW/BI) project is listed as a mandated project in the MITA State Self-Assessment (SS-A) To-Be Roadmap. The project’s goal is to enhance staff effectiveness and efficiency through improving the ease of access to comprehensive and reliable client-centric data available across the HHS Enterprise.

For Medicaid, the key outcomes envisioned for this project include:
- Enhanced forecasting, trend analysis, and decision support capabilities across Medicaid programs;
- Improved data definition, transformation, integrity, and quality;
- Ability to develop strategies to improve health outcomes by consolidating data across business units; and
- Ability to track and measure health outcomes.
HHSC envisions the EDW/BI system as the long term solution to enhance, consolidate and/or link currently compartmentalized analytical systems and data warehouse capabilities across the HHS Enterprise for more comprehensive and useful data to support strategic and operational decision-making. HIE-driven analytical capabilities and reporting enhancements that are proposed as part of this MHP to existing systems, such as Encounter Data Warehouse, Vision 21, and MEHIS, may be considered for inclusion in the EDW as part of its long term vision.

The MITA SS-A also identified the need for data governance and enterprise data management. These approaches, when leveraged, would improve the outcome of HIE-related projects. Data governance initiatives would establish organizational and process mechanisms across the HHS Enterprise to improve data quality, consistency, accuracy, and usefulness across programs. Enterprise data management, when implemented with systems for master patient index and master provider index, provide efficient mechanisms to link and manage internal and external information from various data sources with high accuracy.

### 3.2.7 Medicaid Frew Pilot Projects

The Medicaid Frew pilot initiatives are a response to the *Frew v. Suehs* lawsuit over utilization of preventive services in Texas Medicaid for children under age 21. A $1.8 billion funding plan was established to expand children’s access to Medicaid services. Of 22 Frew pilot projects currently under way, several involve health IT or enhanced provider communication strategies, as described in Appendix D, which may be complementary to the EHR Incentive Program.

### 3.2.8 Foster Care Health Passport

In 2005, the Texas legislature enacted Senate Bill 6, which called for the development of a uniform, comprehensive medical services delivery model for children in foster care through a single managed care entity, including the development of an electronic health information system for the program—the Health Passport. STAR Health, a statewide managed care program for children in foster care, was created through a partnership with HHSC’s Medicaid and CHIP Division and the Department of Family and Protective Services (DFPS). STAR Health serves about 30,000 children statewide.

HHSC was awarded $4 million in Medicaid Transformation Grant funding, which was used to develop the Foster Care Health Passport. The Health Passport became operational on April 1, 2008. The Passport is a secure claims-based electronic health record (EHR) system that provides access to authorized users. Via the internet, it provides access to a child’s health information for state staff, network providers, and medical consenters. The Health Passport was initially populated with two years of Medicaid and CHIP claims history and pharmacy data. When a child leaves foster care, data from the Health Passport is available, in electronic or printed formats, to a child’s legal guardian, managing conservator, parent, or to the child if at least 18 years of age or an emancipated minor.

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12 See: [http://www.dshs.state.tx.us/cshcn/medicalhome/docs/2009mh/frew01.doc](http://www.dshs.state.tx.us/cshcn/medicalhome/docs/2009mh/frew01.doc)
3.3 Status of Public Health and Biosurveillance Health IT Activities

In September 2009, the Department of State Health Services (DSHS) established a State Health Information Partnerships (SHIP) Office as a point of contact for health IT initiatives relating to public and biosurveillance health information. DSHS aligns its business systems to support Texas health IT activities and leverage IT projects already in progress.\(^\text{13}\)

DSHS supports and or maintains nearly half of all service delivery applications in the HHS Enterprise. DSHS supports systems that are like EHRs and benefit the following providers and/or consumer groups:

- Substance abuse providers
- State hospitals
- Community Mental Health/Mental Retardation centers
- Consumers of health information data:
  - Birth, death, and divorce records
  - Immunizations, cancer, birth defects, trauma, and adult/child lead
  - Infectious disease (STDs, HIV, tuberculosis, etc.) identification and management
  - Hospital discharge
  - Newborn screening.

Additionally, DSHS is responsible for the following disease registries, which will be aligned with state-level health IT activities:

**Health Registries**
- Trauma Registry
- Birth Defects Registry
- Cancer Registry
- Child and Adult Blood Lead Registry
- Tuberculosis (TB) Case Registry
- Texas Immunization Registry (ImmTrac)

**Health Statistic Systems**
- Hospital Data Discharge
- Vital Statistics
- Healthcare Associated Infections (HAI)

**Disease Prevention and Wellness Systems**
- Laboratory Newborn Screening (NBS) Enhancements
- National Electronic Disease Surveillance System (NEDSS).

As part of the planning process for the MHP, the Texas Medicaid/CHIP Division and DSHS signed an Interagency Contract (IAC) to work together to demonstrate how HHSC could align the existing MITA To-Be Roadmap, the Public Health Information Technology Architecture

(PHITA), HIE, and EHR activities. Historically, public health data collected through DSHS has been shared with Texas Medicaid to support shared program goals. HHSC is planning for increased data access to and exchange with programs that support Family and Community Health Services as well as Mental Health and Substance Abuse Services, beginning in 2010 and 2011. The Texas Immunization Registry is developing plans to make available its registry data to MEHIS in 2011.

The following descriptions show the status of projects in DSHS that are being aligned to advance HIE and EHR goals.

### 3.3.1 Clinical Management for Behavioral Health Services (CMBHS)

Clinical Management for Behavioral Health Services (CMBHS) is a health IT tool that was designed to replace the legacy IT systems for mental health and substance abuse. The first production release of CMBHS was successfully deployed to Austin-area substance abuse providers on December 14, 2009. The application will be deployed to substance abuse providers across the remainder of the State on a region-by-region basis. A second production release is currently under development and will include substance abuse prevention and intervention data as well as more advanced medication data; its release is scheduled for deployment in the fourth quarter of fiscal year 2010.

A data exchange approach is being developed to allow mental health providers to automatically transmit information into CMBHS from their local Electronic Medical Record (EMR). A data standards workgroup that includes DSHS staff and mental health provider staff is currently working to:

- Finalize the data elements and formats for the data exchange;
- Finalize second production release of the application for deployment to various behavioral health providers (FY 2010); and
- Incorporate policy, programmatic, and resource issues garnered from this project into the broader HHSC State planning efforts associated with health IT initiatives (FY 2010).

### 3.3.2 Electronic Medical Record in State Hospital System

The State Hospital System has been at the forefront of EMR adoption for the public behavioral health hospital system. DSHS has deployed a modified off-the-shelf software product, called the Client Record System (CRS), in 11 public behavioral health care hospitals across Texas to support quality care for patients. The CRS clinical functionality has been augmented by a pharmacy management system and electronic medication administration system.

These systems, tailored for the behavioral health care environment, are expected to complement HHSC’s broader HIE activities and goals. They also support the State Hospital System’s vision to be a partner with consumers, family members, volunteers, policy makers and service providers to provide quality services responsive to each patient’s needs and preferences in eleven State Hospitals.
3.3.3 State Immunization Registry

ImmTrac is the Texas immunization registry developed by the state. The web-based ImmTrac Registry receives vaccination information for children from private and public health care providers across the state, including input from the Vital Statistics Unit, Women, Infant and Children (WIC) clinics, Medicaid, the Texas-Wide Integrated Client Encounter System (TWICES), and health plans. ImmTrac consolidates and stores a child’s immunization information electronically in a secure, central system. It allows providers to see immunization history for patients, add immunization encounters to patient records, and add consented individuals to the registry. Other types of users (school nurses, childcare centers) are also able to view immunization histories of children. ImmTrac is also used for Emergency Responders and their family members, as well as for tracking immunizations, anti-virals and medications provided in response to or preparation for a disaster.

ImmTrac currently supports flat-file format for batch interfaces, and is not HL7 compatible. DSHS has proposed and received tentative grand award from CDC for $1.039M to make interoperability enhancements to ImmTrac to be completed by August 31, 2012. The grant allows system enhancements for interoperability of EHRs and immunization information systems (IIS), which will include:

- Identifying large volume reporters (e.g., hospital systems, large multi-site clinics) who are currently using or planning to purchase EHR products;
- Identifying a pilot group with whom ImmTrac will attempt an HL7 real-time, bi-directional interface pilot;
- Identifying the EHR vendors who have a market presence in Texas;
- Purchasing middleware applications needed to allow ImmTrac to trade data in HL7 format and allow for real-time HL7 messaging.

In addition, DSHS will seek a vendor to assist with:

- Assessing selected EHR products and reporter systems to determine how these can implement ONC standards;
- Developing a standards documentation and implementation manual for project partners and future EHR/IIS trading partners;
- Selecting partners in setting up communication architecture (messaging system) for ONC-compliant EHR/IIS data interchange; and
- Fulfilling reporting requirements of the grant.

There are two other local registries – Tarrant County and City of San Antonio. Neither has a direct link to the ImmTrac System, but the San Antonio Registry does report through the Department of State Health Services (DSHS) TWICES system. The Immunization Registry, ImmTrac at DSHS is designated by statute as the immunization registry for the State of Texas.
3.3.4 Biosurveillance Reporting

Although there is not a statewide biosurveillance system in Texas, the Texas Association of Local Health Officials (TALHO) is building a networked, state-of-the-art, biosurveillance system that is capable of serving public health agencies and other stakeholders across Texas.\textsuperscript{14} TALHO’s system copies limited patient medical data from hospital management systems to their database, where the data are analyzed for statistical anomalies that can reveal health threats or outbreaks. Both health providers and public health agencies can obtain alerts and reports when the system detects significant statistical anomalies.

A limitation of biosurveillance reporting in Texas is the lack of a legislative mandate requiring health care providers to share health data in the absence of a public health emergency. Consequently, it can be difficult to voluntarily engage providers in health information exchange. Fifty-two emergency departments in various health service regions in Texas use a combination of mail, phone, fax, e-mail, batch or real-time electronic transmission, and the web-based National Electronic Disease Surveillance System (NEDSS) Base System to communicate outbreak information to county health departments, local health care providers, and to larger databases, such as those managed by TALHO and the CDC. TALHO works with organizations such as the Texas Organization of Rural and Community Hospitals (TORCH) to build relationships with hospitals to better accommodate data-sharing and syndromic surveillance.

3.3.5 Health Registries Improvement Initiative

The goal of the Health Registries Improvement project is to improve the timeliness, completeness, and validity of health information collected through registries and disease surveillance systems. An assessment phase is expected to address upgrading sub-standard technology to web-based systems, integration of common functions such as receipt and management of electronic lab reporting across registries, removing duplicative reporting from common sources of data (e.g. hospitals), and improving data linkages to increase efficiencies in data collection. Registries that will be included are those devoted to birth defects, cancer, trauma, lead poisoning, immunizations, and infectious diseases. Key activities of the initiative will be staged as follows:

- Conduct a technological assessment of select health registries in the Environmental Epidemiology and Disease Registries Section and in other disease surveillance program areas. (FY 2010)
- Implement recommendations for improvements in technology and data collection based on this assessment. (FY 2012)
- Develop recommendations for integration of health registries. (FY 2011)

3.4 Assessing Current Health IT Adoption by Practitioners and Hospitals

As a part of the MHP process, the HHSC Medicaid/CHIP Division coordinated efforts to survey Texas provider and hospital communities on their use of and plans for EHR adoption. This

effort was coordinated with OeHC, THSA and the RECs to ensure there was no duplication of effort. Survey questions were designed to help build a shared understanding of the status of EHR adoption, EHR service capabilities, and providers’ preliminary plans to participate in the Medicare and/or Medicaid EHR Incentive program and health exchange activities. The survey results will form the baseline of EHR adoption and HIE in Texas and serve as a benchmark for program evaluations.

HHSC began administering the survey in July 2010, with separate hospital and practitioner surveys. While responses to the survey by hospitals were good, the responses from professionals were too low to be statistically valid. Therefore HHSC has contracted with the Texas A&M Public Research Institute to complete the survey with adequate sample size in the next few months. As part of this project Texas A&M will analyze the results from both surveys which will be used as our baseline measurement. Results are expected in March 2011. Below is a summary of the surveys that were initiated in July 2010.

3.4.1 Status of Health IT Provider Survey

The provider survey was administered using data from the State Professional Licensing Board to develop the sampling universe and was disseminated in both electronic and paper formats to allow providers who are not currently connected electronically to participate. Because nurse-midwives comprise less than 1 percent (0.5%) of the provider population in Texas, they were not specifically targeted for inclusion in the survey. Results are expected to be based on a sample of 2,000 respondents, including 1,500 stratified by Medicaid-eligible provider type and 500 non-Medicaid respondents. The providers’ survey also queries respondents about broadband access to the Internet.¹⁵ Table 1 quantifies the number of providers in Texas for each type of Medicaid-eligible professional.

<table>
<thead>
<tr>
<th>Eligible Providers</th>
<th>Licenses¹⁶</th>
<th>% of Total Licenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>48,373</td>
<td>59%</td>
</tr>
<tr>
<td>Dentists</td>
<td>20,903</td>
<td>26%</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>4,132</td>
<td>5%</td>
</tr>
<tr>
<td>Nurse Midwives</td>
<td>351</td>
<td>0%</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>7,920</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td>81,679</td>
<td>100%</td>
</tr>
</tbody>
</table>

3.4.2 Status of Health IT Hospital Survey

The hospital survey was administered electronically to all 583 hospitals in Texas and will remain ongoing until a full sample size is reached. As of August 11, 2010, 44 percent of the

¹⁵ Draft Survey to Providers, and Draft Survey to Hospitals, provided by OeHC, May 24, 2010.
¹⁶ Data reflects most recent figures from the Texas Medical Board, Board of Nursing, and the State Board of Dental Examiners.
state’s facilities have responded. This response represents 46 percent (36,994) of inpatient beds in the state, 48 percent (81) of non-metro hospitals, and 44 percent (8) of hospitals that restrict admission primarily to children.

Responses from the Health IT Hospital Survey will be merged with the most recent Annual Survey of Hospitals, in which all acute care hospitals participate (though some state mental health hospitals and some rural hospitals are exempted) to comply with state laws on hospital reporting. A description of preliminary results is in Appendix E.

3.4.3 Physician Electronic Medical Record Adoption in Texas

In the absence of 2010 survey results, results from a fall 2009 survey conducted by the Texas Medical Association (TMA) provide the most recent information on physician EMR adoption. The TMA survey was about EMRs, which has a different meaning than EHRs, as defined by ONC. 17 The term was not defined in the survey, and may have been considered interchangeable. Results of the survey, sent to 10,000 physicians, were based on responses from 370 respondents, for a 4 percent response rate. 18 The sample obtained did not allow for statistical reporting among providers with a large percentage of Medicaid revenues. The results, highlighted below, most likely overstate actual physician adoption rates, as the bulk of the responses were received electronically.

<table>
<thead>
<tr>
<th>Status of EMR Use</th>
<th>2009</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using EMR in physician practice</td>
<td>43%</td>
<td>33%</td>
</tr>
<tr>
<td>Plans to implement</td>
<td>41%</td>
<td>--</td>
</tr>
<tr>
<td>No plans to implement</td>
<td>16%</td>
<td>--</td>
</tr>
</tbody>
</table>

The survey found that 43 percent of respondents reported currently using an electronic medical record in their practice, up from 33 percent in 2007 and 27 percent in 2005. Forty-one percent of physicians reported that they plan to implement an EMR, and 16 percent reported no plans to implement an EMR.

Primary care physicians and physicians in larger practices were more likely to report that they currently use an EMR. Of the 44 percent of physicians who reported that their EHR system is capable of sending health information electronically to other sources, only one-fifth (21%) reported currently using that feature.

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17 “Defining Key Health Information Technology Terms,” National Alliance for Health Information Technology Report to the Office of the National Coordinator, April 28, 2008.
3.4.3.1 Types of EMR Systems Physicians Use

The majority of respondents who have implemented an EMR purchased or licensed software for use in their office (64%). Less than one-quarter are using an Internet-based system (22%), and 11 percent are using a hospital-based system only.

Physician respondents in the TMA survey reported a median of 25 percent of practice revenues from Medicare and 5 percent from Medicaid. The majority of all respondents (59%) reported that they will try to qualify for the EHR incentive payments by showing meaningful use of EHRs. Of those with interest in applying, half (51%) expected to seek the incentive payment based on Medicare participation, and only 15 percent expected to do so based on Medicaid participation. Another one-third of respondents said they needed more information.

3.4.4 Hospital EHR Adoption in Texas

The Texas Department of State Health Services (DSHS), in collaboration with the American Hospital Association and the Texas Hospital Association, conducts the Annual Survey of Hospitals. All hospitals in Texas complete the survey, which includes questions about EHR adoption, EHR functions, and physician utilization of electronic ordering. The 2007 survey found that less than half (47%) of Texas hospitals have partially adopted (33%) or fully adopted (14%) EHRs. The hospital survey showed the following for hospitals that have fully or partially adopted EHRs:

<table>
<thead>
<tr>
<th>Hospital EHR function includes:</th>
<th>Percentage of hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-level information</td>
<td>88%</td>
</tr>
<tr>
<td>Results management</td>
<td>91%</td>
</tr>
<tr>
<td>Order entry management</td>
<td>84%</td>
</tr>
<tr>
<td>Decision support</td>
<td>72%</td>
</tr>
</tbody>
</table>

3.5 Health Information Exchange Organizations in Texas

The number and stages of development of HIE organizations is growing and changing. In January 2009, the THSA disseminated a census to identify all of the HIE projects in Texas; the census identified 18 HIEs at various stages of planning and operation throughout the state. A 2010 THSA survey identified 25 HIEs—an increase of 7 new HIEs. The organizations reported meeting various stages of development as defined by eHealth Initiative (eHI), including seven Texas HIEs operating at Stage 6 or higher. A large number of HIEs are at a very low level of maturity, with 15 of the 25 HIEs categorizing themselves in stages one, two, or three. See

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Appendix F for a description of the eHI framework and a description of the 25 HIEs in Texas and their stages of development.

The following map shows the self-reported maturity levels and geographic coverage of the HIEs currently operational in Texas. As the Texas Statewide HIE Operational Plan evolves, the participation of Texas Medicaid in statewide HIE may be further developed; progress will be detailed in future updates of the Medicaid Health IT Plan.

**Figure 1. Geographical Coverage of the Texas HIE Initiatives**

Source: Texas Strategic and Operational Plans for Statewide HIE (August 25, 2010 Draft)

### 3.6 Challenges of Broadband Internet Access

#### 3.6.1 Broadband Internet Access in Texas

In July 2009, the Texas Department of Agriculture (TDA) was charged by the Governor with guiding efforts to make broadband services available across the state and to pursue federal grants in improve access to broadband service in rural communities. In response, TDA established the Texas Broadband Task Force. The task force consists of private-sector
stakeholders and representatives from the Office of the Governor, various state agencies (including HHSC), the Texas Legislature and the Public Utility Commission (PUC).

Using ARRA grant funds, TDA commissioned Connected Texas to work with all broadband providers in Texas to create detailed maps of broadband coverage in order to accurately pinpoint remaining gaps in broadband availability.\(^{22}\) Connected Texas (http://www.connectedtx.org) is a partnership between the Texas Department of Agriculture and the national, nonprofit, Connected Nation. The information gathered by Connected Texas will also be included in the new, national broadband map mandated by the federal government, which is scheduled to be available beginning February 2011. The most current picture of broadband availability in Texas is shown in Figure 2.

**Figure 2. Broadband Internet Access in Texas**

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3.6.2 Federal Communications Grants

Texas organizations have been successful in securing federal broadband grants from the Federal Communications Commission, Department of Commerce, and Department of Agriculture to fund broadband access projects that will benefit health care providers across the state. The list and description of the Texas broadband grant awardees are included in Appendix G. To date, these grants total $79,442,192 in federal funding.

3.7 Health IT Activities Supported by ONC

The HITECH Act has provided several opportunities for Texas-based institutions to receive funding through the ONC to advance health information technology efforts in Texas. To date, the State of Texas and Texas-based institutions have been awarded over $84 million in HITECH funding to help develop health information exchanges, promote the adoption of electronic health records, and, through education and training, develop the workforce necessary to implement and sustain health information technology. In addition to the $28.8 million awarded to HHSC for the State HIE Cooperative Agreement Program described in section 3.1 of the report, other HITECH-funded activities are described below.

3.7.1 Health IT Regional Extension Centers

Among the 70 Regional Extension Centers (RECs) funded by the ONC, four were awarded in Texas. Three state universities and one private foundation, with coordinating support from the Texas Medical Association, were awarded nearly $36 million to start up and provide services to nearly 6,800 primary care providers (PCPs) in private practice, community health centers or rural health centers with 10 or fewer providers, and recently received an additional $2 million in ONC funding to support adoption of certified EHRs in the outpatient settings of critical access and rural hospitals (CAHs/RHs) in Texas with fewer than 50 beds (Table 4).23 Each institution is the fiduciary agent for one of the four regions, as illustrated in Figure 3.

