NEW YORK STATE OF OPPORTUNITY. | **Department of Health**

State Medicaid HIT Plan (SMHP) Update

New York Medicaid

Electronic Health Records Incentive Program

May 10, 2019

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Executive Summary

This State Medicaid Health Information Technology (HIT) Plan (SMHP), lays out the processes, systems, goals, and initiatives New York State (NYS) will employ to continue to implement and oversee the Medicaid Electronic Health Record (EHR) Incentive Program. To support the continued success of the program, NY Medicaid will continue to provide resources and tools to support providers in achieving and attesting to Meaningful Use (MU) of Certified EHR Technology (CEHRT).

In these endeavors, NY Medicaid will:

- Support the administration of incentive payments to Medicaid eligible professionals (EPs) and eligible hospitals (EHs);
- Continue to build and support the Medicaid EHR Incentive Program Administrative Support Service (MEIPASS);
- Provide oversight of the Medicaid EHR Incentive Program, including routine tracking of MU attestations and reporting mechanisms; and
- Pursue initiatives that encourage the adoption of CEHRT for promoting health care quality and health information exchange (HIE).

This SMHP describes not only efforts currently being undertaken, but also describes future efforts that will continue to promote the adoption and MU of CEHRT, increase provider participation in the NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability Program, improve interoperability, and support a shift to a value-based healthcare system.

In order to improve the quality of care, population health, and reduce costs, it is imperative that care is better coordinated and managed, especially for high needs/high cost patients. To support this, NYS is continuing to develop a robust HIT infrastructure inclusive of EHRs and Qualified Entities (QEs) connected to the Statewide Health Information Network for New York (SHIN-NY), leading to the development of a high-functioning HIT infrastructure, which enables vital patient information sharing.

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Section A
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The State's "As-Is" HIT Landscape

A. The State's "As-Is" HIT Landscape

1. What is the current extent of EHR adoption by practitioners and by hospitals? How recent is this data? Does it provide specificity about the types of EHRs in use by the State's Providers? Is it specific to just Medicaid or an assessment of overall statewide use of EHRs? Does the SMA have data or estimates on eligible providers broken out by types of provider? Does the SMA have data on EHR adoption by types of provider (e.g. children's hospitals, acute care hospitals, pediatricians, nurse practitioners, etc.)?

Since the inception of the New York (NY) Medicaid Electronic Health Record (EHR) Incentive Program in 2011, NY has disbursed nearly 38,000 incentive payments to more than 18,700 unique Eligible Professionals (EPs) and Eligible Hospitals (EHs) totaling more than $960 million dollars. Provider participation in Payment Year 2016 grew to more than 5 times the level of participation in Payment Year 2011. The success of NY's significant provider participation is largely attributable to robust provider outreach activities coupled with development and enhancement of comprehensive educational materials for the NY Medicaid EHR Incentive Program. As the program draws to a close with the final participation year of 2021 approaching, it is NY's goal to continue to engage providers and maximize participation for the remaining years.

The tables below represent the current extent of EHR adoption by EPs and EHs participating in the NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability Program, as of January 2019. This also includes a breakdown of Eligible Providers broken out by provider type.

The data below do not provide specificity about the types of EHRs in use by the State's providers and provider types. Due to the large variety of EHRs being utilized, the data was not included in this report. However, the State provides a detailed report on which EHRs NY Medicaid EHR Incentive Program participants utilize quarterly to CMS for their use and reporting.

Exhibit 1. Program Participants and Payments

	Unique Providers	# of Payments	Payment Total
Eligible Professionals	18,613	37,260	$550,326,920
Eligible Hospitals	171	486	$410,571,431
Total	**18,784**	**37,746**	**$960,898,351**

	Eligible Professionals		Eligible Hospitals	
	Number Paid	Total Paid	Number Paid	Total Paid
Participation Year 1	18,613	$392,919,706	171	$206,993,925
Participation Year 2	7,984	$67,215,243	165	$163,074,584
Participation Year 3	4,924	$41,570,700	150	$40,502,922
Participation Year 4	3,075	$26,029,846	N/A	N/A
Participation Year 5	1,801	$15,268,838	N/A	N/A
Participation Year 6	863	$7,322,587	N/A	N/A
Payment Year 2011	3,378	$70,868,793	82	$99,191,574
Payment Year 2012	5,401	$94,674,462	123	$152,847,579
Payment Year 2013	6,145	$87,425,383	129	$104,672,034
Payment Year 2014	6,649	$90,972,718	101	$41,547,617
Payment Year 2015	5,939	$79,693,196	28	$6,534,819
Payment Year 2016	7,398	$106,802,648	15	$3,850,197
Payment Year 2017	2,350	$19,889,720	8	$1,927,610
Total	37,260	$550,326,920	486	$410,571,431

Exhibit 2. Program Eligible Provider Types and Participants

Participation Year	Provider Type	Paid Providers	Total Amounts Paid
1	Acute Care Hospitals	196	$ 206,887,630.75
	Children's Hospitals	1	$ 1,837,958.00
	Certified Nurse Midwife	380	$ 8,032,500.00
	Dentist	2,559	$ 40,353,750.00
	Nurse Practitioner	2,740	$ 57,885,000.00
	Physician	13,331	$ 277,163,873.00
	Physician's Assistant	29	$ 616,250.00
Participation Year 1 Total		19,236	$ 592,776,961.75
2	Acute Care Hospitals	188	$ 159,861,462.47
	Children's Hospitals	1	$ 1,470,366.00
	Certified Nurse Midwife	178	$ 1,496,000.00
	Dentist	345	$ 2,439,500.00
	Nurse Practitioner	1,179	$ 9,800,500.00
	Physician	6,384	$ 52,385,575.00
	Physician's Assistant	9	$ 76,500.00
Participation Year 2 Total		8,284	$ 227,529,903.47
3	Acute Care Hospitals	155	$ 39,877,969.07
	Children's Hospitals	1	$ 367,592.00
	Certified Nurse Midwife	118	$ 1,003,000.00
	Dentist	145	$ 1,147,500.00
	Nurse Practitioner	655	$ 5,550,500.00
	Physician	4,013	$ 33,728,033.00
	Physician's Assistant	3	$ 25,500.00
Participation Year 3 Total		5,090	$ 81,700,094.07
4	Acute Care Hospitals	0	$ -
	Children's Hospitals	0	$ -
	Certified Nurse Midwife	80	$ 680,000.00
	Dentist	37	$ 314,500.00
	Nurse Practitioner	373	$ 3,170,500.00
	Physician	2,581	$ 21,833,679.00
	Physician's Assistant	1	$ 8,500.00
Participation Year 4 Total		3,072	$ 26,007,179.00
5	Acute Care Hospitals	0	$ -
	Children's Hospitals	0	$ -
	Certified Nurse Midwife	47	$ 399,500.00
	Dentist	18	$ 153,000.00
	Nurse Practitioner	214	$ 1,819,000.00
	Physician	1,520	$ 12,880,338.00
	Physician's Assistant	0	$ -
Participation Year 5 Total		1,799	$ 15,251,838.00
6	Acute Care Hospitals	0	$ -
	Children's Hospitals	0	$ -
	Certified Nurse Midwife	18	$ 153,000.00
	Dentist	8	$ 68,000.00
	Nurse Practitioner	89	$ 756,500.00
	Physician	747	$ 6,336,587.00
	Physician's Assistant	0	$ -
Participation Year 6 Total		862	$ 7,314,087.00
Grand Total		38,343	$ 950,580,063.29

2. To what extent does broadband internet access pose a challenge to HIT/E in the State's rural areas? Did the State receive any broadband grants?

NY Medicaid recognizes that broadband internet access has an impact on successful adoption of EHR technology. In 2009, the Office of the New York State (NYS) Chief Information Officer and Office for Technology (CIO/OFT) released the results of an effort on the part of the NYS Council for Universal Broadband to map the estimated availability of wired broadband internet access throughout the State. The results of this study suggest that while broadband internet access is unlikely to be a barrier to Health Information Technology/Exchange (HIT/E) activities in most areas, New York, like most states, will have broadband access challenges in certain locations.

Recognizing that more rigorous and detailed information on broadband access was needed, the NYS Office for Cyber Security and Critical Infrastructure Coordination (CSCIC) has conducted a project funded by the National Telecommunications and Infrastructure Association (NTIA) to study broadband access and infrastructure and to map NY's unserved and underserved areas. This effort incorporates data from many sources, including proprietary data from internet service providers and validation by telephone and internet-based surveys. Analysis of availability of broadband in NYS began in February 2009 by the Broadband Mapping Unit (BMU) at the Geographic Information Systems (GIS) Program Office. In November 2012, the broadband mapping program was transferred from the Office of Cyber Security (OCS) within the NYS Division of Homeland Security to the NYS Office of Information Technology Services (ITS). A comprehensive map of broadband availability in NYS was completed in 2014.

In 2015, Governor Andrew M. Cuomo, with legislative support, established the $500 million New NY Broadband Program. The program provides NYS grant funding to support projects that deliver high-speed internet access to unserved and underserved areas of the State, with priority to unserved areas, libraries, and educational opportunity centers. At the inception of the New NY Broadband Program, 1 million residents and 4,000 businesses lacked access to the minimally qualifying level of broadband, 6Mbps/1.5Mbps, 5.4 million residents and 55,000 businesses were unable to access broadband speeds of 25Mbps/ 10Mbps, and 70% of New York State, or 7 million residents and 113,000 businesses were unable to access 100Mbps/10Mbps broadband speeds. The New NY Broadband Program, the largest and most ambitious state investment in broadband in the nation, set a goal of achieving statewide broadband access at minimum speeds of 25Mbps by the end of 2018.

Prior to launching the New NY Broadband Program, the NYS Broadband Program Office (BPO) conducted statewide outreach to interested parties and stakeholders, to provide the public with an opportunity to contribute their ideas and recommendations on the program's design and structure. The BPO accepted applications for the program's first funding round from March 1 – April 15, 2016 and awarded $54.2 million of state funding and an additional $21.6 million in private

sector funding to support 25 broadband deployment projects. This investment spanned 27 counties including underserved and unserved areas of NYS including public libraries, community organizations, government locations, and healthcare facilities. NYS accepted applications for Phase 2 of the New NY Broadband Program from October 17th – November 30th, 2016. Phase 2 resulted in the awarding of $212 million in grants to support 54 additional projects expanding broadband access to 89,514 homes and businesses across the state. Phases I and II of the program in combination with the execution of provider mandates from the NYS Public Service Commission brought access to 98% of the state's population.

The Federal Communications Commission (FCC), as part of its Connect America Fund (CAF), offered funding to providers to service certain areas in NYS. $170 million of that funding that would have been allocated to NYS was declined. In a bipartisan effort, NYS wrote to the FCC urging them to keep the unclaimed funding in NYS to help expand broadband. The BPO launched a solicitation of interest to potentially address these territories in October 2016 and the State continued an ongoing lobbying effort to secure the funding.

On January 26, 2017 the FCC voted to allocate the $170 million to NY, keeping the funds in NY. The federal funding will be used in conjunction with existing state resources to fund certain areas of Round 3 of the New NY Broadband Program, which will bring high-speed internet services to NY's most unserved rural areas. The $500 million New NY Broadband Program, already the largest and most ambitious investment in broadband in the nation, will now reach $670 million. It is anticipated that this final round of funding, announced in March 2018, will accomplish the program goal of "broadband for all" by expanding access to 2.2 million residents ensuring that all New Yorkers have access to internet speeds up to 300 Mbps by the end of 2019 closing the digital divide in NYS and achieving the Governor's goal of "Broadband for All".[1] With the effective implementation of these initiatives access to broadband should not hinder the adoption or meaningful use of EHRs in NYS.