Table 4. Health IT Regional Extension Centers in Texas

<table>
<thead>
<tr>
<th>Regional Extension Center</th>
<th>Minimum No. PCPs to be Served</th>
<th>Original Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>CentrEast Regional Extension Center Texas A&amp;M Health Sciences Center, Rural and Community Health Institute <a href="http://www.centreastrec.org/">http://www.centreastrec.org/</a></td>
<td>1,000</td>
<td>$5,279,970</td>
</tr>
<tr>
<td>Gulf Coast Regional Extension Center</td>
<td>2,855</td>
<td>$15,274,327</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>University of Texas School of Health Information Sciences at Houston</th>
<th>$612,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Texas Regional Extension Center</td>
<td>1,498</td>
</tr>
<tr>
<td>Dallas Fort Worth Hospital Council, Education and Research Foundation (DFWHC-ERF)</td>
<td></td>
</tr>
<tr>
<td>West Texas Regional Extension Center</td>
<td>1,133</td>
</tr>
<tr>
<td>Texas Tech University Health Science Center</td>
<td></td>
</tr>
</tbody>
</table>

Figure 3. Texas Regional Extension Centers

The primary objective of the Texas RECs is to provide technical assistance, guidance and information on best practices concerning EHR adoption and meaningful use. The Texas RECs are targeting their services to small primary care practices in internal medicine, family medicine.
and pediatrics, as well as critical access and rural hospitals. The RECs are partnering with county medical societies, local universities/medical schools and alumni associations as well as the Texas branch of the American Academy of Family Physicians (AAFP). The overall goal of the RECs is to support potentially late or non-adopters of EHRs. Services to the critical access/rural hospitals will include developing exchange of laboratory results with rural community providers who use hospital-based labs for their office practice.  

The RECs have collaborated in defining their core services as including:

- Group purchasing function;
- Support for workflow redesign and longer term training, practice management integration and trouble-shooting;
- Support towards achieving meaningful use to receive Medicare and Medicaid EHR incentive payments;
- Education of providers; and
- Workforce enhancement to meet health IT demands.

The RECs do not plan to endorse any vendor, but will be a source for vetting EHR vendors through summary reports (e.g., specifications, ease of use in varied practice settings, integration ease, references). RECs will also review EHR vendor contracts for market reasonableness (e.g., price and terms).

### 3.7.2 Strategic Health IT Advanced Research Projects

The University of Texas Health Science Center at Houston was awarded $15 million in federal funding through the Strategic Health IT Advanced Research Projects (SHARP) program to address key challenges in adoption and meaningful use of health IT.

Research at the center will focus on an area of health informatics that uses information technology to support problem-solving and decision-making to optimize patient outcomes, which is known as patient-centered cognitive support. This project will be helpful to the EHR Incentive Program by addressing one of the chief challenges to EHR adoption. Many of today’s EHR systems are not as user-friendly as they should be to fully support users’ needs. The systems also do not always take into account the decision support capabilities that physicians and other practitioners need to easily access and use health IT information effectively on a daily basis.

### 3.7.3 Health IT Workforce Grants

Texas State University at San Marcos was awarded $5.4 million through the ONC to directly support the education of about 320 additional students over three years, while establishing additional capacity to meet the ongoing needs of an expanded work force. Other institutional

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24 Personal communications between REC representatives and Medicaid officials, July 9, 2010.
partners include the University of Texas at Austin, School of Natural Sciences, and the University of Texas, School of Health Information Sciences at Houston.

Students will be able to choose one of the following six career paths:
- Clinician/public health leader
- Health information management and exchange specialist
- Health information privacy and security specialist
- Research and development scientist
- Programmers and software engineer
- Health IT sub-specialist

3.7.4 Community College Consortium for Health IT Education and Training
The Community College Consortium provides assistance to establish or expand health IT education programs. The award was structured to cover all regions of the country through five regional lead awardees. The $10.9 million award to Pitt Community College in North Carolina covers the Southern region including Texas. Three Texas institutions—Houston Community College, Midland College, and the Dallas County Community College District—are participating in the consortium.

3.7.5 Beacon Community Grants
Eight entities from around the State of Texas applied for a Beacon Community Grant from the ONC. No entities in Texas were awarded a Beacon Community Grant.

3.8 Coordination of Medicaid Health IT Activities with State HIT Coordinator
As described in section 3.1.2, the OeHC Director is the designated State HIT Coordinator.28 As a member of the HHSC staff, the OeHC Director communicates regularly with the Medicaid and CHIP Division, other HHSC departments, as well as the state level HIE Cooperative Agreement award recipient, Texas Health Services Authority (THSA), the RECs, the SHARP grantee, the Health IT workforce grantee, and the three Federally Qualified Health Center entities that received HRSA health IT funding.

3.9 Status of Heath IT Activities of Special Provider Stakeholders
3.9.1 Federally Qualified Health Centers
There are 64 Federally Qualified Health Care Centers (FQHCs) operating in 304 locations throughout Texas.29 There are also four FQHC “Look-Alikes” that offer services.30 Within DSHS, the Texas Primary Care Office—through a cooperative agreement with HRSA and a

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29 Texas Department of Health Services. See http://www.dshs.state.tx.us/chpr/FQHCmain.shtm
30 Look-Alikes offer FQHC-like services but do not receive all of the benefits of FQHC status.
partnership with the Texas Association of Community Health Centers (TACHC)—works with health care providers and communities to improve access to care for the underserved, by recruiting and retaining providers to practice in federally-designated shortage areas.

In response to a 2002 federal program to expand FQHCs nationwide, Texas created the FQHC Incubator program in 2003 and appropriated $5 million per year. This program was designed to offer grants to organizations to help them qualify for FQHC funding or site/service expansions. Since the beginning of the federal initiative, the number of FQHCs in Texas has doubled from 32 in 2002 to 64 in 2010. The Incubator program has granted funding to 56 FQHCs and all four FQHC Look-Alikes to become certified or to create a new site or service.

Recently, TACHC and two FQHCs in Texas (Table 6.) were among 45 FQHC networks nationwide that were awarded nearly $84 million in grants to help networks of health centers adopt EHRs and other health IT systems. According to TACHC, approximately one-third of the Texas FQHCs have an EMR, while one-third to one-half are looking for new EHR systems. Texas grantees received a total of nearly $6.9 million for the most recent round of HRSA funding under ARRA health IT implementation grants. Barrio Comprehensive Family Health Center, one of the three grantees, also received an earlier round of funding in 2009, and was awarded an EHR Implementation grant in 2008.

**Table 5. Texas Grantees Awarded HRSA Funding for Health IT**

<table>
<thead>
<tr>
<th>HRSA Funding Source</th>
<th>Texas Grantee</th>
<th>City</th>
<th>Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARRA - Health</td>
<td>Texas Association of Community Health Centers</td>
<td>Austin</td>
<td>$982,587</td>
</tr>
<tr>
<td>Information</td>
<td>Lone Star Circle of Care</td>
<td>Georgetown</td>
<td>$2,987,610</td>
</tr>
<tr>
<td>Technology</td>
<td>Barrio Comprehensive Family Health Care Center, Inc.</td>
<td>San Antonio</td>
<td>$2,909,072</td>
</tr>
<tr>
<td>Implementation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grants (HRSA) (2010)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.9.1.1 **Leveraging HRSA Health IT Resources**

Through coordination with the OeHHC, Texas Medicaid will receive regular updates on the experiences and lessons of EHR adoption from the three FQHCs awarded HRSA health IT funding. Medicaid will include input and feedback from the FQHCs in its development of key messages and outreach strategies to encourage eligible Medicaid providers to adopt certified EHR technology and participate in the EHR Incentive Program. The EHR incentive payments will be leveraged to support the efforts of FQHC providers in Texas to achieve meaningful use of electronic health information.

3.9.2 **Department of Veterans’ Affairs – Clinical Facilities**

In Texas, there are five Veterans’ Affairs (VA) medical centers, 17 VA outpatient clinics and 33 community-based clinics that serve veterans in Texas. The South Texas Veterans Health Care System in Bexar County (San Antonio) contracts with other area hospitals to provide care for

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qualified patients. These providers are currently working to integrate VA data with other information systems in San Antonio.

### 3.9.3 Tribal Clinics

The Texas tribal population is very small, consisting of three federally-recognized Native American tribes. These tribes are the Alabama-Coushatta Tribe (Livingston), the Kickapoo Traditional Tribe (Eagle Pass), and the Ysletta Del Sur Pueblo (El Paso). Each of these tribes operates a tribal clinic. The Kickapoo Tribe and the Ysletta Del Sur Pueblo are the only Texas tribes that provide health services and currently bill Medicaid and CHIP. There is a fourth unaffiliated tribal clinic, Urban Inter-Tribal Center (UITC) of Texas, located in Dallas (See Table 6).

There are no HHS Indian Health Service (IHS) facilities located in Texas. However, the four tribal clinics in Texas receive IHS funding.

HHSC attempted to survey the tribes about their EHR adoption status and plans as part of the completion of the Medicaid HIT Plan. One tribal clinic responded. UITC is using the Resource Patient Management System (RPMS) in its clinic and working toward implementing an EHR. Texas Medicaid has a liaison to the tribal clinics who reaches out to the tribes to ensure their awareness of health IT initiatives in Texas and to encourage their participation, whenever possible.

#### Table 6. Tribal Clinics in Texas

<table>
<thead>
<tr>
<th>Indian Health Services Clinics</th>
<th>City of Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Kina Health Clinic (Alabama-Coushatta Tribe of Texas)</td>
<td>Livingston</td>
</tr>
<tr>
<td>Kickapoo Health Clinic (Kickapoo Traditional Tribe of Texas)</td>
<td>Eagle Pass</td>
</tr>
<tr>
<td>Urban Inter-Tribal Center of Texas</td>
<td>Dallas</td>
</tr>
<tr>
<td>Ysletta Del Sur Servie Pueblo (Ysletta Del Sur Pueblo)</td>
<td>El Paso</td>
</tr>
</tbody>
</table>

### 3.9.4 Texas Mental Health Transformation Project

Texas was one of nine states that received a Mental Health Transformation State Incentive Grant from the HHS Substance Abuse and Mental Health Services Administration. The funds support the transformation of state mental health systems addressed in the six goals of the President's New Freedom Commission, including a key goal to use technology to access mental health care and information. Coordinated by a Transformation Working Group that includes

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representatives of state and federal agencies as well as consumers and family members, the Texas Mental Health Transformation Project has engaged in a variety of activities around health IT and HIE including supporting the development of CMBHS in the proof-of-concept stage. Funding includes the development and implementation of technological resources to support jail diversion activities, data sharing, and coordination of care between the criminal justice courts and DSHS. Mental health transformation staff is engaged in working with the DSHS’s CMBHS team and representatives from contracted providers in the development and adoption of policies and standards to facilitate the exchange of health information.

The Texas Mental Health Transformation Project has also supported the use of technology for veterans and their family members to foster better coordination of services between the VA and state-supported health care providers. This project has also been involved in the integration of physical and behavioral health care, helping FQHCs and Local Mental Health Authorities develop plans for coordinating service delivery and addressing the electronic sharing of client information between EMR systems. The Mental Health Transformation project supports the use of an electronic health-risk assessment, designed to enhance the delivery of health care.

### 3.10 Summary

Texas has a broad range of activities currently underway to advance the use of HIE and EHRs. Given the size and complexity of a state like Texas, it is reasonable that one of its chief issues moving towards meaningful use is how public and private entities working on adoption of health IT can come together to achieve effective communication, cooperation and the collaboration necessary to achieve positive change in the delivery of health care.

The Medicaid EHR Incentive Program offers a real opportunity to support eligible providers in the adoption and meaningful use of EHRs to improve health outcomes, care quality and cost efficiency. For Texas Medicaid, the challenge is to garner the resources, both human and capital, to support this transformation. Across the HHS Enterprise, it is critical to allow exchange of program-specific proprietary data for analysis in order to measure quality and cost indicators that focus on the value of care provided to Medicaid clients. Statewide, the challenges are not just access to resources to understand and support technology adoption, but also about moving towards a common goal of improving health care and cost effectiveness.
4. THE STATE’S “TO-BE” LANDSCAPE

Texas Vision for To-Be Landscape—Meaningful Use of Electronic Health Records

There is increasing emphasis, particularly in the Texas Medicaid program, on improving the quality of services and realizing positive health outcomes. Traditionally, providers have been paid for each procedure performed, without rewards for quality of care or health outcomes for the patient. This approach has resulted in ever-increasing costs. For several years national experts as well as Texas policy leaders, and HHSC leaders and specialists, have been addressing the challenge to develop new approaches that encourage the goals of ensuring quality, outcomes, and cost-effectiveness in the health care delivery system.34

HHSC is one of the largest state agencies in Texas. HHSC is accountable for nearly of one-third of the state’s budget or $52.2 billion (all funds) per biennium, and for the health care of nearly 3 million Texans through Medicaid, 71 percent of these individuals are covered through managed care. The Texas Medicaid Health Information Technology Plan (MHP) provides an opportunity to analyze and plan for how EHR technology, over time, can be used to enhance quality and health care outcomes, as well as reduce overall health care costs.35

4.1 Health IT Goals and Objectives

4.1.1 Context for the EHR Incentive Program Vision

The purpose of this section of the MHP is to outline the overall vision for Texas Medicaid’s use of HITECH funds to promote the adoption and meaningful use of EHRs among eligible Medicaid providers. The meaningful use of EHRs is essential to support health care reform goals of improved health outcomes, care quality and cost effectiveness. This vision creates a “line of sight” from the baseline of the current health IT landscape of EHR adoption to the future environment of meaningful use in 2014. This vision helps to create the pathway where “investments in technology per se [are] efforts to improve the health of Americans and the performance of their health care system.”36

The vision of this program is much larger than hardware and software. The vision seeks to establish the point on the horizon where the program is headed – its strategic direction within the larger context of the health care environment and HITECH.

35 CFR §495.332
4.1.2 Texas EHR Incentive Program Vision

The Texas Medicaid vision is focused on two levels of change that must occur, in concert, to realize the goals and benefits of this HITECH program: the state level and the health care system level. The state-level changes center on Medicaid becoming a Value Purchaser. This strategic direction is reinforced by the Texas Health and Human Services (HHS) System Strategic Plan benchmark goals to:

- Restructure Medicaid funding to optimize investments in health care and reduce the number of uninsured Texans through private insurance coverage; and
- Enhance the infrastructure necessary to improve the quality and value of health care through better care management and performance improvement incentives.\(^{37}\)

To realize this vision for Texas Medicaid and eligible providers, the State requires the commitment, energy and resources of a broad set of stakeholders – health care providers, payers, government entities, legislators, and citizens – who have a shared interest in and will benefit from EHR adoption and meaningful use. Texas Medicaid will provide leadership for this vision through communication and collaboration at the state and local levels.

4.1.2.1 “To-Be” Vision for the Texas Health IT Environment

Figure 4. Medicaid Enterprise and Health Care System Goals

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A select group of HHS Enterprise leaders were convened to discuss and set the To-Be vision for Texas Medicaid. The group adopted the following vision for 2014:

**BE A VALUE PURCHASER OF QUALITY HEALTH OUTCOMES BY SUPPORTING AND “E-ENABLING” IMPROVEMENTS IN MEDICAID**

1. Utilize clinical decision support and health informatics to analyze Medicaid data from across the HHS Enterprise. Use data to target health quality improvement initiatives, including cost avoidance for Medicaid programs. Strategies will include:
   - Identifying regional variations in health and care needs, and barriers to care coverage, access and the delivery of services;
   - Aligning appropriate care design, care delivery and payment structures to support payment for episodes of care;
   - Addressing the primary drivers of health care costs – utilization, medical price, hospitalization, long term care; and
   - Measuring provider performance, collaborating with providers to ensure consistency in data collection and reporting, making more transparent provider quality performance information, and working with other payers to standardize and benchmark quality measurement of providers.

2. Establish and maintain a comprehensive and qualified provider network capable of providing quality care based on population needs, unique care conditions, and local service needs by:
   - Identifying and adjusting to changes in utilization patterns and trends;
   - Identifying and addressing care disparities;
   - Evaluating and improving care coordination opportunities;
   - Expanding childhood prevention programs that lead to healthier adults; and
   - Implementing evidence-based best practices in a range of health care settings.

Identifying, assessing and expanding the provider network based on the needs of the current and expanding population covered by Medicaid is important to having a comprehensive and qualified provider network. Without understanding how well the current provider network is addressing the needs of the current Medicaid population or being prepared to address needs of a new population, such as childless adults who will be eligible pursuant to health care reform, Texas Medicaid needs to focus on information that will inform where the network needs to grow or develop to provide high quality care that is safe, effective, efficient, timely, person-centered and equitable.

3. Implement effective and efficient primary and integrated care approaches including:
   - Medical Home models and payment methodologies to support and improve care coordination and health outcomes
• Integration of physical, behavioral and substance abuse services
• Broad systems integration through wider use of health information exchange between Medicaid and health care delivery systems

4. Ensure the secure and private exchange of health care information across the HHS Enterprise, consistent with national standards, and including the following providers:
   • Long term care and behavioral health care providers who serve consumers with high cost and high co-morbidity conditions, even though these providers were not directly included as eligible providers in the EHR Incentive Program, and
   • Rural physicians, dentists, physician assistants, nurse practitioners and certified nurse midwives who were included as eligible providers in the final rule, yet face unique challenges being able to participate in health IT efforts under the EHR Incentive Program.

5. Increase health care coverage through health insurance exchanges and expanded Medicaid eligibility criteria to be implemented under federal health care reform, with a focus on:
   • Increasing health care coverage to support continuity of care,
   • High service and care needs due to previous lack of health care coverage
   • Member outreach and education about service availability and establishing a medical home.

**IMPROVE THE HEALTH AND WELL-BEING OF CITIZENS OF TEXAS THROUGH THE WIDESPREAD ADOPTION AND MEANINGFUL USE OF CERTIFIED EHRs**

1. Improve the quality, safety and efficiency of care and reduce health disparities by:
   • Supporting clinical decision support capabilities that better enable providers to make clinical decisions based on patient-centered and population-centered data and analysis;
   • Pursuing value purchasing managed care strategies through Value Purchasing Request for Proposals (RFPs, and assisting health plans to help providers achieve meaningful use of certified EHRs;
   • Promoting evidence-based practices (EBPs), computerized physician order entry (CPOE) and Clinical Decision Support that target high cost patients;
   • Engaging in Medical Home initiatives targeted to people with high cost needs; and
   • Working collaboratively with providers to expand transparency in the delivery of care through provider profiling and public reporting of appropriate performance measures.

2. Engage patients and families in their health care through:
   • Knowledge, by promoting health literacy and education and the use of accessible and understandable information;
• Data, by using comparative quality information online for health plans, physicians, hospitals, and other providers; and
• Web-based tools that help patients and their families gain secure access to clinical summaries, pharmacy and medical claims history, and a Personal Health Record, and other resources that will empower patients and families in care decisions and care management.

3. Improve care coordination and integration by:
• Aligning data exchange standards and national standards (5010, ICD-10);
• Extracting lessons learned from the e-Prescribing program;
• Examining opportunities under health care reform (e.g. long term care pilot) to promote improvements in transitions of care and appropriate and timely referral; and
• Advancing the Patient-Centered Medical Home (PCMH) model by promoting adoption of NCQA standards for PCMH initiatives in Medicaid managed care networks.

4. Ensure privacy and security protection for private health information by:
• Developing operating policies for all Medicaid-funded health care programs, tracking access to patient data, conducting regular and standardized security analyses and following up with remediation, as needed; and
• Implementing standards for provider access to private health information (PHI) based on user roles, for all systems that maintain PHI.

5. Improve population and public health outcomes by:
• Simplifying public health reporting;
• Improving accountability through transparency as a result of greater collaboration with providers to develop aggregated and standardized quality reporting capabilities;
• Expanding public awareness and understanding of healthcare-acquired infections through public reporting by facility; and
• Enhancing emergency preparedness through timely reporting of accurate information on public health risks such as food-borne illnesses, disease outbreaks and environmental hazards;
• Educating families on the importance and availability of childhood lead screening, and ways to lessen the risks of blood lead poisoning.

Finally, in the detailed implementation phase of the EHR Incentive Program, which will extend from September through December 2010, the HHSC workgroups will continue to develop a strategy for consolidating and integrating existing systems and databases that collect various quality measures. A Medicaid Quality Outcomes workgroup will focus on streamlining and aligning current outcome measures and prioritizing quality improvement initiatives and
strategies based on data findings. These results will then be incorporated to fulfill the vision as a value purchaser.

The workgroup will:
- Obtain stakeholder input;
- Address current and future data analytical staff capabilities; and
- Identify the need for business intelligence and decision support system capabilities dedicated to enabling the Medicaid program to make well-informed, data-driven decisions to improve health outcomes, care quality and cost efficiency.

### 4.1.3 Achieving the Vision

Current efforts to develop the MHP have focused on reaching consensus on the questions in the CMS Medicaid Health IT Plan template, and planning and initiating the provider outreach and engagement process.

The next phase of the project will focus on engaging the broader community in reviewing, vetting and refining this plan, and initiating action on several essential guiding principles. For success, it will be necessary to improve the alignment of Medicaid program goals across the HHS Enterprise. Texas Medicaid also needs to enhance its accountability for care provided to eligible clients. Making health outcomes and quality of care major priorities is an essential first step. A commitment to work collaboratively with providers and key stakeholders to bring more transparency to Medicaid—by paying for value rather than services—is also crucial to advancing accountability, and fulfilling the vision of Medicaid as a value purchaser.

While health IT can provide significant advantages in data gathering and analysis, meaningful use and quality improvements in health care cannot be accomplished by another entity; that is, meaningful use cannot be purchased. Meaningful use requires the entity, whether Texas Medicaid, or the eligible professional or hospital, to actually use information to change practices in a continuous process of quality improvement.

Finally, this type of substantial and transformative change will not be successful without key clinicians who serve as champions at the state and local level. Texas Medicaid will work with the HIE Advisory Council, OeHC, the RECs, the Office for the Elimination of Health Care Disparities (OEHD) and professional associations to identify physician champions who will assist the Medicaid Program in provider outreach and education. Clinical champions dedicate a substantial portion of their time promoting EHR adoption and demonstrating improved health outcomes through the use of EHR technology. Initial steps in this process will include documenting gaps in information and care to achieve broad scale recognition and agreement about the need for change. While these initial efforts may be resisted by some, using champions in the early stage helps to build a shared commitment for change and a willingness of peers to engage in the incremental process of improved health outcomes.

Achieving a vision of improved health, accountable care and cost effectiveness will not occur overnight and will not be achieved by a few individuals. This effort will only be successful if built on communication, commitment and collaboration. The MHP provides a tool to initiate
this process and will serve as a guide for strategic planning and detailed implementation. It is one step in a longer journey that must involve and entice others into a shared vision.

4.1.4 Building Consensus on the Vision

Texas Medicaid is applying a multi-pronged approach to inform and engage providers on the Medicaid Health IT Plan both before and after the plan is submitted to CMS. In particular, Medicaid obtains input on the EHR Incentive Program through the following types of activities:

- **Committee Presentations** – Medicaid provides updates on the EHR Incentive Program and MHP, and solicits feedback and input from members of the following committees:
  - Medicaid HIE Advisory Committee
  - Regional Advisory Committees
  - Public Assistance Health Benefits Review Committee
  - MCO Medical Directors Committee
  - HHSC Advisory Council
  - HHSC Stakeholder Forums

- **Conferences and Provider Forums** – Medicaid accepts opportunities to speak about EHR Incentive Payment plans at conferences and provider forums across the state, including, but limited to, HIT Summits in Texas, THSteps Rural Clinic Provider Conference, and Local HIMSS events.

- **Provider Associations** – The Medicaid Health IT Planning Workgroup and the Office of e-Health Coordination have met and will continue to meet with provider associations, including but not limited to: Texas Medical Association, Texas Hospital Association, and Texas Organization of Rural and Community Hospitals (TORCH).

- **Provider Forums** – Medicaid plans to offer periodic provider forums to share information on the EHR Incentive Program and updates to the MHP. Medicaid hosted its first provider forum in Austin on August 3, 2010. The forum, a public event accessible by web conferencing, initiated the provider education process by providing:
  - An overview of the federal program as provided through the final CMS rules;
  - A framework of the Texas Medicaid Health IT Plan;
  - What providers need to know about the EHR Incentive Program; and
  - An opportunity for providers to provide input on:
    - Priorities or suggestions on how best to move forward with the plan;
    - Feedback on practical implications of the EHR Incentive Program; and
    - Topics discussed at the forum; forum materials were posted on the website for several days following the forum, and suggestions were accepted via the web through August 6, 2010.
• **Webpage** - A web page on an existing website familiar to providers has been developed to provide information on Medicaid’s health IT initiatives, including the EHR Incentive Program; it will continue to be enhanced over time.38

4.2 **Future IT System Architecture**

4.2.1 **MMIS and MITA**

The Texas Medicaid Management Information System (MMIS) has been described as a “complex association of business operations, policies, procedures and computer processing, and subsystems performed in partnership with a coalition of vendors known as the Texas Medicaid & Healthcare Partnership (TMHP).”39 The MMIS is a federally certified MMIS that includes a data warehouse of claims and encounters with decision support system (DSS) functionality for skilled or power users in analyzing Medicaid and CHIP claims and encounters. MMIS adjudicates acute and long-term claims, but does not reprocess claims paid through a capitated managed care model. The fiscal agent contract with TMHP runs through August 31, 2012, with three (3) one year options to extend.

The MITA Assessment, completed in August 2009, reported that HHSC delayed the replacement of the MMIS to coincide with the required transition from the International Statistical Classification of Diseases and Related Problems 9th Revision (ICD-9) to ICD-10 in October 2013.40 This decision was to mitigate the risk of implementing a new MMIS and then retrofitting ICD-10 and X12 5010. The timing of the replacement of the current MMIS will also coincide with two other major transitions:

• Conversion of eligibility data from the System for Application, Verification, Eligibility, Reporting, and Referral (SAVERR) into the Texas Integrated Eligibility Redesign System (TIERS).

• Remediation of the National Provider Identifier (NPI) and Electronic Data Interchange (EDI) to eliminate crosswalks.

The MITA assessment concluded that the goal of consolidation of the Texas Health and Human Services agencies into a commission structure was achieved. However, the “responsibility for management of Medicaid programs, services, and providers, is distributed across operating agencies… [and] more work needs to be done, as compartmentalized business operations continue to exist.”41 The assessment found that agencies were relocated in a consolidated...

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38 See: http://www.tmhp.com/Pages/HealthIT/HIT_Home.aspx.
39 Texas HHSC RFP for Consultant to Assist in the Procurement for the Design, Development and Implementation of the Replacement Medicaid Management Information System (MMIS), No. 529-10-0074, June 28, 2010
40 The code set allows more than 14,400 different codes and permits the tracking of many new diagnosis. Using optional subclassifications, the codes can be expanded to over 16,000 codes. Using codes that are meant to be reported in a separate data field, the level of detail that is reported by ICD can be further increased, using a simplified multiaxial approach.
41 Texas HHSC MITA Assessment As Is Capability Maturity, September 2009.
structure, but more work remains to break down the silos within the Commission structure. Specifically the assessment raised concerns about the compartmentalization of Medicaid into distinct organizations. Part of the rationale of MITA is to review an organization as business processes across Medicaid and help identify capabilities and plan to improve the maturity levels of these processes across the HHS Enterprise. This requires executive decision-making and guidance as to what level of integration and standardization will be developed across Medicaid. MITA provides a framework for the enterprise architecture (EA) for Medicaid.

As the MITA Assessment stated, “Compartmentalization can impede progress towards increased automation, limit effective communication, minimize data sharing activities, and increase costs by decreasing synergies.” Agencies can be compartmentalized, regardless of whether they are located within a commission structure. Compartmentalized agencies are reflected by activities that require separate structures, staff, assessments, unique information flows, and redundant, rather than reusable technology. The goal of any EA, like MITA, is to reduce barriers to effectively working together, reduce processes and information flows since they make more work for providers who serve clients with multiple needs, and eliminate duplicative technology design, development and implementation costs.

The assessment appeared to identify opportunities for realignment of functions and technologies across public health and Medicaid, where there is often significant overlap in Texas. One of several examples is Texas Health Steps (THSteps), the state’s Early and Periodic Screening and Diagnostic Testing (EPSDT) program, located in the Department of State Health Services and supervised by the Medical Director in the Medicaid/CHIP Division. Planning and decision-making for this program, and its services and technical infrastructure, is bifurcated across these departments. Realignment may be necessary to provide seamless decision-making, governance and information flow across these areas, and to effectively leverage federal matching dollars.

As mentioned earlier, a key initiative identified in the MITA assessment and currently in planning to support the long term vision of reducing the compartmentalized nature of Texas Medicaid is the Enterprise Data Warehouse/Business Intelligence project. Recently completed business requirements, completed with participation across the HHS Enterprise, include a detailed analysis of the MITA maturity improvements for current business processes. The requirements have identified enterprise-level reporting, forecasting, and decision-making needs across programs, policies, and executive functions. The requirements cover Texas Medicaid’s needs for client-centric, clinical views of integrated, episodes of care and drug utilization patterns to paint a picture of a client’s complete life history.

The EDW/BI project also anticipates analytical needs required to support initiatives such as health care reform and HIE. The project is expected to provide timely and accurate information, enabling retrospective and predictive analytics to achieve the strategic visions of improved outcomes, reductions in cost of care, and improvements in quality of care. Implementation planning and procurement strategies for the EDW/BI system will be closely coordinated with MMIS replacement and re-procurement planning decisions. Until the EDW/BI system is in

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42 Ibid.
place, however, HHSC and it’s claims administrator, TMHP, will employ recently acquired analytical tools and consulting services through Ingenix. The Ingenix Impact Pro tools will be used across the HHS Enterprise to:

- Identify Medicaid members at clinical risk;
- Identify intervention opportunities (cost drivers);
- Assess the value and quality of health care delivery programs;
- Predict future needs based on current consumption patterns; and
- Monitor MCO performance based on established quality parameters.

### 4.2.2 Other Critical Projects

The purpose of HITECH is not as an end in itself but a “means of improving the quality of health care, the health of populations, and the efficiency of health care systems.” HHSC will use opportunities in HITECH to actively work to align its projects and procurements so that they reinforce this purpose, and will seek opportunities to “reuse” information and technical capabilities rather than further compartmentalizing programs and maintaining silos of information and technology systems.

Towards that end, several recent procurements offer significant opportunities for alignment with the MHP and EHR Incentive Program. These procurements are described in more detail in Appendix C. They include contracts related to value-based purchasing in Medicaid/CHIP managed care products and services; cost containment strategies in anticipation of budget reductions; and quality-based reimbursement and payment methodologies. HHSC supports a recommendation that there be further communication and collaboration related to these initiatives and the EHR Incentive Program. This is consistent with the findings of the MITA Assessment, the envisioned future of the MHP and the goals of HITECH.

### 4.3 Future HIE Governance Structure

The chief governance challenges facing the HHS Enterprise are how to coordinate projects and maintain alignment across the enterprise, Medicaid, and statewide and national initiatives related to EHR adoption and interoperability.

As previously referenced, HHSC has 24 IT-related projects identified in the MITA To-Be Roadmap that was developed prior to the enactment of ARRA and the ACA. These two initiatives will significantly impact the growth of and demand for IT-enabled projects beyond those that are currently envisioned. To achieve interoperability for meaningful use, the Medicaid/CHIP Division will need to ensure continued collaboration with eligible professionals and hospitals and ongoing coordination activities with the RECs, HIEs, and THSA.

In Texas Medicaid, internal governance will be achieved through a governance body that is chaired by the Medicaid Director and includes the Medicaid Health IT Director, other Medicaid division managers, and key MMIS vendors. This body will be responsible for day-to-day

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43 David Blumenthal, M.D., M.P.P., “Stimulating the Adoption of Health Information Technology,” NEJM, April 9, 2010
governance and operational oversight on projects that are completely within the Medicaid/CHIP division. However, Medicaid has a presence in other HHSC agencies and Medicaid health IT projects will cross agency boundaries. These cross-agency projects will be governed by the Medicaid health IT governance body and will be coordinated through the Office of e-Health Coordination. The OeHC is organizationally placed in the Office of Health Services which oversees all health related programs and services across the HHSC Enterprise, including Medicaid. As such, the Office of e-Health Coordination is formally recognized within the HHSC Enterprise as the coordination point for all health IT activities that cross organizational boundaries within the HHSC Enterprise (see Sec. 3.9).

Another central point of coordination and governance is the Medicaid Electronic Health Information Exchange Advisory Committee. This committee has broad representation, including representatives from all HHSC agencies and the OeHC. There are also committee members that represent THSA, regional HIEs, the RECs, health plans, hospitals, pharmacies and physicians. The role of the advisory committee is to review Medicaid plans and projects and provide guidance, advice, continuity, and direction to Medicaid on Health IT.

While there are separate and distinct responsibilities for the successful implementation of the HIE infrastructure and programs, there are many more interdependencies that call for Medicaid to have a key role in the governance and implementation of the HIE infrastructure. The Medicaid Health IT Director and staff have been active participants in THSA’s workgroups to develop the statewide HIE plan. Medicaid plans to continue to participate in HIE planning and implementation activities as they unfold. The Medicaid Health IT Director, the CEO for THSA and the HHSC eHealth Coordinator (State HIT Coordinator) have established weekly coordination calls with stakeholders to keep all parties informed.

4.4 Technical Assistance to Providers for Adoption and Meaningful Use of EHR Technology

The RECs have agreed to facilitate provider outreach for the EHR Incentive Program, including links to the HHSC website for registration and attestation in the program. Pending CMS approval, HHSC plans to contract with the RECs to support EHR adoption of Medicaid dentists, specialist physicians, and not-for-profit community hospitals fewer than 100 beds which operate in medically underserved areas. This technical support will be consistent with the criteria and fees per the RECs agreement with the Office of the National Coordinator for Health IT (ONC). In the near future, HHSC will be incorporating this funding in an I-APDU. Details are described in the MHP, Appendix H.

4.5 Addressing Populations with Unique Needs

During the 2009 Texas 81st Legislative Session, the Texas legislature passed Senate Bill 1824, which addresses quality measures and other issues of children with special health care needs (CSHCN)\textsuperscript{44}. The bill also created a task force to develop a five-year plan to improve the

\textsuperscript{44} According to the federal Maternal and Child Health Bureau, children with special health care needs are defined as “those who have or are at increased risk for a chronic physical, development, behavioral, or
coordination, quality, and efficiency of services for children with special needs. This legislative framework, in conjunction with health IT initiatives and meaningful use measures, provides the cornerstone for collecting evidence-based measures of quality care for CSHCN using the HIE infrastructure developed for Texas Medicaid. Medicaid will continue to pursue further discussions with the Special Needs Task Force regarding how the program will leverage health IT initiatives and the EHR Incentive Program to improve health outcomes for children with special health care needs.

In addition, the Office for the Elimination of Health Care Disparities (OEHD) within HHSC will also support the EHR Incentive Program by
- evaluating barriers to provider participation in areas where health care disparities have been identified
- reviewing client and provider educational materials to enhance effectiveness among cultural communities

4.6 Using Grant Awards for Implementing EHR Incentive Program

HHSC received $4 million in Medicaid Transformation Grant funds to develop and enhance the Foster Care Health Passport and to begin development of the infrastructure for Medicaid HIE, such as a standardized data exchange with the State laboratory for Medicaid lab results, implementing the HIE pilot (discussed earlier), including an HIE opt-out consent process, and enhancements to the MEHIS infrastructure for health information exchange.

Overall, the implementation of the Foster Care Health Passport was considered a success and is currently operating as envisioned. Following the April 2008 implementation of the Passport, HHSC’s Medicaid and CHIP Division held several sessions to discuss and obtain feedback on “lessons learned” from staff involved in the development and implementation of the Passport and STAR Health.

Working closely with DSHS, Medicaid staff also used transformation grant funds to develop a standardized HL7 data exchange and web service for sharing laboratory test results. These test results include lab tests associated with TH5tep assessments, newborn screening, and other tests performed exclusively by the state lab. While the electronic lab results are currently being shared with the Health Passport, the results will be incorporated with MEHIS when it becomes operational.

4.7 Need for New State Legislation

Texas HHSC does not anticipate the need for new legislative changes in order to implement the EHR Incentive Program. DSHS may need legislation, however, to support expanded data sharing, as utilization limitations exist on certain collected data.

emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”
4.8 Summary

HHSC is utilizing this planning process to further refine its vision as a value purchaser. HHSC understands and supports the primary purpose of the HITECH EHR Incentive Program—to support the adoption and meaningful use of certified EHRs to improve health outcomes, care quality and cost efficiency. Additionally, HHSC recognizes that Texas Medicaid cannot be fully engaged in this vision without additional changes. Thus, the goals for this program must align with other HHSC activities and provider-level activities to e-enable improved health outcomes.

HHSC will also need to continue to work on aligning current and future activities—the MMIS re-procurement, health IT activities in departments and programs across the HHS Enterprise, and coordination of the state-level HIE strategy and approach—with MHP goals to create and reinforce the message of change. The result will be improved health outcomes for Texans.
5. THE EHR INCENTIVE PROGRAM

5.1 Executive Summary

This Executive Summary provides a brief narrative and more detailed graphical overview of the proposed registration, attestation and payment disbursement process for the EHR Incentive Program. As described by CMS, the first step in the EHR Incentive Program will be registration in the National Level Repository (NLR). HHSC will receive notification of the registration. HHSC will then send a communication (by e-mail or postal service) to NLR-registering providers to contact them about the rest of the attestation and payment disbursement process for Texas Medicaid. The communication will specify that the first step is to check if they are enrolled in Medicaid under the National Provider ID (NPI) that they used to register in the NLR and describe what provider types are eligible. All information provided will parallel information on the HHSC website.

A more detailed narrative description of how Texas Medicaid plans to administer the process follows the Executive summary, organized as follows:

- 5.2 Hospital Eligibility Attestations
- 5.3 Eligible Professional Eligibility Attestations
- 5.4 Appeals
- 5.5 Payment Assignment and Disbursement
- 5.6 Capturing Meaningful Use and Outcomes Measures
- 5.7 Changes to Information Systems and Implementation Vendor Contracts

Providers will submit eligibility attestations for Texas Medicaid EHR incentives using an online portal. To facilitate completion of the process, detailed instructions and online assistance is provided to help providers calculate patient volume and attest to completed information. As detailed below, completing the online process will fulfill all provider attestations and other requirements to receive incentives. Payment will be made in the first month after incentive payment is approved.

In addition to issuing payment to the individual provider or hospital, EPs may also use the portal to assign the payment to themselves or to their group or clinic. Texas’s proposed attestation and payment procedures are graphically laid out below in Figure 5.

HHSC will also follow-up with providers who fail to complete the online enrollment. HHSC will track all providers who register as Texas Medicaid applicants with the NLR. The names of providers who do not complete the online process with HHSC will be retained so that HHSC may reach out to these providers about their participation in the EHR Incentive Program.
5.2 Hospital Eligibility Attestation

After receiving notification of CMS registration, HHSC will then confirm that the hospital is licensed and not sanctioned. This confirmation will occur electronically between the EHR incentive enrollment system and the TMHP provider database. HHSC will then send an e-mail or postal communication to the hospital to inform them about the rest of the enrollment process. Hospitals will then complete the enrollment process in the portal. In the online enrollment portal, hospitals will attest to sufficient Medicaid practice volume, financial elements of the incentive formula, AIU of certified EHR technology, and meaningful use for providers who have reached the meaningful use stage. The first element of the online enrollment process will be to confirm the Provider ID as a Medicaid-enrolled hospital provider.

5.2.1 Hospital Volume Attestations

The next step of the hospital process will ask the acute care hospitals to attest to patient volumes. Portal screens will provide hospitals with the capability to enter Medicaid and total encounter data needed to calculate patient volume percentage.

5.2.2 Hospital Adopt, Implement and Upgrade Attestation

In the next step of the process, hospitals can attest to the adoption, implementation or upgrade of a certified EHR. HHSC will then validate that the EHR is certified by checking against ONC’s web service for EHR certified products and obtaining a CMS EHR certification number. If
providers did not provide a CMS EHR certification number, Texas will require eligible providers to submit this information from the “Certified HIT Product List” (CHPL) before proceeding through the portal.

5.3 Eligible Professional Eligibility Attestation

After receiving notification of CMS registration, HHSC will confirm that the EP is licensed, not sanctioned, and not deceased. This confirmation will occur electronically between the EHR incentive enrollment system and the TMHP provider database. HHSC will then send an e-mail or postal communication to EPs to inform them about the rest of the enrollment and attestation process.

HHSC will verify the status of the EPs enrollment in Texas Medicaid. Some EPs may need to complete a Medicaid enrollment process or update their existing enrollment in Medicaid, in order to receive the incentive payment directly.

EPs will then complete the attestation process in the portal. In the portal, providers will attest to Medicaid practice volume, AIU of certified EHR technology, and meaningful use for providers who have reached the meaningful use stage.

5.3.1 Medicaid Enrollment

The first element of the online attestation portal will be to confirm the Provider ID as a Medicaid-enrolled provider. In some cases, providers may register in the NLR with NPIs that are not known to Medicaid. This is because some performing Medicaid providers (e.g., physicians that practice in FQHCs and RHCs or nurse practitioners that practice under a physician), currently bill for their services using the NPI and Taxpayer Identification Number (TIN) of an associated provider or their clinic and are therefore not recognized Medicaid billing providers in the Texas MMIS. In order to issue an incentive payment, an EP must be either enrolled in Medicaid under their personal NPI-TIN, or complete a limited Medicaid enrollment process linking their personal NPI to the NPI-TIN used for billing. The limited enrollment is only valid for participation in the EHR Incentive Program and cannot be used for billing claims. The provider will be required to identify the NPI that is currently used for billing. Under the limited enrollment, the incentive payment must be assigned to the billing NPI-TIN. Alternatively, if the EP wishes to receive the payment directly they must assign the payment to their personal NPI rather than the NPI they use for billing, and they will be required to complete the full Medicaid provider enrollment process as a billing provider.

5.3.2 Attesting to Medicaid Patient Volume

The EHR incentive portal will provide EPs with the capability to enter Medicaid and total encounter data needed to calculate patient volume percentage using either the encounter, panel or group option. EPs will need to show sufficient non-hospital practice volume and meaningful use for providers who have reached the meaningful use stage. If an EP wishes to
attest using patient volume from multiple locations, they need to attest as an individual using either the encounter or panel option.

The first step of the EP attestation process will ask EPs to attest to non-hospital practice volumes and Medicaid volumes. As allowed by the EHR incentive regulation, Texas will give EPs the choice of reporting encounter volume or for primary care providers with patient panels, adjusting the patient encounter volumes to include current Medicaid managed care and primary care case management (PCCM) patients. Panel patient counts must be unduplicated from other patient encounters included in the calculation. Texas currently operates two small Medical Home pilots and the Frew Initiative (see Sec. 3.3.5) is adding medical home pilots. The number of these programs may expand in future years, so that providers participating in those programs will then be eligible for reporting on panels rather than encounters. The patient volume calculation for each option is described below.