3. Does the State have Federally-Qualified Health Center networks that have received or are receiving HIT/EHR funding from the Health Resources Services Administration (HRSA)? Please describe.

Federally-Qualified Health Centers (FQHCs), commonly known as Community Health Centers, are community-based primary care health centers that serve anyone, regardless of their ability to pay or their status with health insurance coverage. NYS has more than 90 FQHCs operating at more than 800 individual sites in every region of the state, serving more than 2.2 million patients annually. The Community Health Care Association of New York State (CHCANYS) operates as the voice of community health centers as the leading providers of primary health care in NY.

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[1] http://www.nysac.org/files/BroadbandUpdateReport2017(1).pdf

In 2012, Health Resources Services Administration (HRSA) announced 37 Health Center Network grants totaling $18 million awarded across the country including one FQHC in NYS.[2] In 2013, because of auxiliary funding through the Affordable Care Act (ACA), six additional grants were made available to expand the use of HIT, one of which was awarded to a NYS based FQHC. These HRSA Health Center Network grants were awarded to support the implementation and adoption of health information technology (HIT) through the adoption and meaningful use of certified EHR technology (CEHRT) and technology-enabled quality improvement strategies. To promote the sharing of knowledge and expertise to address operational and clinical needs, these grants required that recipient health centers represent a collaborative of at least 10 health center organizations.

In August 2018 it was announced that 63 FQHCs in NYS would receive HRSA Health Center Quality Improvement FY2018 Grant awards, totaling $7.5 million across the state.[3] Each of these 63 unique FQHCs received the Advancing HIT Award, reserved for FQHCs that utilize HIT systems improve access to and quality of care received in their community. In addition, 53 of these FQHCs also received the EHR Reporters Award, representing their successes in the use of EHRs to report on Clinical Quality Measure (CQM) data for all patients.

4. Does the State have Veterans Administration or Indian Health Service clinical facilities that are operating EHRs? Please describe.

Veterans Administration

The Veterans Health Administration of the Department of Veterans Affairs (VA) operates twelve medical centers, forty-eight Community-Based Outpatient Clinics (CBOCs), and sixteen Vet Centers throughout the state. The VA currently operates a custom EHR, the Computerized Patient Record Service (CPRS), as part of the overall Veterans Health Information Systems and Technology Architecture (VistA).

VA hospitals have collaborated to exchange medical record information electronically with Qualified Entities (QEs) in their regions. HEALTHeLINK, a QE in Western NY, and HealtheConnections in the Syracuse region have established bi-directional exchange with the VA for their respective regions. QEs in Rochester and the Bronx are testing for a bi-directional exchange and have agreements for VA providers to access information with patient consent. The other QEs are actively working to achieve full connectivity with the VA facilities in their regions.

In a decision made in June of 2017 by then VA Secretary, Dr. David Shulkin, the Department of Veteran's Affairs will be transitioning to a commercial off the shelf (COTS) EHR solution developed by Cerner Millennium (Cerner).[4] The VA will be making the transition to Cerner over the course of the next ten years, a move that

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[2] https://bphc.hrsa.gov/programopportunities/qualityimprovement/awards.aspx?state=NY

[3] https://www.hrsa.gov/about/news/press-releases/2013-08-01-hccn.html

[4] https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2914

will foster interoperability not just between the VA and the Department of Defense but also with civilian care organizations across the country.[5]

Indian Health Service

Currently NY has eight federally recognized tribes within its borders as well as the American Indian Community House (AICH), which offers services to American Indians and Alaska Natives (AI/AN) from all areas of the country. Per NYS Public Health Law § 201(1)(s), NYS Department of Health (NYS DOH) is required to administer to the medical needs of Indians on reservations. In addition to federal funds provided by the Indian Health Service (IHS), NYS DOH provides supplemental funding for health care for nine Indian nations in the state. State funded clinics on Indian reservations have been in existence for more than three decades.

IHS has provided a clinical information system to four tribal outpatient clinics in NY: Oneida Indian Nation Health Program in Oneida, St Regis Mohawk Health Services in Akwesasne, and Seneca Nation of Indians in Allegany and Cattaraugus Counties. The Resource and Patient Management System (RPMS), is based on the VA's VistA infrastructure. Two other tribes, the Tonawanda and Tuscarora, use Electronic Medical Record (EMR) contract managers for their EHRs.

RPMS has been utilized by IHS for 33 years and, through partnership and cost sharing with the U.S. Department of Veteran's Affairs, IHS has been able to develop and design specific applications to meet the unique needs of the Indian healthcare delivery system. On June 5, 2017, the VA announced its plans to modernize their EHR and move from the current VistA to a COTS system. This announcement forced IHS to evaluate the future of RPMS to determine if the agency can maintain costs without the support of the VA or if the IHS too should consider a new option. This decision is still pending legislative action.[6]

5. What stakeholders are engaged in any existing HIT/E activities and how would the extent of their involvement be characterized?

NYS has engaged various stakeholder groups throughout the planning and implementation of the NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability Program. Through the development of relationships with other state agencies as well as non-profit and private sector partners the state was able to establish an extensive outreach plan ensuring that providers have been informed of the requirements and the benefits of EHR meaningful use. This outreach has been made possible through collaboration with provider groups across the state as well as through the diligent efforts of the two NYS Regional Extension Centers (RECs). The RECs continue to facilitate provider education and engagement in the NY Medicaid EHR Incentive Program.

Medicaid providers make up one of the largest stakeholder groups vested in HIT/HIE. NYS has developed an extensive outreach program to inform Medicaid

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[5] https://www.va.gov/vetdata/docs/SpecialReports/State_Summaries_New_York.pdf

[6] https://www.usetinc.org.

providers of the requirements and benefits of the NY Medicaid EHR Incentive Program. As part of this outreach, NYS DOH engaged with various associations representing the provider population to better educate providers, hospitals, and institutions. Partnering organizations include; Healthcare Association of New York State (HANYS), HIT Strategy Group, Greater New York Hospital Association (GNYHA), Healthcare Financial Management Association (HFMA) – Metropolitan Chapter, and various Meaningful Use collaboratives hosted by the RECs.

Outreach performed by NYS DOH has included webinars, collaboratives, reference materials, tutorials, newsletter, a public website, and a dedicated support center. The focus of these resources is varied and include registration, Meaningful Use (MU), the attestation submission process, as well as programmatic information such as Medicaid EHR Incentive Program guidelines and deadlines, eligibility information, and Medicaid EHR Incentive Program Administrative Support Service (MEIPASS).

NYS has also focused on engaging Medicaid MU eligible and supportive provider organizations to connect to the Statewide Health Information Network for New York (SHIN-NY) to realize the benefits of health information exchange and facilitate Medicaid providers in achieving meaningful use. New York eHealth Collaborative's (NYeC) and the QEs' work in this area is explained in question A9.

In addition to outreach, education, and guidance made possible through external relationships with stakeholders, NY has been able to leverage relationships among various state agencies to ensure the integrity and continuous improvement of the of the program and the overall HIT landscape in the state. Through coordinated efforts, NYS has incorporated the appropriate oversight and auditing of the EHR incentive program, MU, and data integrity. These state agency relationships ensure not only compliance with all federal regulations, requirements, and guidance on implementation, privacy, and security but have also been instrumental in moving the State toward a HIT environment that supports interoperability and re-use. These relationships are detailed in response to question A6 below.

6. Does the SMA have HIT/E relationships with other entities? If so, what is the nature (governance, fiscal, geographic scope, etc.) of these activities?

NY Medicaid assigned the Division of Operations and Systems (DOS) the responsibility of administering the Medicaid EHR Incentive Program. DOS administers Final Rule guidelines provided by CMS and additional guidelines, as defined by NY Medicaid, within their authority.

DOS is responsible for the management of contracts related to the administration of the NY Medicaid EHR Incentive Program. Activities that fall under this DOS responsibility include:

- Managing the contract requirements as they relate to the design, development, implementation (DDI) and maintenance of the MEIPASS system.
- Expanding the capacity of the current help desk to support eligible providers using MEIPASS.

- Providing technical assistance to providers to assist them as they utilize MEIPASS to attest to MU activities.

NY Medicaid EHR Incentive Program staff will interact as necessary with other DOS staff in supporting the integration and coordination of MEIPASS within NY's Medicaid Management Information System (MMIS).

NYS Office of the Medicaid Inspector General (OMIG)

OMIG integrates the audit requirements of the NY Medicaid EHR Incentive Program into its audit processes and work plan to ensure proper payments are made. OMIG staff conduct audits and reviews of Medicaid providers to ensure compliance with program requirements and recover overpayments, as needed. They dedicate a combination of State and contractor staff to EHR Incentive Program oversight and ensure execution of the NY's approved audit strategy. This oversight responsibility is assigned to the Division of Medicaid Audit (DMA). Oversight staff develop and update as needed the policy and program review methodology. This includes identifying the resource requirements, processes, and needs of OMIG to test, audit, and effectively measure providers' adherence with program requirements. Staff analyze the data submitted by providers receiving payment from the NY Medicaid EHR Incentive Program and execute necessary controls for oversight of program funds. Additionally, these staff draft audit procedures used by contracted auditors to conduct random and targeted desk and field reviews of individual providers enrolled in the NY Medicaid EHR Incentive Program.

NYS continues to receive guidance from CMS on the development of the joint Medicare/Medicaid audit strategy. OMIG reviews and assesses the CMS-provided guidance and modifications to the audit strategy to ensure that OMIG policies and program review methodologies are consistent with Federal recommendations. Additionally, in collaboration with NYS DOH, OMIG is leading an inter-state focus group to both learn from and provide best practices on program compliance across states. OMIG will modify audit processes as needed to support these strategies.

NYS DOH Office of Quality and Patient Safety (OQPS)

OQPS, in its role overseeing the SHIN-NY, is responsible for administration and management of Health Information Technology for Economic and Clinical Health (HITECH) Act HIE activities. Through a combination of NYS and contractor staff, OQPS executes and administers contracts with NYeC, the provider of statewide services and QE services; and other entities as needed, to support the statewide implementation of HIE services and enhance capabilities within the SHIN-NY to support providers' achievement of MU objectives and enhance program oversight and management. OQPS also oversees HIT policy related to information exchange on behalf of NYS DOH.

NYS DOH Office of Public Health (OPH)

OPH is the office within NYS DOH that oversees public health reporting. OPH's role is to work with NY Medicaid to ensure that the public health reporting requirements meet both Medicaid EHR Incentive Program requirements and NYS public health reporting regulations, so OPH can continue to use the data to execute its public health oversight. In this role, OPH dedicates a combination of NYS and contractor

resources to provide subject matter expertise on the initiatives that impact Medicaid EHR Incentive Program administrative components associated with public health reporting and the public health data message conformance.

NYS Office of Mental Health (OMH)

OMH executes the state portion of the OMH connectivity to the SHIN-NY initiative, exploring the capacity for bi-directional exchange of clinical and administrative health information with QEs and NYS OMH-operated psychiatric facilities. OMH operates 24 psychiatric centers and almost 100 affiliated clinics, and regulates, certifies, and oversees more than 4,500 programs operated by local governments and nonprofit agencies. This large, multi-faceted mental health system - comprised of inpatient and outpatient programs, emergency, community support, residential and family care programs – serves over 700,000 individuals each year.

NYS Office of Information Technology Services (OITS)

OITS provides centralized IT services to NYS agencies, sets technology policy for all NYS agencies, and monitors all large technology expenditures. OITS dedicates a combination of NYS and contractor resources to provide oversight for IT security policies, IT project management reporting, and technical architecture for all NYS agency DDI initiatives that include technology system development or enhancement. This includes providing technical oversight, guidance, and overseeing Procurement Services Hourly Based Information Technology Services (HBITS) contractor staff for the Meaningful Use Registration for Public Health (MURPH) system and the public health data message conformance enhancements.

NYC REACH and NYeC

NYS has two RECs, the New York City Regional Electronic Adoption Center for Health (NYC REACH) and the New York eHealth Collaborative (NYeC). The two RECs aid in the recruitment and retention of eligible medical professionals and have supplied Medicaid providers with an array of EHR assistance including counseling and guidance on the adoption, implementation, and meaningful use of CEHRT for MU through educational materials and hosted events.

NYC REACH is currently developing a statewide MU curriculum to support NYS's efforts to maintain or increase provider engagement in the NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability Program. NYC REACH will ensure distribution of this curriculum to all New York City (NYC) providers and NYeC will be responsible for distribution of the curriculum to providers across the remainder of the state.

NYeC, under the direction of NYS DOH, also facilitates the SHIN-NY, a network composed of seven QEs that connect health care providers across the state on a local level. The SHIN-NY is an integral part of improving the quality of patient care, reducing unnecessary health care expenditures, and promoting NYS policy objectives. Use of the SHIN-NY is not only a valid approach to achieve these goals but also a critical tool for providers to meet MU criteria.

Qualified Entities (QEs)

In connection with NYS DOH's efforts on the SHIN-NY, NYS DOH established a public/private partnership with NYeC and the regional health information organizations (RHIOs) that participate in the SHIN-NY as QEs. Through its contract with NYS DOH, NYeC is responsible for sub-contracting with the QEs to provide (1) support to enhance program oversight of implementation activities, (2) late stage implementation of statewide HIE services (participation in SHIN-NY governance, data governance, technical investigation and bug-fixes/enhancements, provision of new MPI licenses, etc.), (3) support the onboarding of Medicaid MU eligible and supportive providers, (4) delivering education and training activities for Medicaid MU eligible and supportive providers, and (5) DDI solutions for Security Gap Closure and Enabling Quality Measurement.

Each QE must comply with the defined SHIN-NY policy standards and provide a minimum level of technical and member services to QE participants in their region. The QE must demonstrate that they meet the SHIN-NY regulatory requirements to be certified as a QE by the NYS DOH.

7. Specifically, if there are health information exchange organizations in the State, what is their governance structure and is the SMA involved? ** How extensive is their geographic reach and scope of participation?

The SHIN-NY, overseen by the NYS DOH and facilitated by NYeC, is a network-of-networks composed of seven QEs across the state that connects healthcare providers (hospitals, health plans, individual practitioners, and public health officials) on a local level. The SHIN-NY serves hundreds of hospitals, thousands of medical providers, and millions of people who live in or receive care in NYS.

The SHIN-NY governance model is an open, transparent process, with the Statewide Collaborative Process (SCP) at its foundation. The SCP outlines how NYS DOH collaborates with stakeholders who engage in HIE, and other impacted stakeholder groups including patients/consumers. NYS DOH relies upon the SCP in developing common policies and procedures, standards, technical approaches, and services to support NYS's HIE infrastructure.

The NYS DOH is the SHIN-NY regulatory authority, and in this role considers SHIN-NY policy and technical implementation guidance recommendations from the SCP. NYS DOH oversees the implementation and ongoing operation of the SHIN-NY, including:

- Implementation of infrastructure and services to support the private and secure exchange of health information among QEs and QE participants;
- Performance of regular audits of QE functions and activities to ensure data quality, security, and confidentiality within the SHIN-NY;
- Provision of technical services to ensure the quality, security, and confidentiality of data in the SHIN-NY;
- Assessment of QE participation in the SHIN-NY and, if necessary, suspension of a QE's access to or use of the SHIN-NY;
- Publication of reports on health care provider participation and usage, system performance, data quality, the QE certification process, and SHIN-NY

security, and any other actions as may be needed to promote development of the SHIN-NY.

The SHIN-NY operates under a set of agreements between NYS DOH, NYeC (the provider of statewide services), QEs, and QE participants. These agreements ensure and promote the exchange of clinical information among authorized users for authorized purposes to improve the quality, coordination, and efficiency of patient care, reduced medical errors and carry out public health and health oversight activities, while protecting privacy and security. Pursuant to such agreements, NYeC, QEs and QE participants agree to be bound by policy and technical requirements reflected in Statewide Policy Guidance that has been created through the SCP that includes the opportunity for input from all SHIN-NY stakeholders.

NYS DOH's partnership with NYeC and the QEs led to the creation of the Qualified Entity for Health Information Technology Certification Program, which is comprised of policy and security elements, including:

- Privacy and Security Policies and Procedures for QEs and their Participants in NYS;
- Oversight and Enforcement Policies for QEs;
- QE Dial Tone Service Requirements;
- QE Member Facing Services Requirements;
- QE Organizational Characteristics Requirements; and
- HITRUST Security Certification.

The two primary SCP sub-committees, the SHIN-NY Policy Committee and the SHIN-NY Business and Operations Committee, submit recommendations to NYS DOH for its consideration and approval. The committees request public comment on recommendations, and consider public comments received in the final recommendations submitted to the NYS DOH.

The SHIN-NY Policy Committee, made up of a set of diverse key stakeholders selected through a nomination process that is reviewed and approved by the NYeC Board of Directors, submits SHIN-NY policy guidance to the NYS DOH on privacy and security. These policies and procedures specify requirements for interoperable HIE via the SHIN-NY. QEs and QE participants must comply with the policies and procedures as a requirement for certification as a QE. The policies and procedures address patient consent, authorization, authentication, access, patient engagement and access, audit, breach, and HIPAA compliance. Policies are aligned with HIPAA requirements as well as SAMHSA rules and requirements regulating sharing of sensitive data. In addition, the policies and procedures adhere to NYS law related to sharing of PHI, sensitive health information, and minor services. Finally, the policies and procedures are aligned with federal fair information sharing principles: Individual Access, Correction, Patient Engagement & Access, Openness and Transparency, Consent, Individual Choice, Collection, Use and Disclosure Limitation, Data Quality and Integrity, Breach, HIPAA Compliance, Safeguards, Authorization, Authentication, Accountability, and Audit.

The SHIN-NY Business and Operations Committee (BOC), made up of QE and NYeC representatives and one SHIN-NY Policy Committee delegate, assists in the strategic direction, operation, and continuous improvement of the SHIN-NY. The BOC advises NYS DOH and NYeC on SHIN-NY policies and procedures, the impact of the business and technical decisions on QEs and QE participants, SHIN-NY services, and the implementation of the SHIN-NY Roadmap, including performance of the QEs, NYeC technical services, and the SHIN-NY enterprise. It was established to:

1. Periodically review, assess, and advise on operational, technical, security, legal and policy services and processes that relate to the SHIN-NY policy standards;
2. Develop strategies, processes, and recommendations for the NYeC Board and NYS DOH regarding the SHIN-NY policy standards that impact the business and technical operations of the SHIN-NY, including, but not limited to, the following:
   a. The scope of permitted purposes for the SHIN-NY, access to and use of the SHIN-NY, and the clinical and administrative data available through it. Permitted purposes are defined and described in the SHIN-NY regulation, including the policies and procedures.
   b. Certification requirements that are material for data exchange.
   c. Additional SHIN-NY applications, infrastructure, and services to be made available as part of access to and use of the SHIN-NY and the SHIN-NY services;
3. Review and comment on all recommendations from the SHIN-NY Policy Committee, including recommendations regarding the SHIN-NY policy standards, prior to submission to the NYeC Board and to NYS DOH for approval;
4. Develop strategies, plans, and recommendations for the sustainability of the SHIN-NY; and
5. Participate in joint meetings with the SHIN-NY Policy Committee as needed to align the activities of the SHIN-NY Policy Committee and the BOC.

The BOC also seeks input from experts and other external advisors and establishes subcommittees and workgroups as necessary to complete its work. The Chair of the BOC is charged with developing the rules by which the BOC conducts its business.

8. Please describe the role of the MMIS in the SMA's current HIT/E environment. Has the State coordinated their HIT Plan with their MITA transition plans and if so, briefly describe how.

MEIPASS is solely used to enable providers to attest, receive their incentives, and is integrated with NYS's MMIS in key areas including:

- leveraging security infrastructure to allow authorized users to access MEIPASS for attestation purposes;
- leveraging current provider information ensuring a provider is an eligible provider type, actively enrolled with NY Medicaid, a member in good standing (properly licensed, not sanctioned), etc.; and
- leveraging current payment processing making incentive payments to the provider in the same way they currently receive Medicaid claim payments.

NYS DOH has initiated efforts to complete an extensive analysis, ensure stakeholder readiness, and perform careful planning to inform its MMIS strategy. A key component of this strategy will be to advance its Medicaid Information Technology Architecture (MITA) maturity.

9. What State activities are currently underway or in the planning phase to facilitate HIE and EHR adoption? What role does the SMA play? Who else is currently involved? For example, how are the regional extension centers (RECs) assisting Medicaid eligible providers to implement EHR systems and achieve meaningful use?

EHR Adoption

NY Medicaid conducts planning activities in support of the ongoing implementation and evolution of the NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability Program. The following provides a summary of specific activities including: provider outreach, development and enhancement of comprehensive educational materials, coordination with NYS trade organizations and professional associations, and coordination with NYS's two RECs. Finally, NY Medicaid operates a dedicated support center offering phone and e-mail support to Medicaid providers regarding EHR Incentive Program guidelines, eligibility, attestation review, and MEIPASS support.

i. Provider Outreach

Substantial effort has been dedicated to planning outreach activities in support of educating providers on the program specific activities which include outreach on new educational materials, program deadline reminders, webinars, and other topics of interest to the provider community. Emphasis has been placed on retention of provider participation and re-engagement in the NY Medicaid EHR Incentive Program following the completion of Payment Year 2016.

In addition, outreach includes a provider survey, which allows providers to submit anonymous feedback on service, the program, educational materials, and topics where they would like additional support. This has helped provide insight and guidance on where providers are struggling and where NY Medicaid can enhance offerings to better support the provider community.