5.3.2.1 For EPs Attesting to Patient Volume Using the Encounter Methodology

All providers will attest to their number of patient encounters including Medicaid fee-for-service, Medicaid managed care, Medicaid second payer and all other payers. In order to facilitate pre- and post-payment audits, as necessary, we are asking the EPs to demonstrate their Medicaid share of encounters to be three consecutive calendar months. Our solution will use Medicaid claims as an independent verification of attestations, and this check will be significantly facilitated by having calendar month-based attestations. The program will develop profiles for providers using a rolling full-month approach where provider profiles will be refreshed using a data file with encounter volumes by month, by provider. This will facilitate quick and efficient verification of volume attestations. If providers select partial months, volume attestations will need to be validated with provider-specific, date-specific queries which may delay the payment. Medicaid will encourage providers to use full-three month attestations enabling quick and efficient verification of patient volumes. However, providers who feel it would be beneficial to use partial month volumes will be accommodated.

Using the encounter methodology, all Medicaid encounters will be counted during the three month period for the provider. This includes fee-for-service encounters as well as managed care encounters as the numerator. The denominator is total encounters for the same three month period. If the provider meets the threshold, no further validation is required. If not, primary care providers for Medicaid managed care organizations will be offered the option to include panel patients to their patient counts as described in section 5.3.2 below.

Encounters will be defined around count of claims and encounters per performing provider. We anticipate three months of claims lag in populating our claims database for purposes of verifying EP attestations. For that reason, for providers applying in January and February of 2011, we will notify them that selecting November or December 2010 as attestation months may lead to delay in processing their application, as we will likely need to request additional documentation of Medicaid claims for claims submitted within three months of application. We will encourage providers to select alternative months in order to facilitate confirmation of their attestation without the need for additional information. In accordance with the final rule, an EP
encounter is defined as services rendered on any one day to an individual where Medicaid paid for all or part of the services, including premiums, co-payments, or cost-sharing. Texas does not have an 1115 waiver that involves non-encounter based provider reimbursement.

5.3.2.2 For EPs Attesting to Patient Volume Using the Panel Methodology
Medicaid will also provide EPs the option to attest to Medicaid panel assignments plus patient encounters which are unduplicated from panel counts. In other words, encounters are counted over a three month period and then managed care patients are added as long as they are not duplicated. Panel patients can only be counted under the condition that the patient has been seen within the 12 months before the 90-day attestation period.

This information will support application of the final rule’s eligibility formula for providers using patient panels to establish eligibility.

5.3.2.3 For EPs Attesting to Patient Volume Using the Group Option
Medicaid will provide an option for physicians or other EPs practicing in a group to attest to patient volume by group or clinic workload. This option still requires an individual to go to the portal to complete the attestation process for each provider claiming incentives. Providers using this option may impute the group’s patient volume for their individual attestation. Texas will require EPs doing this to attest that:

1. The clinic or group practice’s patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP in the group only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);

2. there is an auditable data source to support the clinic’s patient volume determination; and

3. so long as the practice and EPs decide to use one methodology for the same participation year (in other words, clinics can not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data).

5.3.3 Adopt, Implement and Upgrade (AIU) Attestation
In the next step of the attestation process, EPs can attest to the adoption, implementation or upgrade of a certified by entering the CMS EHR certification number. HHSC will then validate that the EHR is certified by checking against ONC’s web service and validating the CMS EHR certification number. If providers did not provide a CMS EHR certification number, Texas will advise eligible providers to obtain and submit this information from the “Certified HIT Product List” (CHPL) before proceeding. EPs have the option of attaching supporting documentation. Documents may be added via the EHR incentive portal or faxed. (Faxed documents will be converted into an electronic image file.) Enrolling providers will be instructed that they should retain evidence of their EHR acquisition in their files in case they are selected for audit.
### Table 7: Optional Documentation to Show Evidence of Adopted, Implemented or Upgraded

<table>
<thead>
<tr>
<th>Type of Use</th>
<th>Evidence — Any of the below</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adopted</strong></td>
<td>1. Purchase Order</td>
</tr>
<tr>
<td></td>
<td>2. Contract</td>
</tr>
<tr>
<td></td>
<td>3. Software License</td>
</tr>
<tr>
<td><strong>Implemented</strong></td>
<td>1. Contract</td>
</tr>
<tr>
<td></td>
<td>2. Software License</td>
</tr>
<tr>
<td></td>
<td>3. Training: evidence of cost or contract.</td>
</tr>
<tr>
<td></td>
<td>4. Hiring — job description or payroll records</td>
</tr>
<tr>
<td><strong>Upgraded</strong></td>
<td>1. Purchase Order</td>
</tr>
<tr>
<td></td>
<td>2. Contract</td>
</tr>
<tr>
<td></td>
<td>3. Software License</td>
</tr>
</tbody>
</table>

#### 5.4 Appeals

Texas Medicaid will establish an appeals process for three distinct conditions in accordance with federal regulation:

1. Appeals regarding provider eligibility regarding a determination of Medicaid volume or other eligibility criteria.
2. Appeals regarding payments, with individuals participating who can speak to both hospital and EP data sources.
3. Appeals regarding EHR use — adopt, implement and upgrade (Year 1) and meaningful use (Year 2) of EHRs.

All three appeal types will be conducted by the program administrator. If the program administrator rejects the appeal, the final appeal will be referred to the Medicaid/CHIP Health IT division within HHSC. This process is detailed graphically below.
5.5 Payment Assignment and Disbursement

Payments will be made annually to each qualifying provider through the payment system in the Texas MMIS which routinely validates the appropriate NPI and Taxpayer Identification Number (TIN) based on the providers Medicaid enrollment information. Payment will be made in the first month following incentive payment approval (not to exceed 45 days from approval). Texas Medicaid does not plan to disburse incentive payments through Medicaid managed care plans. Existing OIG/Medicaid audit requirements will apply to EHR incentive payments. Audit procedures are detailed in Section 6.

In addition to issuing payment to the individual provider or hospital, payment for eligible professionals can be assigned, at the EP’s discretion, to an employer or an affiliated entity such as a practice or clinic with which the EP has a contractual arrangement allowing the employer or entity to bill and receive payment for the EP’s covered professional services designated by the provider.

For eligible hospitals, Medicaid has the flexibility to spread out hospital incentive payments over as few as three or as many as six years. Texas wants to give the hospitals most of their EHR incentive support quickly. Texas will therefore use a three-year payout for the incentives. The hospital payout schedule is 50 percent in the first year, 40 percent in the second year, and 10 percent in the third year.
5.5.1 Providers practicing at more than one site
The provider cannot assign split incentives across multiple entities; only one incentive payment will be issued each year for any one provider. An EP can attest as an individual and assign the payment to themselves; or an EP may instead choose to assign the incentive payment to one of the employers or contracted billing entities. How they allocate the incentive payment with their associates is at their own discretion.

5.5.2 Assigning Payments to Entities Promoting EHR Adoption
HHSC is not planning to designate any ‘Entities for Promoting EHR Adoption’. Therefore, the option for providers to assign incentive payments to such entities is not available. However, HHSC may designate promoting entities in the future. If so, HHCS will obtain CMS approval before proceeding and the MHP will be updated accordingly.

5.6 Capturing Meaningful Use and Outcomes Measures
In accordance with the EHR incentive regulation Texas will accept attestation of AIU in 2011 and stage one meaningful use beginning in 2012. HHSC will implement a more robust review and verification as required for Stage 2 (2013) and beyond.

Texas will use a portal to begin collection of clinical quality measures in 2012. Texas may also select a portion of the broader meaningful use measures for electronic reporting for purposes of verifying meaningful use as well as for broader quality improvement purposes in that year and beyond. Texas has not yet made the determination which, if any, of the meaningful use measures will be selected for electronic reporting in 2012 and future years. HHSC is evaluating the use of MEHIS along with other options for submitting meaningful use and clinical quality measures. As described earlier, MEHIS will replace the current paper Medicaid identification card with a permanent plastic card, automate eligibility verification, provide access to claims and pharmacy history for all Medicaid clients, and establish a foundation for future health information exchange.

The Medicaid program intends to adopt a “learning environment” approach to the implementation of this program, both internally with staff and externally with providers. In addition to planning for systems needs, HHSC needs to consider how to assist its workforce to develop the required analytical capabilities needed for a changing environment, including the need for clinical decision support (CDS) capabilities to support value-based purchasing, policy development and program improvement.

Texas is not prepared to propose any state-specific changes in the first stage of meaningful use at this time. However, Texas is still considering the option described in the Final Rule to move four menu measures to the core set of measures. Medicaid is initiating discussions with the DSHS, the agency responsible for public health and biosurveillance reporting, to evaluate the costs and benefits of this option. Once the analysis is complete, an update may be submitted to CMS.
5.7 Changes to Information Systems and Implementation Vendor Contracts

Texas will create two new databases within the MMIS between now and the first quarter of CY 2011.

5.7.1 Provider Master Database
The first database will be a Provider Master Database, validating that providers are actively enrolled in Medicaid (and therefore unsanctioned and licensed) and verifying provider relationships to entities assigned incentives (where applicable).

5.7.2 Incentive Payments Database
The second database will be an incentive payments database. This database will include data received from the NLR, provider attestation and supporting data, and a tabulation of Medicaid claims by providers to enable administrative verification of provider eligibility. The IT/fiscal system will generate provider profiles both for supporting eligibility determinations and transactional tracking of provider attestation and incentive program status, be SQL compatible, and interface with claims data.

Attached to these databases will be a new incentive payments application for use in post-payment eligibility audits. This system will process eligibility determination calculations, manage workflow for suspensions and appeals, and calculate incentive payment amounts.

5.7.3 IT Systems Changes
Systems changes to the TMHP portal presentation, and batch interfaces with external and internal databases, are summarized in the graphic below.
5.7.4 Schedule of Systems Changes:

Fall of 2010—Provider Enrollments and CMS Interfaces
1. Modifications to provider subsystems for eligibility determinations. Modifications will include an interface with the National Level Repository. The fall 2010 timeframe is dependent on successful testing of the NLR interface in October 2010.
2. For the EHR incentive portal, Medicaid will provide the capability for EPs and hospitals, to provide supporting documentation by uploading to a web portal using specified file types.
3. Call center software modifications will be made to answer provider questions.
4. Reporting/extracting from the claims/encounters data warehouse will require a new extraction format. (Claims are only a data source, so there are no systems changes needed to the claims subsystem itself.)

First Quarter 2011—Payment Systems and Audit Systems
1. Administrator conducts payment determinations using new elements of the provider portal.
2. Claims system is updated to generate incentive payments.
3. Audit flagging mechanism is built into the provider portal and interface with the audit team.

Second Half 2011 Changes (for 2012 Go-Live)—Receipt of Quality Measures:
For clinical quality measures and other quality-related initiatives, payment and collection of patient-level outcomes will be electronic using a mechanism still to be determined.

We will claim systems costs as follows. Modifications for the NLR Interface and eligibility determinations will be claimed under the I-APD. HHSC intends to use the HIT I-APD for all changes to MMIS that are related directly to EHR incentive administration and will submit in October 2010, in time for round 1 of testing. Short-term changes will be primarily limited to interfaces. Significant changes to MMIS systems are not anticipated, and to the extent possible, system changes for the administration of the EHR incentive program will be decoupled from the MMIS to avoid unintended problems with the current MMIS operations, and aid in the potential transition when the MMIS is re-procured. Any significant changes to the claims system or to other MMIS components, should they become necessary, will be preceded by an amended HIT I-APD.

5.8 Existing Contractors’ Roles in EHR Incentive Administration
TMHP, the contracting organization for MMIS and Medicaid administration, will be integrally involved in implementation. This relationship incorporates MMIS functions. Medicaid MCOs will not be directly involved in implementation, since all MCO providers are also enrolled in Medicaid FFS, and already provide encounter data for purposes of eligibility verification.
6. THE STATE’S EHR AUDIT STRATEGY

HHSC will conduct automated checks of provider attestations against auditable data sources such as Medicaid claims on a pre- and post-payment basis. Based on these checks, HHSC will issue requests for additional documentation in response to gross discrepancies between HHSC data sources and provider attestations. Other program integrity functions will also be conducted.

6.1 Auditing Attestations for Discrepancies with Auditable Data Sources

For most types of eligible professionals and hospitals, Texas has identified auditable data sources that can be checked by HHSC to provide an initial check of Medicaid volume attestation prior to payment. As described below, if provider attestations are grossly out of line with independently verifiable data, such as available Medicaid claims data and cost reports, HHSC will flag applications for possible post-payment audit review. Providers flagged for audits in this manner will initially receive a request for additional information to support attestations. Medicaid will ask the provider to supply billing or other financial documentation and compare their documentation with Medicaid claims data. If information provided is grossly inconsistent with Medicaid data or the other third party data source, a full audit may ensue.

6.1.1 Hospital Screening Process

Hospital attestations regarding Medicaid volume submitted during the provider enrollment process will be checked against available HHSC data. Some of these checks are pre-payment as screen edits and desk audits, while some will be conducted as post-payment audits. The main data source for the state to verify hospital attestation regarding Medicaid volumes will use hospital Medicaid cost reporting. These reports contain discharge volume and hospital days, however, they do not distinguish Medicaid managed care from other managed care payment. Medicaid managed care attested claims will be checked against two other data sources: Disproportionate Share Hospital (DSH) Reporting and the Medicaid managed care encounter database called I-CHP.

<table>
<thead>
<tr>
<th>Type of Payer</th>
<th>Auditable Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid FFS and Medicaid FFS second payer (Duals)</td>
<td>Hospital cost reporting</td>
</tr>
<tr>
<td>Medicaid managed care</td>
<td>Medicaid DSH reports for DSH hospitals, Medicaid Encounter Database (I-CHP) for other hospitals</td>
</tr>
<tr>
<td>Charity care</td>
<td>Medicaid DSH reports for DSH hospitals.</td>
</tr>
<tr>
<td>All other payers</td>
<td>Hospital cost reporting</td>
</tr>
</tbody>
</table>
6.1.2 Eligible Professional Screening Process

EP attestations regarding non-hospital volume submitted during the EHR incentive enrollment process will be checked against available HHSC data for gross accuracy. Depending on the circumstances and extent of the difference, we may perform a desk audit and request additional information. Some of these checks are pre-payment as screen edits and desk audits, while some will be conducted as post-payment audits. To facilitate reporting of patient volume workload, the Medicaid program plans to develop a tool that creates a provider profile of Medicaid client counts based on historical claims and encounter data. Audit screening will seek to identify possible hospital-based providers and EPs with insufficient Medicaid volume to be eligible. We will use provider profiles based on Medicaid claims and encounters as a check of attestations in both areas.

For each eligible provider type, available data sources are as follows:

- **Physicians**: Medicaid claims and Medicaid managed care capitation payments and encounter data.
- **Nurse Practitioners and Certified Nurse Midwives**: Medicaid claims and Medicaid managed care capitation payments and encounter data. Nurse practitioners (NPs) and Certified Nurse Midwives (CNMs) will need to have their own NPI to qualify. If an NP or CNM does not have a billing history, he or she will need to provide documentation of supervising physician relationship and cite that physician’s Medicaid claims history. If an individual provider is not enrolled in Medicaid for payment under a separate NPI, he or she must enroll in Medicaid as a performing provider to receive payment. It is not necessary for that provider to bill under this (new) NPI going forward, but it must be used for the EHR incentive payment claims.
- **Dentists**: Medicaid claims and Medicaid managed care capitation payments and encounter data.
- **FQHC/RHC-based professionals**: Medicaid will request additional documentation of the Medicaid share. HHSC can only confirm a portion of the attested Medicaid volume; however, if the combination of Medicaid FFS, Medicaid managed care, and CHIP encounter data is sufficient to meet patient volume eligibility requirements, no further review will be needed. Texas Medicaid will work the FQHC/RHC to obtain information that can be used to verify EP practices predominately at the facility or a combination of clinic locations.
- **Physician Assistants**: FQHC/RHC corporate information (on license) to confirm that the FQHC/RHC is PA-led.

The verification of attested data is also a cross-state issue that is being researched for the purposes of determining eligibility for the incentive payments for a Texas physician or hospital that may serve another state’s Medicaid member. Texas has a number of major cities near the border with other states (e.g., El Paso, Dallas, and Houston) that serve residents from other states. Eligible providers are being instructed to look at Texas Medicaid volume only to
determine if volume if sufficient. If they need to include out-of-state Medicaid encounters (numerator) in their patient volume attestation, they will be instructed that they also need to include out-of-state encounters in their total (i.e., denominator). Including out-of-state patient volume may facilitate eligibility; however, further analysis is needed and will be coordinated through the CMS Region 6 office and neighboring states to assist Texas in addressing this issue.

For attestations of non-hospital-based status, if more than 93.3% of Medicaid claims appear to be inpatient or from an emergency department, the discrepancy will trigger HHSC to request additional information from the provider. We will use both Place of Service and Procedure Code from Medicaid physician claims to generate the provider profile of all physicians, nurse practitioners (NPs), certified nurse midwives (CNMs) and dentists with NPI numbers in the system. The specific coding that will define hospital-based services, specifically inpatient and emergency department services which require the use of CPT codes to identify those services will be as follows:

- Place of Service code = Facility,

### 6.2 Other Methods to Identify Suspected Fraud and Abuse

Existing Medicaid audit functions are overseen by the Claims Administrator Operations (CAO) unit within HHSC’s Medicaid and CHIP Division. The CAO Contract Compliance unit will oversee annual audits of the EHR provider incentive payments. HHSC anticipates using contractors, which may be selected from the state master contractor’s list or included in a contract for the administration of the EHR Incentive Program. The costs for this contract will be incorporated into a future HIT I-APDU. Audits will be conducted based on a post-payment statistical sampling. Audits would focus on information attested to for the EHR Incentive Program, including but not limited to provider type eligibility, patient volume, and AIU. Volume, scope, methods, and procedures will be based on risk assessments and be materially consistent with HHSC audit protocols. The CAO Oversight Unit will respond to requests for information on the EHR Incentive Program from external audit groups (e.g., CMS program reviews, DHHS Office of Inspector General, etc.) If suspected fraud or abuse is identified, the case will be referred to the HHSC Office of the Inspector General (OIG) for investigation.

#### 6.2.1 Tracking Overpayments

Overpayments to providers are tracked in Accounts Receivable reporting via TMHP’s financial system. Any identified overpayments will result in a state action request from HHSC to TMHP and handled according to Medicaid’s current process for recouping overpayments.

#### 6.2.2 Fraud and Abuse Detection

When fraud or abuse is detected, a referral will be sent to OIG. In accordance with documented processes, referrals to the Enforcement Division of OIG result in investigations of fraud, waste, and abuse in the provision of all health and human services, enforcement of state law relating to the provision of those services, and provision of utilization assessment and review of both
clients and providers. The OIG works closely with the Office of the Attorney General to prosecute provider fraud and ensure no barriers exist between the two offices for fraud referrals. The agency may impose payment holds on providers to compel the production of records and issue subpoenas, with the approval of the HHSC commissioner.

6.2.3 Providers with Cross-state Catchments
For the retrospective audit of EPs, Texas Medicaid will supplement the audits of Medicaid claims and use the provider’s electronic claims systems, which will be particularly helpful for providers with multi-state patient bases. HHSC also discussed sharing Medicaid claims, by NPI, with the other states in CMS Region 6, for audit purposes.

6.2.4 Using Existing Data Sources to Verify Meaningful Use
HHSC identified a series of existing data sources and formulated specific processes to verify meaningful use.

- Claims data will be used in the pre-payment audit function for incentive enrollment.
- Texas will identify a portion of meaningful use measures to monitor meaningful use.
- The e-Prescribing program that will become available during 2011 under a new contract with ACS, which will be monitored for compliance.
- In future years, information from the immunization registry and other public health registries will be used as systems become interoperable.

6.2.5 Sampling as an Audit Strategy
Texas Medicaid will conduct post-payment audits of provider incentive payments. Audits will be conducted based on statistical sampling. Volume, scope, methods, and procedures will be based on risk assessments and materiality consistent with existing auditing standards and protocols. Risk-based sampling will be based on low volume as an audit trigger, among other triggers to be determined. Statistical sampling for lower risks will also take place. Since HHSC is still estimating the numbers of EPs and hospitals that may participate in the EHR Incentive Program, development of the detailed sampling methodology will be deferred until Medicaid can formulate a methodology that utilizes more fully developed estimates of the sampling universe.

6.2.6 Reducing Provider Burden
HHSC is taking a number of steps to maximize the use of administrative and clinical data to minimize requests for documentation and audit risk for providers. As new data sources become available, the State will leverage those sources to help reduce a provider’s administrative burden.

6.3 Program Integrity Operations
The Medicaid/CHIP Audit unit provides oversight of Texas Medicaid/CHIP activities, administrators, providers, and recipients through compliance and enforcement activities
designed to identify and reduce waste, abuse, or fraud. The unit also works to improve the efficiency and effectiveness of the Medicaid/CHIP Division.

Because the Medicaid/CHIP Audit unit develops a risk-based system for auditing Medicaid/CHIP contracts and grants, responds to legislative requests, and makes waste, abuse and fraud referrals, it will also conduct the audit activities for the EHR Incentive Program. Activities will include but not be limited to performance audits, attestation engagements, financial and compliance reviews. Audits and reviews may be conducted in coordination with the Medicaid Provider Integrity unit, Office of Attorney General Medicaid Fraud Control unit, and other related organizations.