To promote and achieve EHR adoption and MU goals, NY Medicaid has developed an extensive outreach program informing Medicaid providers around the state on the requirements and benefits of the NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability Program, thereby encouraging participation in HIE activities.

ii. Development and Enhancement of Comprehensive Educational Materials

While educating providers, NY Medicaid has conducted a multitude of webinars, reaching providers across NYS, including those focused-on registration, achieving MU, and the attestation submission process. In the past several years, NY Medicaid has substantially expanded the webinar offerings and continues to work on enhancing those options to best educate and guide providers. Reference materials and tools have been developed and made accessible directly from a dedicated

public website for the NY Medicaid EHR Incentive Program. Some of the newer reference materials developed are several self-learning tools, including step-by-step tutorials. NY Medicaid also engages providers through LISTSERV®, a newsletter sent via e-mail to the providers with program updates and information. These updates include program deadlines with countdowns, webinar schedules, program changes, and resource links.

iii. Coordination with New York State Trade Organizations and Professional Associations

NY Medicaid has engaged with several stakeholder groups and has been both a participant and sponsor of several events describing the requirements and benefits of the program to Eligible Professionals (EPs). In addition, NY Medicaid coordinates with several trade and professional organizations to help promote engagement in the NY Medicaid EHR Incentive Program, educate providers, and aid those organizations in their representation and support of their provider community. The organizations NY Medicaid has partnered with includes the Community Health Care Association of New York State (CHCANYS), Medical Society of the State of New York (MSSNY), Nurse Practitioner Association (NPA), and New York State Academy of Family Physicians (NYSAFP). To inform and educate Eligible Hospitals (EHs) and other institutional providers, NY Medicaid has also partnered with stakeholder organizations representing these constituencies, including Healthcare Association of New York State (HANYS) HIT Strategy Group, Greater New York Hospital Association (GNYHA), and Healthcare Financial Management Association (HFMA) Metropolitan New York Chapter.

iv. New York State's Regional Extension Centers (RECs)

NY Medicaid engaged NYeC and NYC REACH, the State's two RECs, to coordinate efforts to encourage the adoption and MU of CEHRT. Specifically, NY Medicaid's intent in working with these two organizations is to supplement the efforts made by NY Medicaid to provide more direct and hands-on support and assistance to Medicaid providers participating in the NY Medicaid EHR Incentive Program.

Through the Medicaid Eligible Professional Extension Program (EP2), the two RECs supply a multitude of Medicaid providers with an array of EHR assistance services, including counseling and guidance in adopting, implementing, or upgrading (AIU) and meaningfully using CEHRT, meeting the program objectives, and continuing to support HIE goals and objectives. In addition to recruitment for the NY Medicaid EHR Incentive Program, the RECs provide a variety of ongoing services to assist eligible providers. Educational materials to communicate requirements and program updates are disbursed through newsletters, announcements, and e-mail updates. The RECs also hold events to target large populations of eligible providers and conduct on-site and online educational seminars.

Health Information Exchange (HIE)

i. Adoption and Onboarding

NYS continues to focus on engaging Medicaid MU supportive providers to connect to the SHIN-NY. The Data Exchange Incentive Program (DEIP) is promoted as an opportunity to reduce cost barriers to providers to connect to the SHIN-NY. Specific

provider types that are targets adoption and onboarding include organizations subject to SHIN-NY regulation such as nursing homes, home care, hospice, and behavioral health, as well as a continued focus on physicians. In addition, NYS DOH, in partnership with NYeC, is working to understand and plan for connection to Emergency Medical Services (EMS) providers.

ii. Education and Training

NYS continues engagement and training of Medicaid MU eligible and supportive providers to encourage them to become QE participants. This work is advanced through helping them to understand the benefits of QE participation, the QE-specific privacy and security policies and protocols (e.g., consent, access, auditing and breach procedures, etc.), and provide initial user training on QE-specific services (e.g., patient record look-up, Direct Secure Messaging, QE alerts, lab results delivery, analytics services, etc.). Efforts include implementation of recruitment and education strategies that increase participation in the SHIN-NY by Medicaid MU eligible and supportive providers, as well as participant education on the use of Part 2 data in the SHIN-NY. Outreach continues to consumer/patient groups, via provider training, to increase their understanding and appropriate usage of QE services.

NYS DOH, along with NYeC and the QEs, will also continue to focus on reporting for education and training goals and targets. These targets relate to adoption and participation targets established by each QE in partnership with NYS DOH to drive achievement of the statewide goal to reach 75% adoption by 2021.

10. Explain the SMA's relationship to the State HIT Coordinator and how the activities planned under the ONC-funded HIE cooperative agreement and the Regional Extension Centers (and Local Extension Centers, if applicable) would help support the administration of the EHR Incentive Program.

NY Medicaid coordinates efforts with the statewide HIT coordinator, James Kirkwood, Director of the Division of Healthcare Innovation in the Office of Quality and Patient Safety (OQPS) at the Department of Health. Questions A6 and A7 describe the responsibilities of OQPS in the state's HIT/E landscape. Additionally, the Medicaid EHR Incentive Program work plans are developed and executed to ensure maximum use of and integration with the HIE work products overseen by OQPS. Staff pay particular attention to the alignment of policy goals across initiatives to ensure that clear roles and responsibilities between NY Medicaid and OQPS staff are maintained to avoid duplication of State and Federal investments. To this end, plan integration activities have taken place for the duration of the program.

Question A9 describes the activities carried out by the Regional Extension Centers to support the administration of the EHR Incentive Program, however no activities are currently planned under the HIE cooperative agreement as the program has ended.

11. What other activities does the SMA currently have underway that will likely influence the direction of the EHR Incentive Program over the next five years?

In accordance with current federal legislation and regulation, the final year of participation in the NY Medicaid EHR Incentive Program will be 2021. NY Medicaid will provide continued administration and proper oversight of the program, as described throughout this document, for its duration.

NY Medicaid continues to invest in HIE initiatives to support providers' efforts to improve the health of their patients while lowering health care costs by reducing redundancy and improving care coordination. Moreover, these initiatives are integral to the long-term success of the NY Medicaid EHR Incentive Program by creating the governance and technology infrastructure to enable providers to share data to meet their MU objectives and increase the value of the program, thereby increasing providers' willingness to meet MU requirements and maintain participation in the program.

Medicaid providers' use of HIE capabilities and their participation in the NY Medicaid EHR Incentive Program will be driven in large part by the quality and quantity of data they can locate on Medicaid beneficiaries, and the sophistication and ease of use of the HIE services. Work underway to expand the availability of Medicaid beneficiary data and the robustness of services available via the SHIN-NY and QEs, as well as its overall usability, thereby increasing and sustaining participation in the NY Medicaid EHR Incentive Program includes:

- Focused efforts to onboard Medicaid MU eligible and supportive provider organizations to the SHIN-NY to ensure that Medicaid MU eligible providers will be able to effectively meet MU objectives such as using HIE to transition patients to another Medicaid provider, such as a nursing facility or a home health provider.
- Standing up, upgrading, and/or enhancing public health systems to enable the capability to receive and/or exchange electronic data for public health reporting measures in accordance with published implementation guides using standard transport protocols.
- Enabling the capacity for bi-directional exchange of clinical and administrative health information between QEs and NYS OMH-operated psychiatric facilities to enhance coordination of care, improve clinical decision support, and expand HIE.
- Documenting, evaluating, and prioritizing statewide data sources for readiness to support data exchange with the SHIN-NY to increase the efficiency and affordability of the SHIN-NY.
- Leveraging the SHIN-NY infrastructure to enable the ability to generate quality measures to support the NY Medicaid EHR Incentive Program, the Delivery System Reform Incentive Payment (DSRIP) Program, the State Innovation Model (SIM) program, and value-based payment (VBP) initiatives. This includes testing quality measurement use cases requiring clinical data, assessing and verifying the data contributed by QE participants, and analyzing clinical data and assessing completeness and conformance of

Common Clinical Data Set (CCDs) produced by QEs for exchange within the SHIN-NY.

- Assessing methods and mechanisms necessary to enable consumer access to healthcare data such as patient-centric applications, smart phone integration, and provider-based patient portal integration with the SHIN-NY.

12. Have there been any recent changes (of a significant degree) to State laws or regulations that might affect the implementation of the EHR Incentive Program? Please describe

NYS DOH has adopted regulations governing the SHIN-NY and the QEs that provide the infrastructure for secure sharing of health information among providers and health plans. The regulations set forth standards and requirements for QEs for the governance of the SHIN-NY, and for patient/resident authorization to share information through the SHIN-NY.

The regulations require hospitals, clinics, nursing homes, home care agencies, hospice programs, and health maintenance organizations which use CEHRT, to connect to the SHIN-NY through a QE. Hospitals were required to connect by March 9, 2017, while other facilities and agencies (including nursing homes, home care agencies, hospice programs, and health maintenance organizations) were required to connect by March 9, 2018.[7] These connections must allow private and secure bi-directional access to patient information by providers and plans authorized by law to access that patient information. NYS DOH is authorized to waive these requirements for health care facilities and agencies that demonstrate: economic hardship; technological limitations or practical limitations to the full use of CEHRT that are not reasonably within control of the health care provider; or other exceptional circumstances.

The regulations allow providers to contribute health information to QEs without patient/resident authorization. However, the regulations prohibit QEs from sharing health information with other providers without written authorization from the patient/resident, except in certain circumstances. Information may be shared by a QE without the patient's authorization when it is: necessary for public health or health care oversight activities; required or authorized by law; provided to a federally-designated organ procurement organization to facilitate organ, eye or tissue donation and transplantation; or needed for treatment in the case of a medical emergency.

The regulations also authorize providers to withhold information from the QE, including information about services that minors have consented to (such as reproductive health and mental health services). They prohibit QEs from sharing minor consent service information with a patient's parent without the minor's authorization.

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[7] http://www.nyehealth.org/nyec16/wp-content/uploads/2017/09/Guidance-Document_SHIN-NY-Data-Contribution_Sep2017.pdf

The regulations require NYS DOH to establish, through recommendations of a policy committee and the work of a statewide collaboration process, SHIN-NY policy guidance that sets standards for: privacy and security; monitoring and enforcement; minimum service requirements; organizational characteristics of QEs; and QE certification, as explained in question A7.[8]

13. Are there any HIT/E activities that cross State borders? Is there significant crossing of State lines for accessing health care services by Medicaid beneficiaries? Please describe.

Hixny is a nonprofit HIE, and a SHIN-NY QE, serving providers and residents between NYC and Canada and from Binghamton into Vermont.[9] As of 2019, Hixny's continued growth includes the University of Vermont (UVM) Medical Center which is now contributing data via Hixny. The addition of UVM Medical Center is a first for the NYS and the Northeast where access to secure electronic medical records has crossed borders to connect with providers in other states. The move will multiply the volume of data and will improve the quality of care for thousands of residents in the northern most regions of NYS who see primary care physicians in NY but go to UVM Medical Center for inpatient or specialty care.

NY Medicaid recognizes that additional cross-border HIT/E activities currently underway, or planned for the near future, may have an impact on the successful adoption of EHR technology.

14. What is the current interoperability status of the State Immunization registry and Public Health Surveillance reporting database(s)?

Immunization Registry Reporting

i.   New York State Immunization Information System (NYSIIS)

As part of the MU Public Health Reporting Objective, The New York State Immunization Information System (NYSIIS) participates with EPs, EHs, and CAHs outside the five boroughs of NYC. NYSIIS collects data from any provider that administers immunizations to patients. All providers are required by Public Health Law to report immunizations administered to patients 18 years of age or younger. To report immunizations administered to patients age 19 or older, verbal or written consent is needed.

The immunization data collected is consumed by several internal and external applications. This data is utilized to perform essential patient facing functions such as providing immunization histories and schedules for schools and providers to make informed immunization decisions as well as critical program related functions, like monitoring immunization coverage rates, Vaccines for Children (VFC) program

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[8] https://regs.health.ny.gov/sites/default/files/pdf/recently_adopted_regulations/2016-03-09_shin_ny.pdf

[9] https://www.hixny.org

compliance, vaccine-preventable disease surveillance, and targeted outreach efforts.

Since January 1, 2017, NYSIIS has been able to receive and send immunization data in HL7 v2.5.1 Release 1.5 format via Universal Public Health Node (UPHN) transport method that conforms to the 2015 CEHRT §170.315(f)(1) Transmission to immunization registries standards. All immunization data can be accessed through the New York State Health Commerce System (HCS), via the NYSIIS application. The application is utilized by the registry to create HL7 accounts and conduct quality assurance checks on HL7 messages received, both in NYSIIS's production and test environments. As of January 2019, approximately 88% of practices engaged with NYSIIS are reporting data in HL7 file format. Of those practices, 71% of them were currently utilizing the UPHN transport method. NYSIIS continues to engage providers with 2015 Edition CEHRT, transitioning their reporting to be via the HL7 v2.5.1 Release 1.5, which includes bi-directional functionality.

ii. Citywide Immunization Registry (CIR)

As part of the MU Use Public Health Reporting Objective, the Citywide Immunization Registry (CIR), which is overseen by the New York City Department of Health and Mental Hygiene (NYC DOHMH), participates with EPs, EHs, and CAHs inside the five boroughs of NYC, and is an electronic system which captures and consolidates demographic and immunization records for individuals in the five boroughs of NYC. Immunization records for individuals age 18 and under are required by Public Health Law to be reported to the CIR by all healthcare providers practicing within the five boroughs of NYC. Immunization records for individuals 19 years of age and older should be reported to the CIR, when the patient gives consent (oral or written) for the report. The immunization data is used in several internal and external applications for looking up patient records and immunization reporting. The data also serves critical programmatic functions, like monitoring immunization coverage rates, Vaccines for Children (VFC) program compliance, vaccine-preventable disease surveillance, and targeted outreach efforts.

Providers may report these immunizations to the CIR in three ways – by using the Online Registry (OR) web application, by submitting an electronic flat file (Universal Provider Interface Format (UPIF) format), or by utilizing the CIR HL7 Web Service to perform real-time, bi-directional data exchange with the CIR via HL7 messages.

CIR can receive and send immunization data in HL7 v2.5.1 Release 1.5 format via HL7 Web Services that conforms to the 2015 CEHRT §170.315(f)(1) Transmission to immunization registries standards. All immunization data can be accessed through an internal application called the CIR Administration Tool (CAT), utilized by the registry to create HL7 accounts and conduct quality assurance checks on HL7 messages received, both in the CIR's production and test environments. As of January 2019, approximately 80% of immunization records in the CIR are reported via the HL7 Web Service.

Syndromic Surveillance Reporting

i. NYS DOH Syndromic Surveillance Reporting Registry

As part of the MU Public Health Reporting Objective, the NYS DOH Syndromic Surveillance Reporting Registry participates with EPs, EHs, and CAHs outside the five boroughs of NYC to submit Syndromic Surveillance Reporting data, in accordance with Public Health Law. The registry collects data from EPs who practice in a licensed urgent care center and EHs with an emergency department. The registry collects syndromic surveillance data from EHs, which includes the following syndromes: asthma, carbon monoxide, drug overdose, fever, gastrointestinal infection, heatwave, heroin overdose, hypothermia, neurological, rash, respiratory, and synthetic drugs. In addition, the registry collects chief complaint data from EPs, which will be grouped into the syndromes listed above for EHs.

As of January 1, 2017, the registry was able to accept data via the HL7 2.5.1 standard, the PHIN Messaging Guide for Syndromic Surveillance Release 2.0, and the August 2015 Erratum to the PHIN Messaging Guide. The registry continues to engage providers to begin or upgrade transmission of data to the registry via the 2015 Edition CEHRT criteria, to support MU Stage 3.

ii. NYC DOHMH Syndromic Surveillance Reporting Registry

As part of the MU Public Health Reporting Objective, the NYC DOHMH Syndromic Surveillance Reporting Registry participates with EPs, EHs, and CAHs inside the five boroughs of NYC to submit Syndromic Surveillance Reporting data, in accordance with Public Health Law. The registry collects data from EPs who practice in a licensed urgent care center and EHs with an emergency department. The registry collects syndromic surveillance data from EPs and EHs, which includes some of the following syndromes: respiratory, vomiting, diarrhea, fever, influenza–like–illness (ILI), and asthma

As of January 1, 2017, the NYC DOHMH Syndromic Surveillance Reporting Registry was able to accept data via the HL7 2.5.1 standard, the PHIN Messaging Guide for Syndromic Surveillance Release 2.0, and the August 2015 Erratum to the PHIN Messaging Guide. There are some reporting requirement changes from 2014 to 2015 Edition CEHRT. As of January 2019, the registry is working with multiple hospitals and urgent care centers to measure compliance with the latest reporting requirements. Communications are exchanged until the organizations are able to transmit high quality data with minimal errors. The registry notifies practices once they are submitting production level data.

Cancer Case Reporting

As part of the MU Public Health Reporting Objective, the New York State Cancer Registry (NYSCR) is able to collect data from EPs practicing across NYS.

As mandated by the Public Health Law, all NYS licensed health care providers and practitioners diagnosing or treating cancer patients, all licensed facilities at which patients are treated (e.g., hospitals, radiation centers), all laboratories holding permits to conduct pathology testing (whether independent or hospital-based), are required to report cancer cases to the NYSCR. Laws regarding cancer case reporting to the NYSCR apply to all providers in NY, including those in NYC.

As part of the MU Public Health Reporting Objective, reporting to the NYSCR is intended for EPs who diagnose and/or directly treat cancer. A diagnosing EP is one who definitively diagnoses cancer. The NYSCR considers an EP who directly treats cancer as one who performs/administers treatment modalities (i.e. surgery, radiation, chemotherapy, immunotherapy, hormonal therapy) directed at the cancer. Additionally, a treating EP could be one who decides (with the patient) that there will be no treatment given/received.

On July 15, 2016, the NYSCR declared they would be capable of accepting electronic cancer case reports from EPs, according to the standards required to meet the 2015 Edition CEHRT definition on or before January 1, 2017. The requirements are reflected in the Implementation Guide - HL7 CDA ® Release 2 Implementation Guide: Reporting to Public Health Cancer Registries from Ambulatory Healthcare Providers, Release 1, DSTU Release 1.1 - US Realm. In addition, the NYSCR can receive Cancer Event Reports in clinical document architecture (CDA), via Direct Secure Message and manual upload to the NYS Health Commerce System (HCS) application. The registry is also able to assign, edit, and apply rules and lists of acceptable values to content violations that govern the flow into their downstream extraction and normalization tool (eMaRC Plus).

Electronic Case Reporting

i. NYS DOH Electronic Case Reporting (eCR) Registry

As part of the MU Public Health Reporting Objective, the NYS DOH eCR Registry accepts eCR data from EPs located outside the five boroughs of NYC only. On June 22, 2017, the registry declared they would be capable of accepting eCR data from EPs according to the standards required to meet the 2015 Edition CEHRT definition, § 170.315(f)(5) – Transmission to public health agencies – electronic case reporting, on or before January 1, 2018.

The NYS DOH eCR Registry is working with the Digital Bridge[10] initiative to implement an eCR approach for nationwide interoperability and enhanced delivery of effective disease control and patient care practices.

ii. NYC DOHMH Electronic Case Reporting Registry (ECR)

As part of the MU Public Health Reporting Objective, the NYC DOHMH ECR accepts eCR data from EPs and EHs located inside the five boroughs of NYC. On June 22, 2017, the registry declared they would be capable of accepting eCR data from EPs and EHs according to the standards required to meet the 2015 Edition CEHRT definition, § 170.315(f)(5) – Transmission to public health agencies – electronic case reporting, on or before January 1, 2018.

The NYC DOHMH ECR is working with the Digital Bridge initiative to implement an eCR approach for nationwide interoperability and enhanced delivery of effective disease control and patient care practices.

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[10] Overview of the Digital Bridge Initiative & Business and Technical Specifications for eCR developed by Digital Bridge

Electronic Laboratory Results Reporting

As part of the MU Public Health Reporting Objective, the Electronic Clinical Laboratory Reporting System (ECLRS) is operated by the NYS DOH and available to EHs inside and outside the five boroughs of NYC. NY Public Health Law and Codes, Rules and Regulations require physicians, health care facilities, and licensed clinical laboratories to report all pertinent facts to public health authorities whenever an examination on a NY resident is performed to determine blood lead level or reveals evidence of a reportable communicable disease, HIV/AIDS, or cancer. ECLRS enhances public health surveillance by: providing timely reporting; improving completeness and accuracy of reports; and generally facilitating the identification of emergent public health problems by monitoring communicable diseases, lead poisoning, HIV/AIDS, and cancer. In 2007, NYS mandated electronic reporting of laboratory results for all reportable conditions via the ECLRS.

On July 15, 2016, the ECLRS registry declared they were capable of accepting electronic reportable laboratory (ELR) results from EHs according to the standards required to meet the 2015 Edition CEHRT definition and will continue accepting data according to the standards. The ECLRS registry can accept data submitted in HL7 Version 2.5.1 format and continues to engage and encourage laboratories to submit via the most recent format. Upon upgrading the EHR system, the laboratory will work with the ECLRS coordinator to review HL7 files and ensure high data quality is being transmitted. Once the file review process is complete, the ECLRS coordinator will notify the hospital of successful lab certification. Laboratories submit data via the NYS HCS ECLRS application. Most facilities are utilizing the UPHN transport method.

15. If the State was awarded a HIT-related grant, such as a Transformation Grant or a CHIPRA HIT grant, please include a brief description.

NY Medicaid has not identified other available sources able to contribute to the costs or activities for which the State is requesting HITECH matching funds.

Section B
The State's "To-Be" Landscape

B.   The State's "To-Be" Landscape

1. Looking forward to the next five years, what specific HIT/E goals and objectives does the SMA expect to achieve? Be as specific as possible; e.g., the percentage of eligible providers adopting and meaningfully using certified EHR technology, the extent of access to HIE, etc.

NY Medicaid EHR Incentive Program

Since the last year for Eligible Professionals (EPs) and Eligible Hospitals (EHs) to begin participation in the Medicaid Electronic Health Record (EHR) Incentive Program was 2016, there is a defined universe for participation. There is a total of 18,613 unique EPs and 171 unique EHs who have participated in the New York (NY) Medicaid EHR Incentive Program, a CMS Promoting Interoperability Program, for at least one year. In addition, all incentive payments must be issued by December 31, 2021. Therefore, until that date, NY Medicaid has the following goals, in relation to the program.

i.   Eligible Hospitals (EHs)

EHs may participate in the program for a series of three years, which must all be consecutive. Therefore, the last year for EH payments will be Payment Year 2018. As of January 2019, 165 EHs have participated for two years of the program, and 150 EHs have already completed the program. NY Medicaid is working closely with the remaining EHs to ensure they can complete the program during this final participation year.

ii.   Eligible Professionals (EPs)

Unlike EHs, EPs do not need to participate consecutively and may participate for up to six years in the program. As of January 2019, 863 EPs have completed all six years of the program. The largest drop in participation is seen between Participation Years 1 and 2. This is expected and stems from the variance in payments; an EP receives a much larger incentive payment for the first year of

participation. Also, most providers in NY completed Adopt, Implement, or Upgrade (AIU) in their first participation year, which has less stringent requirements than Meaningful Use (MU), which is required for Participation Years 2 through 6.