The Cost Report Reviews unit provides oversight and ensures accountability of the provider cost reporting process. This unit will be responsible for auditing providers’ qualified costs for the EHR Incentive Program. The unit performs desk reviews and field audits of the following provider cost reports: Intermediate Care Facilities/Mental Retardation; Home and Community Based Services; Community-Based Alternatives; Community Living Assistance and Support Services; Day Activity and Health Services; Primary Home Care, Residential Care; 24 Hour Residential Child Care; Deaf/Blind Multiple Disabilities Waiver; and Nursing Facilities.

The Outpatient Hospital/MCO Audit Unit (OHMAU) was established to perform audits of Medicaid costs as reported in the Medicare Outpatient Hospital Cost Reports. In FY 2009, desk reviews and/or field audits will be completed for FY 2004 through FY 2006. OHMAU will also perform reviews of the Managed Care Organization’s Special Investigations Unit’s Fraud, Waste and Abuse Plans. This unit will need to validate the Medicaid share for the hospital EHR Incentive payment.

The purpose of the audit is to determine whether the provider’s request for reimbursement in the annual Medicare Cost Report includes only reasonable, necessary, and allowable costs incurred in providing outpatient services under the Texas Medicaid program and that the costs were reported in a format required by HHSC. The purpose of Performance Reviews are to determine whether the provider’s Fraud Waste and Abuse Plan includes the required elements and relevant controls and processes to prevent and reduce waste, abuse and fraud in accordance with Title 1, Part 15, Chapter 353, Subchapter F, Rule 353.501 of the Texas Administrative Code. The audits are conducted in accordance with performance audit standards contained in Government Auditing Standards issued by the Comptroller General of the United States.

The audit includes obtaining an understanding of relevant controls, compliance criteria, and processes related to the preparation of the Medicare Cost Report. Accounting records, transactions and supporting documentation were reviewed to determine that only reasonable, necessary, and allowable costs were submitted.

6.4 Sub-recipient Financial Reviews Unit

The Sub-recipient Financial Reviews unit performs three primary responsibilities: desk reviews of Single Audits submitted by sub-recipients; quality control reviews of Certified Public Accountant (CPA) firms that conduct sub-recipient Single Audits; and limited scope audits of
sub-recipients. The Financial Review unit may need to perform one of these types of audit for the EHR Incentive Program to ensure full compliance with program regulations.

6.4.1 Desk Reviews
Desk reviews are conducted to ensure state and federal funds granted to sub-recipients are properly and accurately accounted for and reported in accordance with applicable federal and statutory requirements. Audit reports submitted by sub-recipients are reviewed for completeness, accuracy, and reasonableness.

6.4.2 Quality Control Reviews of CPA Firms
Quality control reviews are conducted to ensure CPA firms that perform sub-recipient Single Audits are complying with the Quality Control Review requirements of the Texas State Board of Public Accountancy. These reviews involve a study, appraisal, or review of the professional accounting work by CPA firms performing attest services for sub-recipients, and ensuring that the quality of work is acceptable. On-sight reviews and evaluations of the CPA firms’ working papers are conducted.

6.4.3 Limited Scope Audits of Sub-recipients
Limited Scope audits are conducted to ensure sub-recipients are receiving timely limited scope audits of their financial records, operational activities, and compliance with laws, regulations, and contractual agreements. These audits involve a limited scope review of financial and non-financial information of sub-recipients to ensure validity and accuracy of reported information, and compliance with state and federal requirements. On-sight audits of sub-recipients are conducted in areas of identified risks.

6.4.4 Cases of Suspected Fraud
The Office of Inspector General (OIG) reports to the HHSC Executive Commissioner. OIG is responsible for investigating waste, abuse and fraud in all state health and human services programs. The Inspector General is appointed by the Governor to identify and reduce waste, abuse and fraud while striving to improve overall efficiency and effectiveness within health and human services.

The Enforcement Division conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or by HHS beneficiaries. These investigative efforts lead to criminal convictions, administrative sanctions or civil monetary penalties. The Enforcement Division includes three sections: General Investigations, Medicaid Provider Integrity and Internal Affairs. This division will be responsible for monitoring the EHR Incentive Program. The Enforcement Division works closely with the other divisions and sections to ensure that allegations of waste, abuse and fraud are properly investigated and program rules are followed.
7. OUTREACH AND EDUCATION

7.1 Plans to Encourage Provider Adoption of Certified EHR Technology

To successfully achieve its communications vision, Texas Medicaid is planning a number of activities over the next 12 months to encourage provider adoption of certified EHR technology. The steps planned fall into three major categories: education, outreach (provider, client, enterprise staff, and legislature) and coordination.

The Provider Outreach and Education (PO&E) Workgroup was formed as part of the process for completing the MHP and is comprised of communications and operations professionals across the HHS Enterprise. The PO&E Workgroup is involved in developing the messages that are part of Texas Medicaid’s education campaign, devising the outreach strategies that are appropriate to communicate educational messages, obtaining feedback from providers and other stakeholders to improve education and outreach activities, and assisting with coordination of education and outreach across the HHS Enterprise and among external stakeholders.

7.2 Key Messages

7.2.1 Informing Providers about the EHR Incentive Program

Texas Medicaid will use consistent, accurate, and up-to-date information about the EHR Incentive Program eligibility criteria, specifically processes about registration, verification of eligibility, payment, appeals and other processes. The agency will also work with other stakeholders to help providers understand the definitions and stages of meaningful use.

Texas Medicaid intends to target specific messages to particular eligible professions (e.g., physicians, dentists, nurse midwives, nurse practitioners, and physician assistants) to promote their participation. For example, EPs who currently bill under their group’s NPI rather than through their own NPI will need to obtain a unique NPI in order to receive the incentive payment, as described in Sec. 5.1. Materials will be developed to ensure this information is communicated accurately.

7.2.2 Promoting Administrative Benefits of Adopting EHR Technology

Educational efforts will emphasize the opportunities for providers to reduce administrative burdens through adoption and meaningful use of certified EHRs. The communications plan to encourage adoption of certified EHR technology among Texas Medicaid providers will include linking its clinical management benefits and administrative efficiencies with the rollout of other planned health information systems improvements in Texas Medicaid. These messages will be used to counter negative perceptions some providers may have about Texas Medicaid payment timeliness and patient eligibility errors.
7.2.3 Making the Case for Quality Improvement through EHR Adoption

Providers must make an investment in certified EHRs before they can obtain the EHR incentive payment. Among providers who may resist or delay adoption of health IT, it will be important to highlight the evidence on quality improvement, including better care coordination and continuity of care that can result from using EHR technology and exchanging health information. Attention will also be given to the cultural, social, and economic concerns that affect health outcomes and the potential of provider adoption of EHRs to reduce health disparities. HHSC’s Office for the Elimination of Health Care Disparities (OEHD) will be integral in developing messaging and reaching out to clients and providers in areas where disparities are apparent. In addition, Texas Medicaid, in coordination with administrators of Texas Health Steps (the EPSDT program) and MCOs, will specifically promote the advantages and benefits of certified EHRs. For example, providers who participate in Texas Health Steps will be able to use certified EHRs to improve their ability to comply with required EPSDT medical assessments, upon which their performance is often evaluated.

7.2.4 Educating HHS Enterprise Staff about the EHR Incentive Program

For the EHR Incentive Program to be successfully implemented, affected staff within the HHS Enterprise need to have a basic understanding of its purpose, their role in supporting the goals of the program and how it may impact their operations. The PO&E Workgroup will help identify how the EHR Incentive Program may affect staff across various agencies and divisions, both short-term and long-term, and develop educational materials about the program targeted to internal stakeholders.

7.3 Outreach and Education

7.3.1 Provider Outreach

Texas Medicaid is pursuing several strategies for reaching out to providers about the Texas Medicaid EHR incentive program and adoption of EHRs more generally. The key strategies include: presenting at provider stakeholder meetings, organizing provider forums, leveraging HHSC Web-based communications, and leveraging other stakeholder communications.

7.3.1.1 Presentations

Within state government, Texas Medicaid is making periodic presentations to the following stakeholders within the Health and Human Services System:

- Texas Medicaid HIE Advisory Committee
- Regional Advisory Committees (RACs) throughout the state
- Public Assistance Health Benefits Review Committee
- Managed Care Organization (MCO) Medical Directors Committee
- Texas Health Steps Rural Clinic Provider Conference
  - Expert forums for THSteps
  - Regional workshops
• Division directors affected by the EHR Incentive Program

Texas Medicaid will present on the EHR Incentive Program to a variety of external stakeholders that includes medical, dental, hospital and health professions associations and societies.

7.3.1.2 Provider Forums

Texas Medicaid plans to conduct regional, face-to-face forums across the state, particularly to reach out to providers in rural areas. The agency will use these forums to learn about and address providers’ concerns and the barriers they may be experiencing in adopting EHR technology or participating in the EHR Incentive Program. Providers will have the option of participating in forums via web-based conferencing. Texas Medicaid also anticipates conducting periodic webinar-only forums.

7.3.1.3 HHSC Web-based Communications

The TMHP website, which Texas Medicaid providers are already familiar with, is the primary source of web-based communication for the EHR Incentive Program, and will contain links to online resources for providers, including a section on Frequently Asked Questions (FAQs). The TMHP website also hosts a bi-monthly Texas Medicaid Bulletin which will serve as an online source of information and updates about the EHR Incentive Program. HHSC e-mail and Intranet communications will also provide links to online information about the EHR Incentive Program for staff.

7.3.1.4 Other Stakeholder Communications

Other stakeholders have or are expected to host meetings and forums about the EHR Incentive Program and provide regularly updated online communications about the program for their constituents, including Medicaid MCOs, the Regional Extension Centers and their partners (e.g., Texas Medical Association), and various state and county/local associations of eligible professionals.

7.3.2 Client Outreach

Medicaid clients are the primary beneficiaries of the meaningful use of certified EHRs and HIE. Client communication and outreach are necessary to build and sustain client support of EHR use and health information exchange, particularly regarding patient privacy. OEHD will support an educational campaign that will promote wider understanding of the benefits of health information technology among Medicaid clients.

Texas Medicaid and its service partners, including health plans and Texas Health Steps Program, will revise client materials to educate patients about the electronic storage and exchange of medical information as new editions of publication are released. A number of publications have been identified that will include information about health IT in Texas and the impact of electronic health information exchange from a client perspective. These include:

• The 2011 Texas Medicaid client handbook;
• Health plan member materials, including handbooks and enrollment broker letters to client families; and
• Advocacy, special interest, and service agency newsletters and websites.

7.3.3 HHS Enterprise Outreach
A series of internal communications through regular channels such as e-mail, internal newsletters, and periodic management meetings across departments and divisions will provide opportunities to communicate along the chain of command in both directions.

7.3.4 Legislative Outreach
Texas Medicaid officials will make periodic presentations and provide updates to state legislators and their staff about the progress of the EHR Incentive Program and use of related expenditures.

7.4 Coordination
Coordinating education and outreach efforts is critical to the program’s success and efficient use of resources. Coordination efforts will be directed within the enterprise and between the enterprise and external stakeholders.

7.4.1 Departments in the HHS Enterprise and Other State Agencies
Texas Medicaid will be responsible for coordinating with the communications staff for the HHS Enterprise, including the generation and approval of content to inform stakeholders about the EHR Incentive Program. The Office of e-Health Coordination will contribute to content development, and TMHP will advise Texas Medicaid on communications about technical aspects of the program, as appropriate. Texas Medicaid will also coordinate communication and outreach efforts across the Enterprise, including, but not limited to:

• Department of State Health Services (DSHS)
• Department of Aging and Disability Services (DADS)
• Department of Assistive and Rehabilitative Services (DARS)
• Department of Family and Protective Services (DFPS)
• HHSC Office of Eligibility Services (OES)
• HHSC Office for the Elimination of Health Disparities (OEHD)
• Medicaid managed care health plans (MCOs) and medical directors
• Selected Frew Initiative leaders (e.g., IMPROVE website)\(^45\)
• Other state agencies where appropriate (e.g., Texas Department of Rural Affairs)

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\(^{45}\) IMPROVE is an interactive website sponsored by HHSC and designed to allow front-line providers participating in the Texas Medicaid program the opportunity to identify issues or obstacles they have encountered in the Medicaid program and offer their own solutions.
7.4.2 External Coordination Efforts
Texas Medicaid, in consultation with OeHC and TMHP, will have primary responsibility for coordinating communication among external stakeholders. Key external stakeholders in the EHR Incentive Program include but are not limited to the following:

- Health IT Regional Extension Centers (RECs);
- Texas Health Services Authority (THSA);
- Medical associations and health professions societies (e.g., Texas Medical Association, Texas Hospital Association, Association of Texas Midwives, Texas Nurse Practitioners);
- HHSC Regional Advisory Committees (RACs);
- FQHCs and RHCs; and
- Client advocacy organizations.

7.5 Communication Tools for Providers on EHR Incentive Program Procedures
Providers will initially submit contact information to CMS via the National Level Repository (NLR) about their intent to participate in the EHR Incentive Program, as described in Sec 5. Once CMS has submitted provider information to Texas Medicaid, the agency will communicate to the provider to acknowledge enrollment and notify the provider to log into an HHSC website. The communication may be via e-mail or by mail. At the website, the provider will be required to provide an e-mail address and other pertinent information, after which all further communication related to eligibility, payment and other procedures will be electronic.

7.6 Texas Medicaid Website Enhancements
Texas Medicaid will facilitate provider enrollment in the EHR Incentive Program by enhancing the website currently maintained by TMHP. The website, www.TMHP.com, serves as a secure portal for providers to enroll in Texas Medicaid, file claims electronically, verify client eligibility, submit prior authorizations, and perform other functions.

Content added to the TMHP website includes:46

- Frequently Asked Questions (FAQs);
- A glossary;
- Electronic contact form and contact information via phone or fax; and
- Background information and links to related sites, including the CMS EHR Incentive Program site.

7.7 Sources for Providers to Seek Help about the EHR Incentive Program
Telephone and email will be primary resources for individual providers to ask specific questions about the EHR Incentive Program.

46 See: http://www.tmhp.com/Pages/HealthIT/HIT_Home.aspx.
7.7.1 Phone Support

TMHP has a main call center number for general inquiries, claims, educational opportunities, and other special topics. To provide efficient and effective telephone support to providers, Texas Medicaid will work with TMHP to develop Helpline staff training materials and responses to likely questions from providers. In addition, TMHP will work with Texas Medicaid to develop a protocol to elevate questions to a higher level of response when needed.

7.7.2 E-mail Queries

On the TMHP website described above, providers will have an opportunity to submit queries that will be forwarded to staff to triage and respond to or forward appropriately.

Texas Medicaid will coordinate with TMHP to develop procedures and standards for responding and tracking response completions. Periodically, staff will analyze the content of email (and phone) queries to inform updates made to the FAQs available to providers on the TMHP website.
8. THE STATE’S Health IT ROADMAP

8.1 “As-Is” – “To-Be” Pathway

Significant work remains to define the specific steps that must occur within Texas Medicaid and across the HHS Enterprise to achieve the state’s 2014 To-Be vision. HHSC is committed to using the MHP as an opportunity to define its Quality Strategy for the Medicaid Program, as described in Section 4. Through this plan and coordinated implementation steps, Medicaid has set its vision and begun to establish a baseline from which to gauge providers’ progress in the adoption and meaningful use of EHR technologies. As these measures are defined, reviewed and refined, HHSC will establish a systematic process to collect, collaborate and make transparent its assessments of progress for Medicaid and the HHS system. HHSC views this as a first step in what will be an ongoing quality improvement process – Plan, Do, Study and Act.

Fulfillment of HHSC’s vision is dependent on transformative changes across the Enterprise, through its departmental levels, and down to the provider level at the point of care. At the departmental level, the Medicaid Program will focus on assisting EPs and eligible hospitals to achieve Stage 1 meaningful use criteria by streamlining the process for provider registration, attestation, verification and clinical quality measurement and reporting in the EHR Incentive Program.

HHSC will also work to improve internal coordination and collaboration, and to eliminate duplicative quality reporting requirements for providers toward achieving the state’s long-term goal of value-based purchasing. For example, HHSC recently established a Quality Payment advisory committee of HHSC officials and external experts, and created a new unit on quality and performance measurement. The unit will conduct an inventory of state-based and nationally endorsed performance measures that the Medicaid/CHIP Program currently collects from providers. These include measures used by the Physician Quality Reporting Initiative (PQRI), CHIPRA measures, and measures endorsed by the National Quality Forum. Results will be used to propose measures to eliminate and to add and align with the core set of measures required for clinical quality reporting related to meaningful use.

In addition, HHSC will leverage its resources to promote providers’ adoption of the Plan, Do, Study, Act method of quality improvement as part of a sustainable strategy for improving health system performance, including the incorporation of measures of the meaningfully use of EHRs.
8.2 Provider EHR Technology Adoption Expectations

The MU Workgroup developed across-the-board projections of growth in EHR adoption. The workgroup found it difficult to develop a meaningful projection without better data.

Since the provider survey and modeling data from the fiscal agent are not yet complete, the workgroup’s initial recommendations were reviewed by select members of the Core Project Team and the Medicaid Directors. Based on their recommendation, members agreed to model the project based on Moore’s Technology Adoption Curve, which posits that there is a chasm between the early adopters of technology (enthusiasts and visionaries) and the early majority (pragmatists) due to differing expectations of what the technology is to deliver. Early adopters seek to use technology to enhance performance, while later adopters are driven by a need for convenience in their solution. As a result, this “chasm” suggests the need for different communication, collaboration and support strategies between the early and later adopters. While HHSC recognizes there are early EHR adopters, it anticipates that the incentive program will accelerate the adoption rate. To that end, HHSC has begun conversations and planning efforts with THSA as well as the RECs to further develop the analysis and measurement of provider adoption patterns.

Based on an early analysis of data and an understanding of the Technology Adoption Curve, HHSC has identified the following projections for eligible hospital (EH) and eligible professional (EP) adoption rates, as summarized in Table 9.

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Table 8. Projected Adoption by Eligible Provider Type

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>2011 Estimated Baseline</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>EH - Acute Care</td>
<td>10%</td>
<td>20%</td>
<td>40%</td>
<td>70%</td>
</tr>
<tr>
<td>EH – Children’s Hospital</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>85%</td>
</tr>
<tr>
<td>EP – Physician</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP – Pediatrician</td>
<td>5%</td>
<td>10%</td>
<td>25%</td>
<td>45%</td>
</tr>
<tr>
<td>EP – CNMs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP – Nurse Practitioners</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EP – PAs when practicing at an FQHC/RHC</td>
<td>3%</td>
<td>10%</td>
<td>20%</td>
<td>35%</td>
</tr>
<tr>
<td>EP – Dentists</td>
<td>3%</td>
<td>6%</td>
<td>8%</td>
<td>15%</td>
</tr>
</tbody>
</table>

Texas HHSC intends to continue to build on the good work of providers and HHSC and to leverage the wide ranging resources, which Texas actively sought and successfully gained through the HITECH Act. These HITECH resources in Texas provide support for the meaningful use of EHRs as illustrated in the graphic below (Figure 8).

Figure 8. Texas HITECH Resources
In addition to these resources supporting improvement in health care quality, patient safety and cost efficiency, Texas HHSC has communicated with the Office for the Elimination of Health Disparities (OEHD) to explore activities to increase the involvement of minority communities in improving health care using EHR technologies as an essential tool in this process. The need for work in this area was further reinforced by the October 18, 2010 letter from the National Coordinator for HIT stressing the need for action by EHR and HIT vendors and others to help prevent an even wider “digital divide” in improvements in health outcomes and care delivery for minority communities and providers who serve these populations. Dr Blumenthal stated:

It is absolutely necessary that the leading EHR vendors work together, continuing to provide EHR adoption opportunities for physicians and other healthcare providers working within underserved communities of color. Despite our best efforts, data from the National Ambulatory Medical Care Survey indicates that EHR adoption rates remain lower among providers serving Hispanic or Latino patients who are uninsured or relied upon Medicaid. Moreover, this data also identifies that EHR adoption rates among providers of uninsured non-Hispanic Black patients are lower than for providers of privately insured non-Hispanic White patients.

Racial and ethnic minorities remain disproportionately affected by chronic illness, a contributing factor to intolerably high mortality and morbidity rates. Electronic health records possess the ability to help improve both the quality and efficiency of medical care accessible by minorities, so that perhaps rates of chronic illness, mortality and morbidity decrease within these communities. (emphasis added)

OEHD has proposed a number of activities that will be detailed in the Implementation Advance Planning Document to help address this “digital divide” and enhance the effectiveness of the EHR Incentive program to improve quality of care and enhance trust between members of the minority community and their health care providers. OEHD proposes to:

- Serve as a bridge to help optimize communications, graphical user interfaces, and other interactive elements of the program,
- Support the development of culturally sensitive and appropriate communication to enhance understanding of the benefits of adoption and meaningful use of EHRs,
- Foster trust-based relationships with persons covered by Medicaid and Medicaid providers to improve honest and constructive communication about EHRs and meaningful use,
- Share information about EHRs and model EHR technologies with minority community members to identify and address potential problems before or as they arise,
- Observe eligible providers adoption and meaningful use of EHRs to learn and share ways to improve health care delivery, workflow and culturally sensitive and appropriate communication,
• Facilitate trust-building and community member buy-in by equitably engaging community members in education and outreach activities.