NY Medicaid plans to continue making substantial efforts in educating and assisting EPs in meeting the program requirements for future payment years. The goal is to maximize provider participation in the program and limit provider attrition for Payment Years 2019 and on, which is when MU Stage 3 becomes a requirement and providers are required to upgrade their EHR systems to meet the 2015 Edition Certified EHR Technology (CEHRT) criteria. Some of the efforts being continued are as follows:

- Coordination with the Regional Extension Centers (RECs);
- Continued outreach and education via all modalities discussed in question A9; and
- Targeted outreach focused solely on providers who have not participated in the most recent participation years but are still eligible.

Health Information Exchange (HIE)

HIE in New York State (NYS) is envisioned to provide an infrastructure of technology and policies that allow multiple stakeholders to access high quality data that represents a complete picture of the care delivered to a patient and enables measurement of the health outcomes of a population. NY's investments in HIE are aimed at facilitating providers to improve health care quality and health outcomes while reducing costs and supporting Medicaid programs. This includes governance and oversight to ensure adherence to evolving federal and state policy requirements developing and enhancing technical capacity to share patient data; focused data quality improvement activities; developing and implementing processes for evaluation and oversight; and encouraging adoption through outreach and HIE onboarding activities.

The aim of NY's network of electronic health information exchange, called the Statewide Health Information Network for New York (SHIN-NY), is to give all providers treating a patient access to the patient's complete health information, when and where they need it. This enables providers' access to actionable clinical data at the point of care, leads to improved care coordination, and reduces duplicative or unnecessary treatments. In turn, all these efforts lead to better care, healthier patients, and lower costs.[11]

2. What will the SMA's IT system architecture (potentially including the MMIS) look like in five years to support achieving the SMA's long term goals and objectives? Internet portals? Enterprise Service Bus? Master Patient Index? Record Locater Service?

The Medicaid EHR Incentive Program Administrative Support Service (MEIPASS) is used to enable providers to attest and receive their incentive payments, and is

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[11] https://www.nyehealth.org/shin-ny/better-outcomes/

integrated with NYS's MMIS, eMedNY, as described in A8. NYS DOH has initiated efforts to complete an extensive analysis, ensure stakeholder readiness, and perform careful planning to inform its future MMIS strategy. A key component of that planning will be to ensure continued support for the administration and oversight of the NY Medicaid EHR Incentive Program throughout its remaining years.

3. How will Medicaid providers interface with the SMA IT system as it relates to the EHR Incentive Program (registration, reporting of MU data, etc.)?

NY Medicaid will continue to leverage the State Level Repository (SLR) implemented as MEIPASS, which is a contained service within NY Medicaid's MMIS, eMedNY, and is NY's solution for EPs and EHs seeking to attest their eligibility for the NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability Program, demonstrating MU and up through program year 2016, AIU of CEHRT.

Operational support and administration of MEIPASS is conducted by NY Medicaid's fiscal agent, CSRA. As part of the administration of MEIPASS, CSRA will continue operate and manage regular monitoring of automated interfaces with the CMS National Level Repository (NLR), conduct automated and ad-hoc reporting of MEIPASS and provider attestation activity, manage financial transactions related to the NY Medicaid EHR Incentive Program payments, and conduct financial and system audits to ensure the integrity of the attestation and payment system. MEIPASS will continue to undergo annual design, development, and implementation (DDI) which will support program changes as regulations are promulgated by CMS.

4. Given what is known about HIE governance structures currently in place, what should be in place by 5 years from now in order to achieve the SMA's HIT/E goals and objectives? While we do not expect the SMA to know the specific organizations will be involved, etc., we would appreciate a discussion of this in the context of what is missing today that would need to be in place five years from now to ensure EHR adoption and meaningful use of EHR technologies.

This HIE governance structure described in question A7 is expected to remain in place going forward and will be refined as needed to continue to meet State HIE goals.

5. What specific steps is the SMA planning to take in the next 12 months to encourage provider adoption of certified EHR technology?

NY Medicaid will continue to conduct the activities as described in question A9 to encourage provider adoption of CEHRT.

6. If the State has FQHCs with HRSA HIT/EHR funding, how will those resources and experiences be leveraged by the SMA to encourage EHR adoption?

The State's Federally Qualified Health Centers (FQHCs) received HRSA grant funding to support the implementation and adoption of health information

technology (HIT) and technology-enabled quality improvement strategies as described in question A3. FQHCs participating in the NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability Program, will continue to receive support through the regular sharing of resources and information pertaining to the Program as well as attestation status updates. As described in question B8, NY Medicaid will continue to maintain collaborative relationships with trade associates and organizations such as the Community Health Care Association of New York State (CHCANYS) who represent and support providers practicing at FQHCs. The continued collaborative support will in turn encourage and support Medicaid providers in achieving MU.

7. How will the SMA assess and/or provide technical assistance to Medicaid providers around adoption and meaningful use of certified EHR technology?

NYS will continue efforts on engaging Medicaid MU eligible and supportive provider organizations to connect to the SHIN-NY to realize the benefits of health information exchange (HIE) and facilitate Medicaid providers in achieving MU as explained in questions A5 and A9.

8. How will the SMA assure that populations with unique needs, such as children, are appropriately addressed by the EHR Incentive Program?

NY Medicaid EHR Incentive Program

The NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability Program, allows providers practicing in FQHCs and Rural Health Clinics (RHCs) to participate in the program. In addition, CAHs and children's hospitals are eligible to participate. NY has and continues to collaborate with trade associations and organizations, along with NYS's two Regional Extension Centers (RECs), representing providers who service populations with unique needs. This collaborative effort is focused on assisting providers in CAHs, children's hospitals, FQHCs, RHCs, and other practices that provide services to populations with unique needs by providing guidance and assistance to them on how to best meet program requirements, in their unique situations, and continuing to encourage participation in the NY Medicaid EHR Incentive Program.

In addition, Public Health Law requires that providers report immunization data for anyone under the age of 19 to either the Citywide Immunization Registry (CIR) or NYS Immunization Information System (NYSIIS), based on the provider's jurisdiction. As detailed in A14, both registries support providers participating in the EHR Incentive Program. Among other critical uses, the data collected is utilized to provide immunization histories and schedules for schools and providers to make informed immunization decisions as well as to monitor compliance with the Vaccines for Children (VFC) program.

Health Information Exchange (HIE)

NYS continues to focus on engaging Medicaid MU eligible and supportive provider organizations to connect to the SHIN-NY. Specific provider types that are targets for adoption and onboarding as well as education and training efforts include

organizations subject to SHIN-NY regulation (described in question A12) such as nursing homes, home care, hospice, and behavioral health, as well as a continued focus on physicians.

The vast majority of NYS Office of Mental Health (OMH) patients are treated by both NYS OMH facilities and by other Medicaid providers. However, no mechanism or infrastructure currently exists for non-OMH providers to receive NYS OMH clinical information through HIE, thus prohibiting a full picture of NYS OMH patients' clinical information. In partnership with NYS DOH, NYS OMH is focused on enabling the capacity for bi-directional exchange of clinical and administrative health information between Qualified Entities (QEs) and NYS OMH-operated psychiatric facilities in an effort to enhance coordination of care, improve clinical decision support, and expand HIE.

In partnership with the New York City Department of Health and Mental Hygiene (NYC DOHMH), NYS DOH continues to stand up, upgrade, and/or enhance public health systems, including immunization registries, to enable the capability to receive and/or exchange electronic data for MU Public Health Reporting Objective measures in accordance with published implementation guides using standard transport protocols.

9. If the State included in a description of a HIT-related grant award (or awards) in Section A, to the extent known, how will that grant, or grants, be leveraged for implementing the EHR Incentive Program, e.g. actual grant products, knowledge/lessons learned, stakeholder relationships, governance structures, legal/consent policies and agreements, etc.?

As indicated in question A15, NY Medicaid has not identified other available sources able to contribute to the costs or activities for which the State is requesting HITECH matching funds.

10. Does the SMA anticipate the need for new or State legislation or changes to existing State laws in order to implement the EHR Incentive Program and/or facilitate a successful EHR Incentive Program (e.g. State laws that may restrict the exchange of certain kinds of health information)? Please describe.

NYS does not anticipate the need for new State legislation or changes to existing legislation to implement the EHR Incentive Program.

Section C
Activities Necessary to Administer and Oversee the EHR Incentive Payment Program

C. Activities Necessary to Administer and Oversee the EHR Incentive Payment Program

1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

An Eligible Professional (EP) begins the process of applying for the Medicaid Electronic Health Record (EHR) Incentive Program by visiting the CMS National Level Registry (NLR) and logging in with the required information, such as, a National Provider Identifier (NPI) and a CMS Certification Number (CCN). The NLR website collects basic information from the applicant including: name, e-mail address, business address, telephone number, payee NPI and tax information, the program type, state for Medicaid Incentive Program, and type of EP. CMS transmits to New York (NY) Medicaid a list of applicants who selected the Medicaid EHR Incentive Program in NY, along with the registration data collected in the application. Upon receiving application information from the NLR, NY Medicaid generates an e-mail notification to each registrant. This e-mail notifies each registrant that NY Medicaid has received the registration data from the NLR and invites the registrant to log in to the Medicaid EHR Incentive Program Administrative Support Service (MEIPASS) to provide the required state-level registration and eligibility attestation.

The MEIPASS attestation process is initiated from within the provider web interface to the state MMIS, eMedNY. Only active NY Medicaid providers who have completed the first phase of the NLR registration, and for whom the NLR has generated a transaction notification to the state, will be presented with the opportunity to launch the MEIPASS application. An EP may only be an active

Medicaid provider, if they also have a valid license. This ensures that checks on basic eligibility, such as having an NPI and being an eligible professional type, are complete prior to the initiation of the MEIPASS attestation process begins.

2. How will the SMA verify whether EPs are hospital-based or not?

NY Medicaid utilizes the Medicaid Date Warehouse (MDW) to serve as the system of record for the state's Medicaid claims data, and subsequently, it is used as the primary source to validate patient volume data and to determine hospital-based status. NY Medicaid ensures the provider is not hospital-based by comparing covered professional (Medicaid) services in the inpatient acute care or emergency department settings (POS 21 or 23) against the provider's claims data. If 90% or more of the services rendered are deemed hospital-based, NY Medicaid will notify the provider of the findings and request a written response and explanation. If the provider indicates they are hospital-based, they are no longer eligible for the program. If they believe themselves not to be hospital-based, a valid explanation must be included. The responses are reviewed on a case-by-case basis for validity.

3. How will the SMA verify the overall content of provider attestations?

Manual pre-payment validation of all provider attestations is conducted by program support staff. Attestations are held in a pending status, after the provider completes all required components, until pre-payment verification is completed. Program support staff verify the provider attestations against fee-for-service claims history and managed care encounter data, requesting additional documentation from the provider as needed, and either approve or reject the attestation depending on whether the information substantiates the provider's attestation. All providers are offered the opportunity to remediate any issues found during the review process. Below is a list of verifications completed by NY Medicaid, for all attestations. A more detailed list, including verification methodology may be found in the New York State (NYS) Audit Strategy, which is submitted regularly to CMS for review and approval.