In addition, the table below provides a plan of detailed set of steps and activities to support the improvement of health outcomes, care quality and cost efficiency in Texas through the adoption and meaningful use of EHR technologies (Table 10).
Table 9. Plan for Adoption and Meaningful Use of EHRs among Eligible Providers

| Plan to Benchmark and Measure Progress of EHR Adoption and Meaningful Use, 2010 - 2014 |
|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| 2010                                           | 2011                                           | 2012                                           | 2013                                           | 2014                                           |
| Perform provider surveys and develop baseline projections to be included in the MHP | Expected baseline of eligible providers at the innovator adoption level is 2.5%. However, the market may have already surpassed the innovator stage and moved to the early adopter stage which is marked by a growth of 13.5%. Medicaid is targeting 10%-20% adoption among hospitals and 3%-5% for eligible professionals. Providers incentives for adopt, implement and upgrade only by attestation. Few providers will be meaningful users. Understanding of the incentive program, EHR technology and meaningful use grows across the state. | Expected adoption growth among early adopters continues. Adoption by the early majority begins which represents a growth of up to 34%—if HHSC and RECs are successful in addressing “the chasm” between early adopters and the early majority. The target will be 20%-40% among hospitals and 6%-10% among eligible professionals. Adopters from 2011 will begin achieving meaningful use. AIU and/or meaningful use will likely be most pronounced in urban and suburban areas throughout the state. | The Early Majority, adoption continues in 2013. Medicaid is targeting 40%-60% adoption among hospitals and 8%-25% adoption among eligible professionals. Meaningful use among adopters will continue to increase. Key issues will be: available resources to assist providers, ready access to technology infrastructure (certified EHRs, broadband and local champions and success stories) Explore inclusion of a requirement in MCO contracts for e-Transmission of laboratory results. | The Late Majority (up to 34%) will begin investigating the adoption of EHRs. Medicaid targets 70%-85% adoption among hospitals and 15%-45% adoption among eligible professionals. Meaningful use growth across urban and rural communities statewide. |
## 8.3 Annual Benchmarks

### Table 10. Annual Benchmarks for Meaningful Use

<table>
<thead>
<tr>
<th>Measure</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To be a <em>Value Purchaser</em> of quality health outcomes by supporting and “e-enabling” these Medicaid enterprise improvements</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1. Utilize clinical decision support and health informatics to analyze Medicaid data from across the state enterprise. Use data to target health quality improvement initiatives including, cost avoidance for Medicaid.</td>
<td>• Identify high cost/high risk patients, stratify population needs, and ensure use of evidence based practices through core measures.</td>
<td>• Begin collecting core clinical measures and/or alternate core measures from EPs &amp; EHs. Identify top performers or provider champions.</td>
<td>• Review payment structure,</td>
<td>• Require in contracts that Hospitals and HMOs attach a % bonus to providers dedicated to MU criteria and following clinical guidelines.</td>
</tr>
<tr>
<td></td>
<td>• Establish desired outcomes, targets and critical measures.</td>
<td>• Medicaid HMO Quality Challenge Pool (1% of Fees at Risk are in pool for missed targets - redistribute for additional value-added. services/pilots/projects). Priority: Decrease ED and hospital utilization. Secondary priorities will be based on health informatics and analytic findings.</td>
<td>• Start providing physician report cards which ranks how providers are meeting MU criteria and Evidence-based Guidelines (EBGs) compared to peers.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Align reporting quality measures across payer type and/or programs.</td>
<td></td>
<td>• Begin collecting Stage 2 Meaningful Use Criteria.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Determine how EHR Reporting requirements can contribute to Accountable Care Organizations &amp; Healthcare Reform objectives.</td>
<td></td>
<td>• Begin collecting additional children’s quality measures.</td>
<td></td>
</tr>
<tr>
<td>1.2. Comprehensive and qualified provider network capable of providing quality care based on population needs, unique care conditions, and locus of service needs</td>
<td>Increase universal availability of health summary information (lab/test results, prior health visits, medications, other ancillary health services, etc.)</td>
<td>Align measure across programs - FFS, MCOs and children’s measures (FREW, Foster Care and others)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Utilizing MEHIS to make data available – HIE and e-Prescribing network.</td>
<td>• Begin collecting core clinical measures and/or alternate core measures from EPs &amp; EHs. Identify top performers or provider champions.</td>
<td>• Begin collecting Stage 2 Meaningful Use Criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Viewable transfer expand thought to better describe intent</td>
<td>• Easily reportable and accessible Immunization data.</td>
<td>Begin collecting additional children’s quality measures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Increase electronic communication among providers (obtain base-line from the HIE).</td>
<td>• Integrate data within HHSC to providers; newborn screen, lead screening.</td>
<td>• tart providing physician report cards which ranks how providers are meeting MU criteria and Evidence-based Guidelines (EBGs) compared to peers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Integrate data within HHSC to providers; newborn screen, lead screening.</td>
<td></td>
<td>• Provide useful feedback to providers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1.3. Implement effective and efficient primary and integrated care approaches

- PCPs coordinate care with specialists, allied health care (e.g., physical, occupational and speech therapy), behavioral health and dental as needed.
- Care Coordination and integrated health care will be performed by the TX Medicaid Health Management Program for high-cost/high-risk clients. The program will integrate EHR incentive core clinical measures. MCOs case managers responsible for care coordination.
- Medical Home pilots will measure outcomes
- Encourage use of EHRs in the Medical Home pilot
- Explore opportunities for NCQA Primary Care Medical Home accreditation for 2012 or 2013

- Explore open source data solutions for the THSteps visit form - directly reportable as an add-on to certified EHRs.
- Identify or align incentives for EHR within Primary Care Medical Homes.
- Explore requiring NCQA accreditation of Medical Home (levels 1-3).
- Potential expansion of Medical home model throughout the state.
- Implement Preventive Care approaches.
- Expand MEHIS data and functionality.

- Increase % of Primary Care Medical Homes in Texas by 20%.
- Expand MEHIS data exchange features
- Define preventive care approaches for 2012
- Pilot THSteps – EPSDT – visit forms
- Use MEHIS to “push” reminders to providers

1.4. Ensure the secure and private exchange of health care information across the Medicaid enterprise consistent with national standards, and including, specialty focus providers

| Plan how to make data available, meet with providers to review, check and confirm data format is meaningful and then make data available |
| Crosswalk codes to make information available in user-friendly format (e.g. Rx Norm) |
| Break down silos between Medicaid and DADS, DSHS and Managed Care Organization. |
| Begin design phase of a single point of entry into system and view the client life – Encounter Data Warehouse. |

- MEHIS will integrate data throughout the enterprise. Medicaid will explore the development of clinical decision support capabilities.

- Expand MEHIS data exchange capabilities.

- Electronic Data Warehouse will integrate all points of client care and store within warehouse for Medicaid.
### 1.5. Increase health care coverage through health care coverage exchanges under national health insurance reform

| HHSC identifies the systems, staffing, and office space changes that will need to occur to handle 1.5 million new Medicaid recipients beginning January 1, 2014. The Legislature identifies the entity that will administer the Exchange. |
| HHSC develops a detailed workplan for infrastructure changes that will need to occur to handle 1.5 million new Medicaid recipients. HHSC develops a detailed workplan for interfaces that will need to occur with the Exchange. |
| HHSC develops and tests systems modifications and interfaces, hires new eligibility staff, and modifies appropriate administrative contracts. |
| Exchange is implemented January 1, 2014. HHSC begins new eligibility determination processes. |

### 2. To improve the health and well-being of citizens of the state of Texas through the widespread adoption and meaningful use of certified EHRs

| 2.1. Improving alignment of Medicaid program goals across the enterprise |
|---|---|---|---|---|
| 2011 | 2012 | 2013 | 2014 |
| • Reassess data governance structure across the enterprise |
| • Develop data sharing agreements |
| • Ongoing collaboration with DSHS, DFPS and DADS program executives to determine how Medicaid goals can integrate. |
| Ongoing collaboration strategy |

### 2.2. Making Medicaid programs more accountable for the care provided to eligible clients

- Invest in Accountable Care Organizations
- Set targets for desired outcomes
- Develop a design of a quality report card for health plans.
- Evaluate annually for continuity of care, care coordination and improved clinical health outcomes. Possible tools may include client surveys, analytics tools, etc.

### 2.3. Utilizing health IT to obtain improved data to analyze and measure quality factors

| Establish a Medicaid Quality Outcomes workgroup that will perform health care analytics, and decision support to identify areas for quality improvement. |
| The HHSC Quality group has just formed recently and is still developing their workplan and goals and objectives. HHSC intends to develop a Quality coordination infrastructure |

| Analyze |
| provider adoption rates of EHR |
| policy issues |
| legislative requests. |

Examples:
1. THSteps – use reported data to target quality improvement initiatives.
2. Meaningful use of clinical measures.

| Expansion of meaningful use and clinical quality data from EHRs. |
to support the collection and analysis of all clinical quality data received from health plans or providers. Texas HHSC will align quality measures across programs including CHIPRA and to alleviate redundant or duplicative reporting by managed care entities and providers. All data, including the meaningful use data, will be reviewed and analyzed to assess status of health and care quality for Medicaid clients and providers across the Medicaid/CHIP program and guide the development of initiatives to improve quality.

2.4. Providing visibility and transparency into Medicaid quality

- Collaboratively work with provider community to develop measures.
- Reporting of quality metrics for Medicaid via a dashboard.
- Aligning and reporting metrics for HMOs with Texas Dept. of Insurance.
APPENDIX A – Legislative Background

National

On February 17, 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law, and established the framework for financial incentives to stimulate growth and improve the health of the nation’s economy and health care system. ARRA defined specific roles and incentives for the U.S. Department of Health and Human Services (HHS) and its partners – State Medicaid agencies (SMA) – in improving the nation’s health and care through the meaningful use of electronic health record (EHR) technologies. Two Titles in ARRA, Title XIII, Division A, Health Information Technology, and Title IV Division B, Medicare and Medicaid Health Information Technology, comprise the “Health Information Technology for Economic and Clinical Health” (HITECH) Act, which provides unprecedented opportunities for states to plan, design, and meaningfully use EHRs and health information exchange (HIE) to improve health, care quality and cost efficiency.

Title XIII, Health Information Technology, establishes the Office of the National Coordinator of Health Information Technology (ONC) and provides nearly $2 billion in grant funds for the Office to administer in supporting the adoption of EHR’s, the electronic exchange of health information, and research to enhance the use of HIT.

Title VI, Medicaid and Medicaid Health Information Technology establishes the EHR Incentive Payment Program that is administered through the Centers for Medicare and Medicaid Services (CMS), and the Medicaid program is administered in cooperation with the state Medicaid agency. This program is responsible for an estimated $27 billion in direct funds, and a projected $36 to $46 billion in total funds and costs savings nationwide.

These transformative programs are driven by the goals of HITECH to:

1. Improve individual and population health,
2. Increase transparency and efficiency, and
3. Improve the ability to study and advance care delivery.

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The vision of the CMS, which administers this EHR Incentive Program with State Medicaid agencies, is “The right care, for every person every time.” CMS has developed an overarching Quality Strategy for Medicaid and Children’s Health Insurance Program (CHIP) that is aligned with the Institute of Medicine’s “Aims of a 21st Century Health Care System” to ensure care “safe, effective, efficient, person-centered, timely and equitable.” The pillars of the Quality Strategy are to:

- Focus on Patient Centeredness
- Implement Evidenced-Based Care and Quality Measurement
- Support Value-Based Payment Systems
- Leverage Health IT – turn Data into Information
- Continue to Build Effective Partnerships
- Disseminate Information and Provide Technical Assistance
- Facilitate Equity in the Delivery of Care

The Center for Medicaid and State Operations within the Centers for Medicare and Medicaid Services (CMS) issued two State Medicaid Director’s letters, one on September 1, 2009, and one on July 23, 2010, to provide additional guidance and interpretation of the rules. As states develop their SMHPs and I-APDs to implement the EHR Incentive Payment program, CMS addresses their questions and provides further guidance through bi-weekly All-States’ Calls and through FAQs on their website. As the program develops at the national level, these tools have been critical in further directing states.
House Bill 1218 – passed in 2009

HIE Pilot Program

H.B. 1218 established a health information exchange pilot program to determine the feasibility, costs and benefits of Medicaid and CHIP exchanging secure electronic health information with local and regional HIEs comprising hospitals, clinics, physicians’ offices and other health care providers. One feature of the pilot program is to explore the opportunity to obtain comprehensive health information – medical and behavioral health information. The pilot program is structured to begin health information exchange of filled prescription histories, so that implementation and assessment can provide input into the Medicaid EHR Incentive Payment Program related to Stage 1 of Meaningful Use.  

Medicaid Electronic Health Information Exchange System

H.B. 1218 called for development of an electronic health information exchange system to improve the quality, safety and efficiency of health care services provided under the CHIP and Medicaid programs. The legislation requires that the system be developed in accordance with the Medicaid Information Technology Architecture (MITA) initiative of CMS’s Center for Medicaid and State Operations and conform to other standards required under federal law. The System is to be implemented in three stages:

- Stage 1 directs HHSC to implement a health information exchange system that offers an electronic health record for all Medicaid recipients. In addition, Stage 1 requires HHSC to coordinate e-prescribing tools used by health care providers and health care facilities under the Medicaid and CHIP programs and develop a claims-based electronic health record in Medicaid.
- Stage 2 would expand the EHR to include CHIP program clients; add state laboratory results, including the results of newborn screenings and tests conducted under the Texas Health Steps (EPSDT) program; improve data gathering capabilities; and use evidence-based technology tools to create client profiles.
- Stage 3 involves developing evidence-based benchmarking tools that can be used by health care providers to evaluate their own performances on health care outcomes and overall quality of care as compared to aggregated performance data regarding peers; and expanding the system to include data exchange with state agencies, additional health care providers, laboratories, diagnostic facilities, hospitals, and medical offices.

HIE Systems Advisory Committee

The HIE Systems Advisory Committee established under H.B. 1218 advises HHSC on Medicaid activities related to health information technology. A key objective of the Committee is to ensure Medicaid/CHIP HIE is “interoperable” with broader statewide health information

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exchange being planned through the THSA. The advisory committee is responsible for advising HHSC on issues regarding development and implementation of the electronic health information exchange system, including: data to be included; presentation of data; useful measures for quality of services and patient health outcomes; federal and state laws regarding privacy of private patient information; incentives for increasing adoption and usage; and data exchange with regional health information exchanges.

**Health Information Technology Standards**

H.B. 1218 requires that any health information technology used by HHSC or any entity acting on behalf of HHSC, in the Medicaid program or CHIP conform to standards required under federal law. Other aspects of the legislation include having Medicaid adopt an incentive program to encourage nursing homes that serve clients on Medicaid to voluntarily participate in an electronic exchange of health information related to evidence-based practices and quality of care outcomes. Another component of H.B. 1218 includes establishing a program that requires hospitals in Texas to exchange confidential information with HHSC regarding hospital performance related to potentially preventable readmissions.

DSHS’ Mental Health and Substance Abuse division is working with its mental health providers, the Substance Abuse and Mental Health Services Administration, and a number of other states to advance the development of behavioral health data standards that are consistent with the framework established for physical health standards, but meet the specialized needs of behavioral health providers. As they are developed and adopted, the standards will be utilized in such systems as CMBHS. Ongoing work is also addressing the use of a Continuity of Care Document (CCD) for advancing continuity of care. DSHS has partnered with a regional HIE in the development of a Beacon Community program application, with the focus of connecting the state’s behavioral health information systems with a regional HIE. This type of effort demonstrates DSHS’ commitment to the integration of physical and behavioral health.

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50 See: [http://www.senate.state.tx.us/75r/senate/commit/c610/h2010/0415-JosephSchneider.pdf](http://www.senate.state.tx.us/75r/senate/commit/c610/h2010/0415-JosephSchneider.pdf)
APPENDIX B – Approach to MHP Planning

Project Planning Approach
The Texas Health and Human Services Commission (HHSC) initiated a Medicaid Health IT Project to accomplish the objectives outlined in section 4201 of ARRA and to promote the goal of improving health care quality and reducing costs by exchanging health information through the use of certified EHR technologies. On December 3, 2009, CMS approved the Texas Medicaid Planning-Advance Planning Document (P-APD) request of $4,285,057 to develop the MHP.

The planning process primarily focused on determining the internal administrative and managerial process needed to support the Medicaid EHR Incentive Payment Program. Since health information exchange is critical to meaningful use and the value of health information technology, HHSC participated in activities with the Statewide HIE and RECs to support the statewide effort and to ensure Medicaid providers’ involvement in and access to HIE capabilities. In addition to these planning and participation activities, this project identified system enhancements, changes and modifications needed to support the EHR Incentive Payment Program and related health information exchange infrastructure.

HHSC established nine workgroups to ensure key stakeholder participation and input into the planning efforts. The table below shows an overview of each workgroup and its charge.

HHSC also enlisted its MMIS and claims administrator, Texas Medicaid & Healthcare Partnership (TMHP), for assistance in completing some key components of the MHP. TMHP’s primary responsibility is to help the state assess the Medicaid provider capabilities in terms of managing data in order to provide a description of the current Medicaid provider landscape for the MHP and to assist in the development of the incentive payment program. The scope of TMHP project included working with HHSC and other state staff to:

- Perform a data analysis of provider information in order to inform the MHP planning process.
- Provide resources to workgroups to define the EHR Incentive Payment processes and procedures.
- Assist in the development of system changes and requirements for the implementation and tracking of the incentive payments.
- Develop the scope of work for the implementation of EHR Incentive Payment Program and develop a change order request (COR) for necessary system changes for establishing incentive payment processes.

While the scope of the MHP is limited to Medicaid programs and its providers, the Medicaid program is a far-reaching state program that impacts stakeholders inside and outside the HHSC enterprise. Other state programs managed within the HHSC enterprise may be impacted since
Medicaid is frequently the payer for state program providers. Stakeholders internal to the HHSC enterprise include the Department of State Health Services (DSHS), the Department of Assistive and Rehabilitative Services (DARS), the Department of Aging and Disability Services (DADS), and the Department of Family and Protective Services (DFPS). An Interagency Contract was developed with DSHS, the state’s public health agency, to determine the impacts to DSHS programs and systems are adequately analyzed and included in the appropriate planning documents; for example, DSHS collects and reports much of the hospital measures and is, therefore, the major data transfer or collaboration entity for the hospital payments. Medicaid developed a similar agreement with DADS to analyze and identify programs that will improve quality outcomes through the electronic exchange of information. Including DADS in the data exchange is not as critical as obtaining the DSHS program information; however, data exchange in the future with DADS programs has the potential to improve quality of care for the aged and disabled population. The HHSC programs or divisions that may be minimally impacted were invited to participate in an extended core team that includes representatives from each agency in the enterprise.