Exhibit 3. Verification Checks

Validation	Pre Payment		Post Payment	
	Automatic	Manual	Automatic	Manual
Eligible Professional (EP) Type	X		X	
EP is not sanctioned or excluded from receiving Medicaid payments	X		X	
EP is actively enrolled in NY Medicaid	X		X	
EP is not hospital-based		X		X
EP practices predominately at an FQHC or RHC		X		X
EP demonstrates sufficient Medicaid Patient Volume (MPV)		X		X
EP demonstrates adoption, implementation, or upgrade (AIU) of CEHRT	X			X
EP demonstrates Meaningful Use (MU) utilizing CEHRT	X			X
At least 50% of EP's patient encounters occur at a location with CEHRT	X			X
EP satisfies MU Objective and Measure Criteria	X			X
Payment is assigned to an appropriate recipient under 42 CFR § 495.10(f)(1)		X		X
Inputs to hospital incentive calculation		X		X

4. How will the SMA communicate to its providers regarding their eligibility, payments, etc.?

The two primary methods of direct communication with providers enrolled in the NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability Program, are through e-mail (hit@health.ny.gov) and telephone (877-646-5410). When registering with the NLR, providers are required to enter an e-mail address. The e-mail address entered in the NLR is the point of contact for a provider, when it pertains to information about their attestation. If any of the contact information needs to be updated, the provider must update this information in the NLR.

Any notification or request for additional information during the review process will be sent to the e-mail address on file for the provider from the NLR. If a provider is affiliated with a REC, the REC will be included on any e-mail correspondence to the provider, so as to leverage valuable REC services, and incorporate them appropriately. General program information that is not specific to the provider can be conveyed to any inquiring party. Follow up e-mail outreach is sent as a courtesy to providers in efforts to improve response times, ensure providers are aware of any action that is required, and provide support and explanation that will help a provider to complete any required action.

NY Medicaid understands the difficulty providers face when attesting to the program and as a result, offer a wide range of services, educational materials, and a full support team. The support team consists of program staff who are available to assist providers by phone or e-mail. A provider may contact the NY Medicaid EHR Incentive Program Support Team with any inquiries regarding their attestation via phone or e-mail. The provider's status is available for their review in MEIPASS, upon logging in.

Phone inquiries may be received from any phone number and are not limited to the phone number registered with the NLR. Additionally, the release of any information about a provider's attestation is not limited to the phone number registered with the NLR. Outreach by telephone may also be utilized when an e-mail has failed to be delivered to the registered address or if no response to outreach has been received. A less frequent medium of communication with providers includes the eMedNY postal mail.

5. What methodology will the SMA use to calculate patient volume?

Regarding the selection of a representative 90-day period to be used in patient volume calculations, CMS has indicated that no specific standards will be issued as to the definition of "representative." Providers will be responsible for attesting, during the NY Medicaid EHR Incentive Program enrollment process, that the evaluation period they select to calculate their eligibility would withstand a plain meaning test as representative of overall patient volume. Consistent with guidance issued by CMS, providers will be notified that such plain meaning tests will not penalize the provider for normal seasonal variations in patient volume. For example, a provider whose chosen 90-day period includes an increase in overall patient volume relative to other times of the year due to seasonal flu and vaccinations would still be found to be representative if the increase is consistent with seasonal variations in prior years.

For the purposes of calculating patient volume, a "Medicaid patient encounter" is defined as one or more services rendered on any one day to an individual where Medicaid (or a Medicaid demonstration project under §1115 of the Social Security Act) paid for all or part of the service, or all or part of the premiums, co-payments, and/or cost-sharing. From Payment Year 2011 to 2012, providers were instructed not to count services rendered to Medicaid eligible patients that were not paid at least in part by -Medicaid or a qualified Medicaid demonstration project (or by a private insurance whose premiums are paid all or in part by Medicaid or a qualified Medicaid demonstration project), including services for which a claim was not submitted, payment has been denied, or payment was approved but has not yet been received by the provider. Providers are instructed that claims for Medicaid beneficiaries that were resolved with no payment to the provider (so-called "zero pay" claims) are not considered Medicaid patient encounters for the purposes of calculating Medicaid Patient Volume (MPV), although NY Medicaid will continue to follow emerging federal guidance on this matter. Zero-pay claims include:

- Claim denied because the Medicaid beneficiary has maxed out the service limit
- Claim denied because the service wasn't covered under the State's Medicaid program
- Claim paid at $0 because another payer's payment exceeded the Medicaid payment
- Claim denied because claim wasn't submitted timely

Starting in payment year 2013 and beyond, Medicaid encounters include service rendered on any one day to a Medicaid-enrolled individual, regardless of payment

liability. This new definition expands the Payment Year 2011-2012 guidance to include zero-pay claims and encounters with patients in Title XXI-funded Medicaid expansions, but not separate Child Health Plus programs.[12] Starting in payment year 2015 and beyond, only Medicaid fee-for-service and Medicaid Managed Care encounters can be included in the patient volume calculation.

To verify patient volume, providers who choose to attest using the standard patient volume calculation method are asked to provide the following pieces of information to establish their MPV:

- The number of patient encounters for Medicaid clients during that period (i.e., the numerator)
- The total number of patient encounters during the same period (i.e., the denominator)

Users who select the option to attest using the alternative patient volume calculation will be asked instead to provide the following information:

- The number of Medicaid patients "current" on the Provider's patient panel;
- The number of unduplicated Medicaid patient encounters during the reporting period;
- The total number of patients "current" on the panel; and
- The total number of unduplicated patient encounters during the reporting period.

Standard Patient Volume Calculation and Verification

The methodology for calculating patient volume to determine providers' eligibility was established through the federal rule-making process. According to the published rule, eligibility (with respect to patient volume) for any given year is determined by selecting a representative continuous 90-day period during the calendar year (CY) prior to the payment year or the preceding 12-month period from the date of attestation. In the standard methodology, after the patient volume reporting period is selected, a proportion of patient encounters with Medicaid recipients becomes the numerator and the denominator is all patient encounters for the same period. For an EP to receive an incentive payment, their MPV proportion must be greater than 30%, with the exception of pediatricians who qualify for incentives at a reduced rate if their MPV is between 20% and 30%, and EPs practicing predominantly in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) who may substitute "needy individuals" as defined in §495.302 for "Medicaid patients" when demonstrating the 30% proportion. Acute care hospitals require a minimum patient volume of 10% Medicaid to be eligible for incentive payments.

For the purposes of determining eligibility for participation in the Medicaid EHR Incentive Program using the 20% threshold, NY Medicaid defines "pediatrician" as a physician (M.D. or D.O.) who meets all other criteria for eligibility in the program and additionally satisfies at least one of the following:

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[12] https://www.federalregister.gov/d/2012-21050/p-2027

- The practitioner is board-certified in General Pediatrics or a pediatric subspecialty by either the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics (AOBP). This certification must be current and in good standing during the entire MPV reporting period, at the time of attestation, and at the time of each incentive payment.
- The practitioner focuses on treating patients aged 18 years and younger and demonstrates that the majority of care is provided to patients aged 18 years and younger. For providers who opt to attest to patient volume using the standard patient volume methodology, "majority of care" is defined as at least 50% of all patient encounters during the MPV reporting period. For providers who opt to attest to patient volume using the alternative patient volume methodology, "majority of care" is defined as at least 50% of the total of: (a) all patients current on the provider's patient panel, and (b) all patient encounters for patients not on the provider's patient panel.

Alternative Patient Volume Methodology

NY Medicaid also allows providers to qualify for the NY Medicaid EHR Incentive Program using the alternative patient volume methodology set forth in the final rule. Under the alternative patient volume methodology, providers may count Medicaid patients who are currently "active" on the provider's patient panel. To be considered "active", a patient must have an encounter with the provider within the 24-month period leading up to the selected 90-day MPV reporting period. The Medicaid portion of the "active" patients will be counted in the numerator and all panel patients included in the denominator. Additionally, the provider may include unduplicated encounters from the selected MPV reporting period, which are comprised of encounters with patients not currently "active" on the provider's panel. The calculation results in the addition of "active" Medicaid panel patients and unduplicated Medicaid encounters from the MPV reporting period to form the numerator. The denominator is the sum of total "active" panel patients and the total number of unduplicated encounters during the MPV reporting period. The division of the resultant numerator and denominator form the EP's alternative MPV percentage.

Aggregate or Group Methodology

To minimize the burden on providers for documenting sufficient MPV for eligibility in the NY Medicaid EHR Incentive Program, group practices and clinics with more than one EP are allowed to use the aggregate Medicaid and overall patient volume for the entire practice/clinic as a proxy for each provider's individual patient volume. All EPs enrolling in the NY Medicaid EHR Incentive Program from a single practice or clinic must use the same methodology for any given calendar year. In other words, if one EP enrolling from a clinic/practice attests to individual patient volumes, all providers subsequently enrolling for that calendar year are required to attest to individual patient volumes. Whereas, if one EP attests to aggregate patient volumes for the clinic/practice, every other EP will be required to attest to the same MPV reporting period and patient volume, unless it is impossible to do so. Clinics and group practices that opt to use aggregate patient volumes may choose any of the calculation methodologies detailed above. Any EP using aggregate patient volumes will additionally be required to attest that use of the aggregate value is appropriate

for that EP (e.g., that the provider does not exclusively see Medicare, commercial, or self-pay patients within the practice or clinic patient population).

As with individual patient volume attestation, providers using the aggregate practice/clinic patient volumes are responsible for the accuracy of the attested values, and in the event of an audit will be required to supply documentation of the attested values. Notwithstanding the fact that only some of the providers in a group practice or clinic may qualify for the NY Medicaid EHR Incentive Program (based on provider type, for example), aggregate values must represent the entire practice's patient volume and not limit it in any way; including not limiting it to only patients seen by EPs.

6. What data sources will the SMA use to verify patient volume for EPs and acute care hospitals?

NY Medicaid leverages fee-for-service claims history and managed care encounter data from the MDW to verify that the number of Medicaid encounters submitted by the provider matches the number of Medicaid patient encounters reported by the provider, for the attested to MPV reporting period. The MDW is the claims clearinghouse for all Medicaid claims in NYS.

For details on EP calculations, please see question C24 – Eligible Professionals and for details on EH calculations, please see question C24 – Eligible Hospitals.

7. How will the SMA verify that EPs at FQHC/RHCs meet the practices predominately requirement?

In the case of providers practicing predominantly in FQHCs/RHCs who seek to qualify at 30% MPV under the alternative criteria of "needy individuals," NY Medicaid encourages providers to collect information from patients regarding their participation in public assistance programs. This is to establish the percentage of their patients who qualify as "needy individuals", according to the definition set forth in the federal rule on the Medicaid EHR Incentive Program. Providers are notified that Medicaid and Child Health Plus beneficiaries do count toward the 30% "needy individuals" threshold. In addition, providers may count uncompensated care and sliding fee scale encounters.

As part of the attestation, providers who answer "yes" to practicing predominately at an FQHC/RHC are required to supply the name of the practice/clinic. During the attestation review process, NY Medicaid also verifies that the practice/clinic listed on the attestation is a valid and recognized FQHC or RHC.

8. How will the SMA verify *adopt, implement or upgrade* of certified electronic health record technology by providers?

It is important to note that after payment year 2016, providers may not begin the program and therefore, providers are unable to attest to adopt, implement, or upgrade (AIU) for payment years 2017-2021. The information below is for historical purposes.