Project Implementation Approach

This Texas Medicaid HIT Plan (MHP) describes the State’s newly developed policies and processes to implement the Medicaid incentive program, including a description of how HHSC intends to: identify eligible providers, make payments to eligible providers, ensure adequate programmatic oversight of the incentive payments, and educate and encourage providers to adopt certified EHR technology. This MHP outlines the first steps in a multi-phase approach that will develop over time and will, by necessity, include simultaneous planning and implementation activities. A second version of the MHP will be completed in October 2010 to complete the planning process for Year 1 activities that are scheduled to commence in 2011. Annual updates will be submitted thereafter to describe the progress to date and to request approval for new implementation strategies.
## Project Organization and Workgroup Structure and Members

### STEERING COMMITTEE

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<td>Medicaid and CHIP Division (MCD), Office of the Medicaid Director</td>
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### OUTREACH & EDUCATION WORKGROUP

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<tr>
<td>Brenda Watson</td>
<td></td>
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### AUDITING WORKGROUP

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<td>Robert Anderson</td>
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<td>Michael Garbarino</td>
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<td>Anna Sicher, RN</td>
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<tr>
<td>M. Reneé Bostick</td>
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<tr>
<td>Troy Alexander</td>
<td>Director</td>
<td>Center for Program Coordination, Policy</td>
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<td>and Innovation</td>
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<tr>
<td>Linda Altenhoff, DDS</td>
<td>Mgr, Oral health Branch/State Dental</td>
<td>Family and Community Health Services</td>
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<td>XiaoLing Huang</td>
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<td>Ivy Bela</td>
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<td>Chris Guerrero</td>
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<tr>
<td>Jimmy Perez</td>
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<td>Medicaid / CHIP</td>
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<tr>
<td>Yvonne Howze, MD</td>
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<td>Health Information and Vital Statistics</td>
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## MEANINGFUL USE WORKGROUP

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<td>Joe Morganti</td>
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<td>MCD Health Management Programs</td>
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<td>Stephen Palmer</td>
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<td>Taylor Cook</td>
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<td>Adolfo Valadez, MD</td>
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<td>Division for Prevention and Preparedness Services</td>
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<td>Jimmy Perez</td>
<td>Long Term Care Partnership Coordinator</td>
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<tr>
<td>Teresa Richard</td>
<td>Director</td>
<td>Quality Assurance &amp; Improvement</td>
<td>DADS</td>
</tr>
<tr>
<td>Ashley Sullivan</td>
<td>Business Analyst</td>
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APPENDIX C – Texas MMIS Overview and MITA Assessment

Components of existing Texas MMIS system:

- Data Entry
- Claims processing and adjudication
- Claim Check
- Financial
- Health Insurance Premium Payments System (HIPPS) and Insurance Premium Payment System (PPS)
- Long Term Care Client Assessment, Review and Evaluation (CARE) Form Processing
- Third Party Liability
- Provider
- Client/Recipient
- Medicare Buy-In
- Automatic Voice Response System
- Online Provider Lookup
- Provider Portal and Bulletin Board System
- Prescription Drug Point of Sale System
- Pharmacy Claims Payment
- Electronic Data Interchange (EDI) Processing System
- Customer Service Request (CSR) System
- Retrospective Drug Utilization Review (DUR)
- Reports online
- Web Portal
- Case Tracking
- Claims and Encounters Data Warehouse
- Decision Support System (DSS) and ad hoc Query and Report (Business Objects)
- Management and Administrative Reporting Subsystem (MARS)
- Surveillance and Utilization Review System (SURS)
- Medicaid Statistical Information System
- Program Integrity
- System Maintenance and Modification
- System Operations, Disaster Recovery, and Integrated Test Facility
- Additionally, the system has multiple interfaces and ancillary applications that support internal and external users, state agencies and other vendors. The business functions performed by the Fiscal Agent include, but are not limited to the following:

- Primary Care Case Management
- Provider Services
- Client Services
- Decision Support Services
- Medical Policy
- Prior Authorization
- Surveillance/Utilization Review
- Third Party Resources
- Claims Processing
- Long Term Care Programs
- Children with Special Health Care Needs (CSHCN)
- Family Planning
- County Indigent Health Care Program
- Medically Needy Program
- Financial Management
- Management and Administrative Reporting
- Reference Data Maintenance
- Eligibility Verification
Other Critical Medicaid Projects

In July 2010, HHSC release a Request for Quote to hire a vendor to assist HHSC Medicaid/CHIP Division in fully implementing *value-based purchasing* in Medicaid/CHIP managed care products and services. The goals of this initiative are to improve the quality of care provided to Medicaid/CHIP enrollees while reducing total program cost. HHSC seeks to:

1. Evaluate the implementation of value-based purchasing in Medicaid/CHIP managed care products and services, including an evaluation of existing Texas Medicaid/CHIP programs to determine opportunities to more fully implement value-based purchasing in current managed care operations;
2. Analyze availability of existing data as well as the quality and format of program data from various sources for use with this project;
3. Develop a roadmap to further align operations and management of Medicaid/CHIP Health Management Organization’s (HMO) into alignment with value-based purchasing;
4. Provide recommendations based on evidence-based practices and principles; and
5. Assess program resource requirements necessary to achieve value-based purchasing objectives and expectations of managed care program growth over time.

In August 2010, HHSC released an RFQ for a vendor to assist with the development, analysis and implementation of *cost containment strategies* in anticipation of legislative interest and imposition of state agency budget reductions. The project is to analyze, develop and implement of cost containment strategies by:

1. Reviewing and analyzing current cost containment strategies employed by the MCD and make a determination on the degree of implementation and effectiveness of strategy.
2. Researching other nationally recognized and evidenced-based cost containment strategies for the healthcare industry and make recommendations on those most appropriate and applicable to Texas’ programs.
3. Developing a fiscal review for each proposed strategy recommended for implementation.
4. Assessing program resource and human capital requirements necessary to implement cost containment strategies.
5. Preparing a comprehensive report that contains tasks listed above for presentation to HHSC’s executive management staff and for possible presentation to the Texas legislature.

In August 2010, HHSC released an RFQ for a vendor to assist the Medicaid/CHIP Division develop, document and implement of *quality-based reimbursement and payment methodologies* for specified Medicaid/CHIP programs. HHSC is working to develop quality-based payment proposals to submit to CMS for pilots and projects newly available under the
health care reform, and provide financial incentives to providers in fee for service, primary care case management and in HMOs, to provide quality services to enrollees and the state, and to continually increase quality.

HHSC wants to conduct research for the HHSC staff and the quality-based payment advisory workgroup on quality-based payment initiatives, including but not limited to: quality of care standards, evidence-based protocols and measurable goals for the pilots. The project will assess current payment methodologies, recommend quality-based rate processes for Medicaid/CHIP, develop proposals, such as waivers, state plan amendments, and/or proposals on quality based payment initiatives, including but not limited to: Bundled payments for episodes of care that include hospitalizations, Global capitated payments to safety net hospital systems, and Pediatric medical providers organized as accountable care organizations (ACOs) to share in cost-savings Health homes, including for enrollees with chronic conditions (Patient Protection and Affordable Care Act Section 2703).

MITA
The Gap Analysis reiterated many of these themes across each of the MITA Business Process Areas:

- **Member Management** – The Member Management business area suffers from many obstacles seen in other business areas. These include compartmentalized processes, redundant systems, lack of data standardization, and overstretched staff. Some of the remedies identified include increased use of EHR, movement toward focus on health outcomes, and increased automation/reduction in paper and manual processes. HHSC currently has two major projects underway that will increase several MITA Maturity Levels: consolidating SAVERR into TIERS, and the implementation of the MEHIS project.

- **Provider Management** – Texas is making strides in offering automated, self-service channels for providers, but significant barriers still exist to achieving higher MITA Maturity Levels. Continuing requirements for original signatures and notarized forms prevents complete automation of some processes in this business area. Also, complex medical policies and business rules leads to tedious documentation requirements and claims denials. This can result in a high volume of appeals and claims reprocessing. While there is a healthy take up of EDI services, much more can be accomplished if these barriers can be overcome.

- **Contractor Management** – Centralization of activities remains the chief obstacle to maturation of the Contractor Management Business Processes. As silos continue to exist across the HHS Enterprise, redundancies can be found in many business areas for many activities. In addition, these processes are affected by variability in the consistency and timeliness of both internal and external communications. Developing and implementing standards and automated processes will help propel the HHS Enterprise toward higher levels of process maturity.
• **Operations Management** – Within the Operations Management business area, manual processes and paper documents are the primary drivers for the business processes. In order for the HHS Enterprise to move to the next levels of MITA Maturity, manual processes need to be replaced by automation and inputs and outputs need to be in electronic format. While some legacy system consolidation is being addressed, more needs to be done. An interim solution is to provide users with an interface to all applicable systems that will give a complete view of the client. With an MMIS replacement likely to occur around 2013, HHS needs to reassess the current policies across all programs from an HHS Enterprise perspective, and consolidate, eliminate, and simplify where possible.

• **Program Management** – The Program Management area has many opportunities for maturity improvement. The leading capability improvement in this area is system support for knowledge management to promote effective policy development, consistent interpretation and application of policy, and improved inquiry capabilities to locate and manage program information.

• **Business Relationship Management** – Compartmentalization among the five HHS operating agencies is an acute problem for the Business Relationship Management processes. Lack of centralization is, therefore, the weak link among the capabilities of the Medicaid Enterprise for this business area. To significantly mature these processes, agency leaders must address the absence of comprehensive standards, which limits the consistency of business process results.

• **Program Integrity Management** – Although some activities within the Program Integrity Management business area involve electronic communications and automated steps, many do not. The majority of business areas utilize non-electronic communication channels and manual steps to complete these business processes. Issues with data access and a lack of HHS Enterprise data standards are also significant concerns.

• **Care Management** – During the Care Management Business Process sessions, several recurring themes emerged. Most notable was the need to break down the existing silos between agencies and programs to improve coordination, integration and communication across the HHS Enterprise. This can be achieved by increasing consolidation of legacy systems to eliminate redundancies of data capture and entry and by creating interfaces between the various systems to allow users to view all relevant data associated to a client without having to log into multiple systems.

The To-Be MITA Roadmap lays out a series of projects that HHSC identified as necessary to improve the capability maturity of the Medicaid enterprise. The Roadmap included 24 total projects requiring support from or interface with IT components. Fourteen of these projects were mandated by federal or state regulation. Since the Roadmap was created before the enactment of ARRA and the Patient Protection and Affordable Coverage Act (ACA), the health care reform act, it does not include projects necessary to implement critical provisions of these major reforms. In addition, the Roadmap does not take the next step to prioritize and scope
resources necessary to for successful accomplishment these projects. As a part of the EHR Incentive Payment Program, it will be necessary for the Medicaid enterprise to develop governance and cost allocation processes to increase the likelihood of successful implementation.

**Figure 10.** Texas HHSC MITA Roadmap – Projects sorted by Type

Fundamental to the success of many of these projects is the replacement of the MMIS with a component-based, rules-driven system comprised of a service oriented architecture (SOA). In addition, a modern MMIS must be agile, adaptable, interoperable and fully capable of integrating, normalizing and analyzing cost and quality data to support performance management across the enterprise and health care system.

**Medicaid Eligibility and Health Information System**

As described earlier and in Appendix A, H.B. 1218 in 2009 directed HHSC to undertake several initiatives to expand the use of health information exchange (HIE). First, HHSC was to establish a Medicaid and CHIP HIE system in three phases with the Medicaid Eligibility and Health Information System (MEHIS) establishing the HIE infrastructure.
The HIE Advisory Committee began meeting in February 2010 as the second phase, and the third phase was launched in October 2009 with the beginning of work to create a pilot project with an HIE within one region of the state. HHSC has identified HIE organizations and intends to support the HIE pilot through MEHIS.

MEHIS is designed to replace Medicaid’s current paper format of identification with permanent plastic cards that allow eligible Medicaid providers secure access to eligibility verification and adjudicated claims history information. MEHIS will enable providers to use a card reader to access HHSC database through a portal and verify client eligibility at the point of care.

Figure 11. EHI System & Interfaces

Further, MEHIS will enable providers to access a claims-based electronic health record (EHR) for Medicaid recipients. The new system will support aggregation of eligibility, claims, encounters, prescription history, immunization history, program information (i.e. THSteps), and notification.

While the MEHIS design supports secure and confidential access to claims administrative data, which has been called an “EHR-like” or “EHR-lite,” the initial system as currently planned does not provide certified EHR functionality, such as access to clinical data. MEHIS will have automated program notification, and provider and client portal capabilities and call center access.

Texas Medicaid Health Information Technology Plan (MHP)
Final Plan, October 21, 2010
Finally, MEHIS will establish an infrastructure for future Medicaid HIE. Most importantly, through the MHP planning process, HHSC has determined that MEHIS will be the single access point for providers to submit meaningful use and Clinical Quality Measures in the eligible provider’s second year of participation.

The real value of MEHIS is that it will help to make MMIS data actionable. To date, provider submit claims and plans submit encounters which serve as the basis for payment. With MEHIS data will be leveraged to enable targeted and purposeful communication between Medicaid and clients. For example MEHIS will offer automated reminders of periodic services through a variety of media, such as e-mail, text-messaging or mail based on provider and consumer preferences.
### APPENDIX D – State Mandated Frew Projects

**Table 11. Medicaid Frew Pilots with HIT Components**

<table>
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<tr>
<th>Frew Project Title</th>
<th>Description</th>
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<tr>
<td>Call Center Technology for Medical Transportation</td>
<td>Enhancements to technology for the Medical Transportation Program (MTP) call center are expected to increase accessibility to the program and increase utilization of MTP services. Technology enhancements will expand the capabilities of the existing telecommunications system, maintain the additional technology, equip MTP management and call center staff with the tools to effectively monitor, evaluate, train and retain staff.</td>
</tr>
<tr>
<td>Pediatric Specialty Telemedicine Network</td>
<td>The purpose of this project is to increase access to specialty services for children enrolled in Medicaid who live in rural areas or areas without access to pediatric subspecialists. HHSC partnered with the Univ. of Texas Medical Branch (UTMB) and the Texas Tech Health Science Centers for telemedicine projects designed to increase specialty services for Medicaid-enrolled children to improve their access to quality care.</td>
</tr>
<tr>
<td>Health Home Pilot Project</td>
<td>The purpose of this project is to fund multiple health home pilots in Texas Medicaid to identify health home model(s) that are sustainable, replicable, and cost-effective.</td>
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<tr>
<td>Interactive Medicaid Provider Voice (IMPROVE)</td>
<td>IMPROVE is a provider-focused initiative designed to foster better relations and understanding among Medicaid providers and Texas Medicaid. IMPROVE is an interactive website designed to allow front-line providers the opportunity to identify issues or obstacles they have encountered in the Medicaid program and offer their own solutions.</td>
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APPENDIX E – Medicaid Provider Survey Results

Collaborative Provider and Facility HIT Surveys

The two greatest technical challenges in collecting survey results are creating a sound surveying methodology and collecting results from a representative sample. Previous work to survey providers in their use of health information technology has been plagued by problems in these areas which have created severe sampling bias and brought the results into question.

While coordinating on a statewide survey will maximize resources and is capable of producing defensible results, potential problems with methodology and sampling are compounded due to the specific provider type and geographic complexity of the various program needs.

Provider and Facility Methodology and Sampling

Facilities- All hospitals in Texas are required to respond to the Annual Hospital Survey. This survey contains detailed information about most hospitals in Texas with the exception of some nursing homes and federally operated facilities. Combining this information with the HIT/HIE surveys will provide very complete data on the majority of hospitals in the state. The HIT/HIE survey can be disseminated using the same contacts that are responsible for submitting the Annual Hospital Survey. The HIT/HIE Hospital Survey should attempt a 100% response rate.

Providers- It is notoriously difficult to get high response rates from providers, particularly physicians. For our purposes, the existing difficulties are compounded by the need to use a mix of sampling modes to avoid building a technology bias into our sample.

For the purposes of this survey providers are defined as physicians, dentists, physician assistants, nurse practitioners, and nurse midwives. Medicaid providers will be surveyed via an invitation to the electronic survey mailed to a sample of providers. Another sample will be sent paper surveys. Completed surveys of Medicaid providers should total 1500.

Stratification by provider type can be done using one of two methods. The first method would sample types of providers proportionally to the total provider population. A second option is to attempt to sample each provider type to achieve a sample of each type that will exceed a high confidence level.
Both methods of stratification will produce defensible results, but there are disadvantages to both methods. In the case of proportional stratification, results will be truer to the provider population and the largest groups of providers, physicians and dentists, will have a sample that exceeds a 95% confidence level. This proportionality might make it easier to achieve the necessary sample in a shorter period of time. However, the results for physician assistants and nurse practitioners will not achieve a high confidence level which will complicate interpretation. Stratifying by provider type to achieve a high confidence level will make interpretation by each type more straightforward, but it will take longer to produce the desired sample size. There is also the risk that by limiting the number of physician responses, the survey will be unable to capture additional variation that may be of interest in this population (geographic, age, specialty, etc.).

In the non-Medicaid provider population, providers will also be invited by mail to participate in the electronic and paper survey. Only non-Medicaid physicians and dentists will be invited to participate. Limiting this sample to these types of providers will produce more significant results and target the types of providers where difference between Medicaid and non-Medicaid provider types are likely to be more significant. Complete non-Medicaid surveys should total 500. This sample should be stratified proportionally to capture additional variations in the physician population.

Not included in the discussion above is Texas’ nurse-midwife population. Nurse-midwives are an insignificant proportion of the provider population in Texas (less than 0.5%). Rather than include this population in the larger survey sample, invitations should be sent for the electronic survey using the Medicaid and non-Medicaid contact information that is available. The results from this sampling can be included in the final environmental scans as a separate analysis, but should not be combined with the results from other provider types.

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51 Data reflects most recent figures from the Texas Medical Board, Board of Nursing, and the State Board of Dental Examiners.
Hospital Adoption

The 2010 Health Information Technology Survey for Hospitals was developed to measure EHR adoption in the state’s hospitals, determine the utilization levels of specific EHR functions, estimate HIE participation, and gauge interest in the Medicare and Medicaid incentive programs.
Like the practitioner survey, the hospital survey process will remain ongoing until a full sample size is reached. As of August 11, 2010, 44 percent of the state’s facilities have responded. This response represents 45.7 percent (36,994) of inpatient beds in the state, 47.6 percent (81) of non-metro hospitals, and 44.4 percent (8) of hospitals that restrict admission primarily to children.

The preliminary results of the hospital survey show that 23.72 percent of hospitals have fully implemented EHRs in all units and 38.34 percent have partially implemented or begun implementation. Another 35.97 percent of hospitals are planning EHR implementations in the next one to two years. Only 10.28 percent of hospitals do not have or intend to implement an EHR in the next two years. Of the hospitals that have not planned to implement EHRs, they are predominantly in metro areas (88%), have an average of 62 licensed beds, and are a mixture of acute long-term care (9), general (6), rehabilitation (4), psychiatric (3), and surgical (2) facilities.

**Table 13. Hospital Survey Results**

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<th>Level of EHR Adoption</th>
<th>Percent</th>
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<tr>
<td>EHR is implemented in all units</td>
<td>23.72</td>
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<td>EHR is implemented in at least one unit</td>
<td>17.39</td>
<td>44</td>
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<td>Implementation begun</td>
<td>20.95</td>
<td>53</td>
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<td>Implementation planned in the next year</td>
<td>15.02</td>
<td>38</td>
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<tr>
<td>Implementation planned in next two years</td>
<td>12.65</td>
<td>32</td>
</tr>
<tr>
<td>No implementation planned</td>
<td>10.28</td>
<td>26</td>
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Of the hospitals that have implemented or begun implementation, the most popular functions are patient demographic characteristics, medication lists, and discharge summaries. The functions that are least likely to be implemented are drug dose support, advanced directives, and consultation requests.

**Table 14. Hospital EHR Functions**

<table>
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<tr>
<th>EHR Functions</th>
<th>Implemented in all units</th>
<th>Implemented in at least one unit</th>
<th>Implementation begun or planned</th>
<th>No implementation planned</th>
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<tr>
<td>Demographic characteristics of patients</td>
<td>78.29%</td>
<td>10.53%</td>
<td>11.18%</td>
<td>0.00%</td>
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<td>Physicians’ notes</td>
<td>30.26%</td>
<td>18.42%</td>
<td>43.42%</td>
<td>7.89%</td>
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<td>Nursing assessments</td>
<td>55.92%</td>
<td>23.68%</td>
<td>16.45%</td>
<td>3.95%</td>
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<td>Problem lists</td>
<td>39.47%</td>
<td>20.39%</td>
<td>32.89%</td>
<td>7.24%</td>
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<td>Medication lists</td>
<td>60.53%</td>
<td>19.08%</td>
<td>18.42%</td>
<td>1.97%</td>
</tr>
<tr>
<td>Discharge summaries</td>
<td>58.55%</td>
<td>17.76%</td>
<td>21.70%</td>
<td>1.97%</td>
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<tr>
<td>Advanced directives</td>
<td>50.00%</td>
<td>14.47%</td>
<td>23.03%</td>
<td>12.50%</td>
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</tbody>
</table>
Laboratory reports | 73.68% | 9.87% | 12.50% | 3.95%
Radiologic reports | 72.37% | 9.21% | 11.18% | 7.24%
Radiologic images | 63.16% | 12.50% | 15.13% | 9.21%
Diagnostic-test results | 65.13% | 13.16% | 16.45% | 5.26%
Diagnostic-test images | 51.97% | 16.45% | 23.68% | 7.89%
Consultant reports | 53.29% | 14.47% | 23.03% | 9.21%
Laboratory tests | 70.39% | 12.50% | 12.50% | 4.61%
Radiologic tests | 67.11% | 11.54% | 13.16% | 7.89%
Medications | 64.47% | 12.50% | 20.39% | 2.63%
Consultation requests | 44.74% | 10.53% | 33.55% | 11.18%
Nursing orders | 53.29% | 17.11% | 25.00% | 4.61%
Clinical guidelines | 34.21% | 14.47% | 42.11% | 9.21%
Clinical reminders | 34.87% | 16.45% | 40.13% | 8.55%
Drug-allergy alerts | 60.53% | 15.13% | 21.05% | 3.29%
Drug–drug interaction alerts | 56.58% | 15.13% | 25.00% | 3.29%
Drug–laboratory interaction alerts | 44.74% | 11.18% | 34.21% | 9.87%
Drug-dose support | 42.11% | 13.16% | 32.24% | 12.50%

The facilities that plan to implement in the next year or two show a similar preference for these EHR functions.

When asked about HIE participation, 22.41 percent of responding hospitals reported that their facility currently participates in HIE. These hospitals most often use HIE to exchange electronic clinical laboratory ordering and results delivery, eligibility and claims transactions, and quality reporting.

### Table 15. Hospital HIE Functions

<table>
<thead>
<tr>
<th>HIE Functions</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electronic eligibility and claims transactions</td>
<td>34.0%</td>
</tr>
<tr>
<td>Electronic prescribing and refill requests</td>
<td>21.0%</td>
</tr>
<tr>
<td>Electronic clinical laboratory ordering and results delivery</td>
<td>43.0%</td>
</tr>
<tr>
<td>Electronic public health reporting</td>
<td>17.0%</td>
</tr>
<tr>
<td>Quality reporting capabilities</td>
<td>23.0%</td>
</tr>
<tr>
<td>Prescription fill status and or medication fill history</td>
<td>18.0%</td>
</tr>
<tr>
<td>Clinical summary exchange for care coordination and patient engagement</td>
<td>21.0%</td>
</tr>
</tbody>
</table>

Of hospitals that do not currently participate in HIE, most would see value in electronic clinical summary exchange for care coordination and patient engagement (76%), clinical laboratory ordering and results delivery (75%), and quality reporting (66%).
The majority of hospitals that participate in HIE report paying more than $400 a month for their HIE services while 12 percent report paying between $200 and $300, 45 percent report paying between $0 and $100, and 18 percent report receiving HIE services for free.

The majority of hospitals (71%) who do not currently receive HIE services indicated that they would be willing to pay a monthly fee to receive these services.
APPENDIX F – HIE Organizations in Texas

Since 2005, the eHealth Initiative (eHI) has been assessing the development of HIEs, based on a framework developed through their work with HIE leaders across the country. eHI has identified a fairly predictable model of HIE development that emerging entities progress through at rates of change. These stages of development represent a progression of maturity ranging from stage one (recognition for HIE in the community) to stage seven (expansion of an operational HIE to a broader coalition beyond the initial operating model). Measured over time, eHI has tracked and recorded on the growth, and maturing development of HIEs across the country using the following framework.

In January, 2009 the THSA disseminated a census to identify all of the HIE projects across the state of Texas, in order to provide greater information to policymakers regarding HIT and HIE, and to facilitate a productive dialogue among groups involved in similar projects. Specifically, the census sought to capture projects at any stage of discussion, planning, development, or operation that involve or will involve the electronic sharing of patient-level health information among two or more entities to support the delivery of care. Staff will be verifying this information through telephone interviews.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Development Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>Recognition of the need for health information exchange among multiple stakeholders in your state, region or community. (Public declaration by a coalition or political leader)</td>
</tr>
<tr>
<td>Stage 2</td>
<td>Getting organized; defining shared vision, goals, and objectives; identifying funding sources, setting up legal and governance structures. (Multiple, inclusive meetings to address needs and frameworks)</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Transferring vision, goals and objectives to tactics and business plan; defining your needs and requirements; securing funding. (Fundied organizational efforts under sponsorship)</td>
</tr>
<tr>
<td>Stage 4</td>
<td>Well under way with implementation – technical, financial and legal. (Pilot project or implementation with multiyear budget identified and tagged for a specific need)</td>
</tr>
<tr>
<td>Stage 5</td>
<td>Fully operational health information organization; transmitting data that is being used by healthcare stakeholders.</td>
</tr>
<tr>
<td>Stage 6</td>
<td>Fully operational health information organization; transmitting data that is being used by healthcare stakeholders and have a sustainable business model.</td>
</tr>
<tr>
<td>Stage 7</td>
<td>Demonstration of expansion of organization to encompass a broader coalition of stakeholders than present in the initial operational model.</td>
</tr>
</tbody>
</table>
1. CENTEX SYSTEMS SUPPORT SERVICES - AUSTIN

Centex Systems Support Services is a consortium of providers and other entities which have formed a regional 501(c)(3) non-profit corporation to provide information technology infrastructure to support the implementation of a common practice management/electronic health record among traditional safety net providers and permit the sharing of patient data across the provider settings according to agreements established between the participating providers.

→ Organizations Involved: Centex Systems Support Services members and the Travis County Healthcare District.

→ Data and Functions: Demographic, clinical, imaging, and lab results.

→ Stage 4

2. COALITION OF HEALTH SERVICES

The Coalition of Health Services was established in 1996 as a 501(C)3 corporation in Amarillo, Texas. The Board of Directors represents rural hospitals and acute care facilities that collectively cover the Northern most 26 counties of the Texas Panhandle. The Coalition’s network currently provides ISP connectivity for six rural and one tertiary facility and all Coalition hospitals are in various stages of EMR implementation. The Coalition’s goal is to create a system where health information data can be exchanged among facilities and providers throughout the region.

→ Organizations Involved: Coalition of Health Services members.

→ Data and Functions: Demographic, referral, and radiology.

→ Stage 4

3. CRITICAL ACCESS HOSPITAL-HIT - WELLINGTON AND FRIONA

Wellington and Friona are two communities in the Panhandle chosen to serve as demonstration projects for HIT in rural areas. The goal of this project was to improve health care safety, quality, efficiency, and effectiveness through the implementation of HIT. The initial funding for the project came from a grant from the federal Health Resources Services Administration to the Texas Office of Rural Community Affairs and was managed by the Texas A&M Health Science Center Rural and Community Health Institute. The project provided participants with the ability to link community healthcare information and also link to their tertiary care referral center, Northwest in Amarillo. This grant also provided telemedicine connectivity through Texas Tech University.

→ Organizations Involved: Collingsworth General Hospital in Wellington, Parmer County Community Hospital in Friona, Northwest Hospital, and Texas Tech University.

→ Data and Functions: Encounter data, lab results, electronic-prescribing, and telemedicine connectivity.

→ Stage 5
4. CRITICAL CONNECTION - AUSTIN

Critical Connection’s mission is to establish connectivity between patients, physicians, hospitals, other caregivers, and payers and to create a collaborative environment of secure, electronically shared healthcare information. The HIE is beginning to integrate hospital data and has recently introduced a revenue model.

→ Organizations Involved: Over 300 physicians in Central Texas.
→ Data and Functions: Imaging and lab results.
→ Stage 4

5. DIABETES COMMUNITY COLLABORATIVE – CORPUS CHRISTI

The Diabetes Community Collaborative is a community-led effort to impact the incidence of diabetes in the greater Corpus Christi area. The collaborative is working to increase patient involvement and awareness in diabetes management, particularly in uninsured and underinsured populations. In the future, the Collaborative plans to build on past initiatives in Corpus Christi and develop an HIE that can assist providers and patients with diabetes care.

→ Organizations Involved: The DCC includes the Department of Health, physician offices, community health workers, community health clinics, pharmacies, labs, Texas A&M School of Nursing, Del Mar College and a variety of social service agencies including the local United Way, Food Bank, Salvation Army, and the American Diabetes Association.
→ Data and Functions: The functions to be implemented are still under consideration.
→ Stage 2

6. EXPRESS CONNECT HIE- DALLAS-FORT WORTH

The ExpressConnect HIE is a comprehensive physician-directed Health Information Exchange (HIE) that offers a medical care vision for a patient-centric medical home, where individuals and families can move easily across the spectrum of primary and specialty care. This HIE will be collecting patient care data from over 800 participating primary care and specialists physicians in Dallas Fort Worth and improve efficiency in clinical practices by offering practitioners and appropriate health officials the ability to track patient outcomes at the individual, practice, and population levels.

→ Organizations Involved: Founding Members Medical Clinic of North Texas and Heart Place.
→ Data and Functions: allergies, problem lists, medication, and demographic data.
→ Stage 3
7. **GENESIS INFORMATION EXCHANGE- NORTH TEXAS**

The Genesis HIE, developed by North Texas’ largest independent physician association, offers centralized access to numerous electronic functions of patient care delivery and gives participants a choice of several EMR systems. The program enables physicians to accomplish meaningful use of interoperable EHRs by addressing barriers to adoption including financial and technical support. Genesis also promotes comparative effectiveness through clinical integration, collaboration, and implementation of best practice protocols by specialty.

→ Organizations Involved: Genesis Physicians Group.

→ Data and Functions: EHRs, referral management, lab orders and results, e-prescribing, and single sign-on.

→ Stage 5

8. **HARRIS COUNTY HEALTH CARE ALLIANCE - HARRIS COUNTY**

The Harris County Healthcare Alliance is working to develop a business plan and use case in the Houston market. They hope to leverage some of the technology and programs in place at participating organizations to facilitate an HIE. The Alliance plans to initially focus on uninsured and low income patients.

→ Organizations Involved: Numerous local health care agencies, hospitals and public clinics throughout the Houston area.

→ Data and Functions: The functions to be implemented are still under consideration.

→ Stage 1

9. **HEALTHCARE ACCESS SAN ANTONIO - BEXAR COUNTY**

HealthCare Access San Antonio is a health care consortium serving the medically uninsured in Bexar County that was formed to develop a shared patient database to integrate and coordinate health care for the uninsured.


→ Data and Functions: Encounter Data

→ Stage 5
10. HEALTHCARE ALLIANCE OF MONTGOMERY COUNTY - MONTGOMERY COUNTY

Heart of Montgomery County is a community collaborative of individuals, organizations, non-profit agencies and providers who are exploring the development of an HIE for Montgomery County.
→ Organizations Involved: Working on agreements with area hospitals and clinics.
→ Data and Functions: The functions to be implemented are still under consideration.
→ Stage 2

11. HEALTH QUALITY AND INTEROPERABILITY LABORATORY FOR TRAINING (HEALTHQUILT) - HARRIS COUNTY

HealthQuilt is a pilot strategy developed by the University of Texas School of Health Information Sciences to establish a “network of networks” around patient-centered medical homes. HealthQuilt has developed an HIE to facilitate physician-to-physician communication and support community clinics, primary care physicians, ancillary services, and specialists.
→ Organizations Involved: 20 participating physicians to date including University of Texas and private practice physicians.
→ Data and Functions: EMR, evidence based practice support, messaging, and consultation to specialists for disease management.
→ Stage 4

12. INTEGRATED CARE COLLABORATION - CENTRAL TEXAS

The ICC is a non-profit regional collaborative of hospital systems, clinics, and other providers who provide care for the uninsured and the underinsured in Central Texas. ICC manages and continues to develop the ICare System which offers treatment support and provides data for research and program analysis on the uninsured.
→ Organizations Involved: Numerous local health care agencies, hospitals, and public clinics throughout Central Texas.
→ Data and Functions: Demographic information, encounter data, medications data, and lab results.
→ Stage 7
13. KLEBERG RURAL HEALTH NETWORK - KLEBERG COUNTY

The Kleberg Rural Health Network seeks to build a continually adapting, open, self-sustaining health information system that can demonstrate quantifiable social, clinical, and economic benefits for county patients and providers. A goal of the project, in addition to preparing physicians to implement electronic medical records, is to implement an HIE focused on improving outcomes for high-prevalence, high-cost chronic diseases.

→ Organizations Involved: Three rural health care providers, a children’s health insurance plan, and Texas A&M Kingsville.

→ Data and Functions: Lab transactions, electronic prescribing, and clinic registry model that will trigger patient appropriate interventions.

→ Stage 4

14. NORTH TEXAS EMERGENCY DEPARTMENT HIE - DALLAS-FORT WORTH

The Dallas-Fort Worth Hospital Council and the Dallas-Fort Worth Hospital Council Education and Research Foundation are working with 75 hospital members, medical societies, third party payers, and other ancillary service providers to implement an HIE that will eliminate duplicative medical procedures and focus on patient safety, readmissions, and comparative effectiveness. The Foundation hosts a data warehouse with historical data for member hospitals and has developed a regional master patient index to track, analyze, and study readmissions and comparative effectiveness. A planned subset of this HIE will be to eliminate duplicative procedures and promote better patient safety in emergency departments at many North Texas hospitals.

→ Organizations Involved: Dallas-Fort Worth Hospital Council Members and the Dallas-Fort Worth Hospital Council Education and Research Foundation.

→ Data and Functions: Encounter data and comprehensive integration strategies.

→ Stage 2

15. NORTH TEXAS HIE/HIE 5 - DALLAS

The North Texas HIE, also known as HIE5, aims to create an electronic exchange of patient information between providers and build a comprehensive master patient index for the county.

→ Organizations Involved: The Dallas County Medical Society, ProPath, and several ancillary service providers.

→ Data and Functions Demographic information, lab results, imaging, and medication history.

→ Stage 3
16. SANDLOT - FORT WORTH

SandlotConnect®, which went live in Fort Worth in 2008, serves over a million patients and more than 800 providers. The HIE allows for the flexible exchange of information between physicians, healthcare systems, and future networks. The project seeks to continue to add functionality and improve the existing data and communication infrastructure.

→ Organizations Involved: Numerous clinics, hospitals, and local health care agencies, throughout Tarrant County.

→ Data and Functions: Electronic-prescribing, imaging, lab results, electronic medical record, continuity of care record, continuity of care document, electronic referral, and secure messaging.

→ Stage 6

17. SOUTHEAST TEXAS HEALTH SYSTEM - RURAL SOUTHEAST

STHS, located in Goliad, is planning a system that will send patient referrals to neighboring metropolitan health care centers. Building on earlier HIE experience, STHS is developing a business process model and a formal HIT governance structure to create a foundation to securing additional funding for development and.

→ Organizations Involved: Brazos Port Regional Health System, Matagorda County Health District, Memorial Medical Center in Port Lavaca, DeTar Health System, Lavaca Medical Center, and Columbus Community Hospital.

→ Data and Functions: Demographic information, medications, and allergy information for referrals.

→ Stage 2

18. TEXAS HEALTH INFORMATION NETWORK COLLABORATIVE - STATEWIDE

The Texas Health Information Network Collaborative (THINC) is a consortium created to enhance connectivity for expanding healthcare accessibility and availability through the utilization of telecommunications and information services. The THINC HIE project, funded through a Federal Communications Commission grant, will design construct, and maintain a secure, effective, and sustainable broadband telecommunications network.

→ Organizations Involved: More than 200 healthcare facilities in the state.

→ Data and Functions: The functions to be implemented are still under consideration.

→ Stage 2
<table>
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</tbody>
</table>

Operational HIEs
### APPENDIX G – Texas Broadband Grant Awardees

**Table 17. Texas Broadband Grant Awardees**

<table>
<thead>
<tr>
<th>Name</th>
<th>Description</th>
<th>Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Texas Healthcare Information Network for Collaboration (THINC)</td>
<td>THINC received $16 million in 2007 funding from the Federal Communications Commission to support a Rural Health Care Mechanism Pilot program in Texas. This funding represented 85 percent of first year development costs, with the other 15 percent funded through membership and user fees. The state’s largest provider of rural healthcare services, CHRISTUS Health System, is the fiscal agent for and statewide coordinator for the consortium.</td>
<td>$16,000,000</td>
</tr>
<tr>
<td>TierOne Converged Networks, Inc. TX</td>
<td>This approximately $19 million award, will allow TierOne Converged Networks, Inc. to offer broadband service speeds of up to 6.5 megabytes per second in 11 north Texas counties.</td>
<td>$19,244,200</td>
</tr>
<tr>
<td>DOC - Peoples Telephone Cooperative TX</td>
<td>This approximately $28.8 million award will allow the People Telephone Cooperative (PTC) to offer affordable middle-mile broadband service in eastern Texas. The project plans to directly connect as many as 190 community institutions to broadband.</td>
<td>$28,825,356</td>
</tr>
<tr>
<td>DOC - Texas A&amp;M University TX</td>
<td>This approximately $6.6 million award, with nearly $3 million in matching contributions, will allow Texas A&amp;M University System to offer affordable middle-mile broadband service in areas of Texas. The project plans to connect almost 50 community anchor institutions, including more than 12 institutions of higher education serving more than 110,000 students and 27,000 faculty and staff.</td>
<td>$6,550,775</td>
</tr>
<tr>
<td>DOC - City of Brownsville TX</td>
<td>This approximately $865,000 award, matched more than $370,000 in matching contributions, will allow the City of Brownsville, Texas to foster economic growth by increasing public computer access and awareness of the benefits of broadband.</td>
<td>$865,920</td>
</tr>
<tr>
<td>DOC - Library &amp; Archives Commission, State TX</td>
<td>This approximately $8 million award, with nearly $3.7 million in matching contributions, will allow the Texas State Library &amp; Archives Commission to deploy the Technology, Expertise, Access and Learning for all Texans (TEAL) project which will provide greater broadband computer access at faster speeds by upgrading 125 public computer centers and establishing approximately 30 new centers equipped with 2,200 new workstations.</td>
<td>$7,955,941</td>
</tr>
</tbody>
</table>
APPENDIX H – Regional Extension Center Technical Support

Providers seeking to meaningfully use electronic health records (EHRs) face a variety of challenging tasks, which experience has shown that robust local technical assistance can result in effective implementation of EHRs and quality improvement. Therefore, Texas Medicaid is seeking to obtain the support of the four Texas Health Information Technology (IT) Regional Extension Centers (RECs) to provide support to Medicaid providers not currently addressed by the Office of the National Coordinator (ONC) for Health IT, specifically:

- dentists,
- specialty physicians, and
- Not-for-profit community hospitals under 100 beds that serve areas designated as medically underserved.

Texas Medicaid expects that each REC will provide services to the Medicaid provider groups specified above, consistent with ONC specifications for the priority primary care practitioner. ONC’s purpose and goals for the RECs is to provide education, outreach, and technical assistance to providers in their geographic service areas select, successfully implement, and meaningfully use certified EHR technology to improve the quality and value of health care. Consistent with these goals, RECs help providers achieve compliance with the Medicare and Medicaid EHR Incentive Program. The specific scope of service the RECs will be expected to provide for Texas Medicaid is:

1. **Education and Outreach to Providers** – The RECs will provide for dissemination of knowledge about the effective strategies and practices to select, implement, and meaningfully use certified EHR technology to improve quality and value of healthcare. At a minimum, this support should consist of materials designed to be widely and rapidly disseminated, both for provider self-study and for use by other RECs. Other education and outreach activities can include, but are not limited to:

   - support of regional communities of practice for providers and those who support their health IT implementation;
   - health IT training events for clinical professionals and their support staff; and
   - instruction and assistance on using health IT to enhance the patient-provider relationship and encourage patient self-management.

Training events, programs, and communities of practice may be co-sponsored with other local resources, such as (but not necessarily limited to) state and local health services oversight agencies, professional organizations, provider organizations, and consumer organizations.

2. **Vendor Selection** - This includes assistance in assessing the health IT needs of providers, and selecting and negotiating contracts with vendors or resellers (of EHR systems, hardware and network infrastructure, and IT services). RECs should assist providers in holding vendors accountable for adhering to service level agreements. RECs are expected to offer
unbiased advice on the systems and services best suited to enable the providers to become meaningful users of EHRs. RECs will avoid entering into business arrangements creating an actual or apparent conflict of interest with the REC’s obligation to act solely in the best interests of advancing meaningful use of certified health IT by the providers it serves.

3. **Project Oversight** - RECs will provide project oversight support, including individualized and on-site coaching, consultation, troubleshooting, and other activities required to assure that the supported provider is able to assess and enhance organizational readiness for health IT, assess and remediate gaps in IT infrastructure, configure the software to meet practice needs and enable meaningful use, ensure adequate software training for all staff, and track and adhere to implementation timelines.

4. **Practice and Workflow Redesign** - RECs will provide support for practice and workflow redesign necessary to achieve meaningful use of EHRs. This support will require working with the providers, and their EHR vendor(s), to implement and troubleshoot the use of the EHR system for the consistent documentation of essential clinical information in structured format, instituting electronic administrative transactions, electronic prescribing, electronic laboratory ordering and resulting, sharing key clinical data across practice settings, providing patient access to their health information, public health reporting, and policies and practices that protect the privacy and security of personal health information. RECs must be capable of mapping and redesigning work processes, updating roles and responsibilities for clinicians and support staff, and leading continuous quality improvement activities involving rapid cycle feedback.

5. **Functional Interoperability and Health Information Exchange** – RECs will assist providers in connecting to available health information exchange infrastructure(s), including local health information exchange organizations and state-based shared utilities or directory services in compliance with applicable statutory and regulatory requirements, patient preferences, and the state plans for health information exchange. RECs will focus on meeting the functional interoperability needs of practices, including, but not limited to the electronic exchange of administrative transactions, laboratory orders and results, medication prescriptions, quality and public health reports, patient summaries, and the information required to ensure continuity across the spectrum of care.

6. **Privacy and Security Best Practices** – RECs will support providers in implementing best practices with respect to the privacy and security of personal health information, including: implementation and maintenance of physical and network security, user-based access controls, disaster recovery, encryption and storage of backup media, human resources training and policies; and identification of state laws and regulatory requirements that impact privacy and security policies for electronic interoperable health information exchange.

7. **Progress Towards Meaningful Use** – The RECs’ personnel shall participate in program training and be able to provide their clients effective assistance in attaining meaningful use. Participation in this training will also assure that the educational and informational offerings to providers in the centers’ geographic areas are accurate and aligned with, but not
duplicative of, the education and outreach on the provider incentives that will be furnished to providers nationwide by CMS. RECs shall review the utilization of the EHRs within their participating practices, and provide appropriate feedback and support to improve low utilization of features essential for meaningful use (e.g., electronic prescribing). Where structural, technical, or policy barriers hinder progress, the RECs will work with the HITRC and local stakeholders to report to ONC the existence and nature of these barriers. RECs will also help priority primary-care providers to understand, and implement technology and process changes needed to attain MU requirements and demonstrate this achievement.

**Fees**
Texas Medicaid will pay fees consistent with ONC provisions, plus the 10% state match to be paid by the provider or hospital in accordance with the following fee schedule and achievement of milestones:

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>REC Fee</th>
<th>Plus 10% Provider Fee</th>
<th>#Potential Providers</th>
<th>Total Estimated Costs*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist</td>
<td>$ 5,000</td>
<td>$ 500</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>Physician Specialist</td>
<td>$ 5,000</td>
<td>$ 500</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>Community Hospital</td>
<td>$18,000</td>
<td>$1,800</td>
<td>100</td>
<td>$1,800,000</td>
</tr>
</tbody>
</table>

* Estimated costs over the life of the program since the providers need to achieve meaningful use in order to be paid for the final milestone.

The ultimate measure of a REC’s effectiveness will be whether it has assisted providers in becoming meaningful users of certified EHR technology. Payments to the RECs will be equally divided with achievement of the three milestones. Program outcomes will be assessed consistent with ONC quantitative performance measures and milestones:

- Milestone 1: signed contracts
- Milestone 2: certified EHR implementation
- Milestone 3: Achievement of meaningful use