During the first year of their participation in the NY Medicaid EHR Incentive Program, providers who seek to demonstrate eligibility for the program based on AIU activities and are required to attest to having undertaken activities to adopt, implement, or upgrade Certified EHR Technology (CEHRT). Activities that qualify include:

- Development or upgrade of custom EHR technology with subsequent certification by an ONC-ACTB;
- Purchase/acquisition or installation of commercial off-the-shelf (COTS) CEHRT;
- Integration of individually CEHRT modules;
- Testing of the CEHRT;
- Training in the use of the CEHRT; and
- Business process engineering to integrate the CEHRT into the clinical workflow.

For each participation year in the program, providers are required to identify the CEHRT they are using. As part of initial registration with the NLR, providers may specify the CMS EHR Certification ID of their EHR system, but this field is optional. Additionally, NY Medicaid will allow providers to supply additional CMS EHR Certification IDs during the MU attestation process. Providers are required to attest that any Certification IDs submitted to NY Medicaid reflect a system which meets CMS standards, for the appropriate payment year. MEIPASS uses a CMS-provided web service to validate, at the time of provider attestation that the CMS EHR Certification ID is valid; if the provider enters an invalid CMS EHR Certification ID, or the CMS web service is unavailable, MEIPASS will prevent the attestation from being submitted until the issue is resolved. When the CEHRT number is entered in the CMS Registration, the provider will need to access this again if they need to change this number and will not be able to do so in MEIPASS.

The accuracy of the attestation as to the specific certified EHR system that is being adopted, implemented, or upgraded by each provider is ultimately the responsibility of the provider. Providers are currently not required to submit evidence in pre-payment review of having the CEHRT. Although, if chosen for a post-payment audit, providers are required to provide supporting documentation of evidence of completing EHR activity. Providers are responsible for adopting and subsequently meaningfully using CEHRT and keeping up to date with changes in certification status. Providers are also responsible for updating information in their CMS Registration or attestation to reflect any changes made to their CEHRT and are instructed that it is their responsibility to maintain all applicable records to support the attestations for a period of no less than six years in the event of post-payment audit.

9. How will the SMA verify meaningful use of certified electronic health record technology for providers' second participation years?

As explained above in question C8, the accuracy of the attestation as to the specific certified EHR system that is being meaningfully used by each provider is ultimately the responsibility of the provider. Providers are currently not required to submit

evidence in pre-payment review of having meaningfully used CEHRT. Although, if chosen for a post-payment audit, providers are required to provide supporting documentation of evidence of completing EHR activity. In addition, during the attestation process, providers are required to attest to having met the MU objectives and measures, as indicated in question C3.

10. Will the SMA be proposing any changes to the MU definition as permissible per rule-making? If so, please provide details on the expected benefit to the Medicaid population as well as how the SMA assessed the issue of additional provider reporting and financial burden.

NYS does not propose any changes to the MU definition as permissible per rule-making.

11. How will the SMA verify providers' use of *certified electronic health record technology*?

For all payment years, MEIPASS validates that the CEHRT ID attested to is valid and meets the CEHRT edition requirements for the applicable payment year and stage of MU. For details please see questions C8 and C9. However, MEIPASS is unable to verify that a provider is utilizing the CEHRT. This verification is not checked during the pre-payment review process, but there is a need for a provider to supply MU and electronic Clinical Quality Measure (eCQM) data that would come directly from an EHR system during the attestation. However, if selected for a post-payment audit, the provider will be required to submit documentation supporting their use of CEHRT. This is detailed in the NYS Audit Strategy, which is submitted regularly to CMS.

12. How will the SMA collect providers' meaningful use data, including the reporting of clinical quality measures? Does the State envision different approaches for the short-term and a different approach for the longer-term?

MU and eCQM data are reported to NYS during the completion of the MEIPASS attestation.

Meaningful Use (MU) Data

MU measures are evaluated based on requirements outlined in 42 CFR 495.6, and any subsequent rule making, depending on the stage and year the provider is attesting to. Measures are reviewed for reasonableness and, when possible, existing data from sources like the MDW, NYS and New York City (NYC) Public Health Agencies (PHAs), and statistically similar provider types is leveraged. However, after analyzing existing data sources, it was determined that few additional data sources exist in NYS for verification of MU data, given that much of the information collected constitutes new data types. For example, the ability to perform some rudimentary verification checks (such as confirming that an EP was an active Medicaid participant over the reported time frame) can be accomplished using the existing data found in the MMIS and MDW; however, the ability to collect data supporting the verification of measures and objectives outside of the Medicaid

system(s) is limited. Accordingly, OMIG continues work to identify opportunities to leverage additional data sources within the post-payment audit process.

Electronic Clinical Quality Measures (eCQMs)

NYS does not currently support electronic collection of eCQM data, via the MEIPASS attestation, as part of the NY Medicaid EHR Incentive Program. Due to high priority system changes required to support attestation for the remaining payment years, NY Medicaid does not feel it is feasible to implement electronic collection of eCQM data in this capacity, by the end of the program.

13. How will this data collection and analysis process align with the collection of other clinical quality measures data, such as CHIPRA?

As explained in question C12, NYS is not currently collecting or analyzing electronic eCQM data, in relation to the NY Medicaid EHR Incentive Program. However, there are efforts underway surrounding implementation of HIT-enabled quality measurement through clinical data available in the Statewide Health Information Network for New York (SHIN-NY). For additional details on those efforts, please see question A11.

14. What IT, fiscal and communication systems will be used to implement the EHR Incentive Program?

The following systems are used to implement the NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability program:

eMedNY

NY Medicaid continues to utilize the state's current MMIS, eMedNY, for validation of provider enrollment and disbursement of the incentive payments. Additionally, NY continues to leverage eMedNY's security infrastructure to authorize users' abilities to attest for providers as well as to access the providers' records in the current State Level Repository (SLR), MEIPASS.

MEIPASS

MEIPASS continues to serve as the SLR for the collection of providers' registrations and attestations, as well as for the execution of payments. MEIPASS is utilized for payments due to its integration with eMedNY. This integration enforces user security and validates provider eligibility for the program with regards to active enrollment and provider type. NYS's fiscal agent, CSRA, maintains responsibility for the design, development, and implementation (DDI) as well as operational support of MEIPASS. In 2011, testing with the NLR was completed and MEIPASS became available for providers. Subsequently, CSRA has performed updates to the MEIPASS system, to ensure compliance with program changes.

Medicaid Data Warehouse (MDW)

The MDW continues to serve as the clearinghouse for the state's Medicaid claims data, and subsequently, it is used as the primary source to validate patient volume

data and to determine hospital-based status. Furthermore, the MDW stores registration and attestation data transmitted from the SLR.

15. What IT systems changes are needed by the SMA to implement the EHR Incentive Program?

The only IT system changes needed are to the MEIPASS attestation system, to ensure alignment with program requirements for all future payment years. As of January 2019, NY Medicaid is currently working with the MEIPASS vendor, CSRA, to ensure compliance with program requirements for payment year 2018 and will immediately begin updates for payment years 2019 through 2021, following promotion of the 2018 updates.

16. What is the SMA's IT timeframe for systems modifications?

With the need to have all payments issued by December 31, 2021, NY Medicaid has strict dates to open payment years to providers, for attestation. The table below lists the historical and anticipated future dates when payment year attestations will be accepted from providers. Meeting the future dates is essential to ensure that providers have ample time to attest for the final payment years of the Program.

Exhibit 4. MEIPASS Payment Year Availability for Providers

Payment Year	Stage	Open Date (*Anticipated Date)
2011	AIU	Thursday, November 17, 2011
2012	AIU	Tuesday, April 24, 2012
2012	MU Stage 1	Friday, November 2, 2012
2013	AIU	Tuesday, January 1, 2013
2013	MU Stage 1	Tuesday, April 2, 2013
2014	AIU & MU Stage 1	Tuesday, July 8, 2014
2014	MU Stage 2	Monday, December 22, 2014
2014	2014 CEHRT Flexibility Rule for MU Stage 1 & Stage 2	Friday, February 22, 2015
2015	AIU	Monday, February 9, 2015
2015	MU Stage 1 & Stage 2	Wednesday, April 1, 2015
2015	MU Modified Stage 2	Friday, March 10, 2017
2016	AIU	Friday, January 1, 2016
2016	MU Modified Stage 2	Friday, March 10, 2017
2017	MU Modified Stage 2 & Optional Stage 3	Monday, July 16, 2018
2018	MU Modified Stage 2 & Stage 3	*Monday, July 1, 2019
2019	MU Stage 3	*Monday, March 2, 2020
2020	MU Stage 3	*Friday, January 1, 2021
2021	MU Stage 3	*Thursday, April 1, 2021

17. When does the SMA anticipate being ready to test an interface with the CMS National Level Repository (NLR)?

The SLR regularly exchanges interface files with the CMS NLR and has done so since November of 2011. The MEIPASS vendor, CSRA, ensures completion of the

file exchanges. In addition, CSRA works with NY Medicaid to make any necessary updates that have or may be needed, due to changes in the interface files.

18. What is the SMA's plan for accepting the registration data for its Medicaid providers from the CMS NLR (e.g. mainframe to mainframe interface or another means?

NY Medicaid regularly receives and accepts the registration data for NY Medicaid providers from the CMS NLR. For details on the usage of this data, please see questions C1 and C8.

19. What kind of website will the SMA host for Medicaid providers for enrollment, program information, etc.?

The NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability Program, provides a public facing website, which is available through the general NYS DOH website. The NY Medicaid EHR Incentive Program website[13] provides information regarding program eligibility, guidance, assistance, program announcements, and direct links to MEIPASS. In addition, special guidance is provided regarding the Public Health Reporting Objective and Post-Payment Audit. NY Medicaid continues to expand the educational resources and information on the website.

20. Does the SMA anticipate modifications to the MMIS and if so, when does the SMA anticipate submitting an MMIS I-APD?

NYS DOH has initiated efforts to complete an extensive analysis, ensure stakeholder readiness, and perform careful planning to inform its future MMIS strategy. A key component of that planning will be to ensure continued support for the administration and oversight of the NY Medicaid EHR Incentive Program throughout its remaining years.

21. What kinds of call centers/help desks, and other means will be established to address EP and hospital questions regarding the incentive program?

NY Medicaid understands the difficulty providers face when attesting to the program and as a result offers a wide variety of resources to assist in educating and supporting providers in successful completion of the program. The portfolio of support offerings for NY program participants includes:

- Help Desk Support Monday through Friday 8:30AM-5:00PM EST
  - Telephone Support
  - E-mail Support
- Direct Provider Communications and Outreach
- LISTSERV® Messages
  - NY Medicaid EHR Incentive Program LISTSERV®

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[13] https://www.health.ny.gov/ehr

- - o Public Health Reporting Objective LISTSERV®
- Provider and Stakeholder Webinars
- Step-by-Step Help Guides
- Tutorial Help Videos
- Frequently Asked Questions (FAQs)
    - o NY Medicaid EHR Incentive Program FAQs
    - o Public Health Reporting Objective FAQs
- Comprehensive Program Website
- Feedback Survey – Available for response and feedback to be submitted on the website, is disseminated to all webinar attendees, and a link is included in all e-mail outreach.
- Coordination with Professional Organization and Trade Associations
- Regional Extension Center (REC) Support

22. What will the SMA establish as a provider appeal process relative to: a) the incentive payments, b) provider eligibility determinations, and c) demonstration of efforts to adopt, implement or upgrade and meaningful use certified EHR technology?

Pre-payment Review Appeals

NY Medicaid has an issue resolution process in place for providers, who wish to appeal NY Medicaid's declination of a payment, during the pre-payment review process. The deadline to submit an appeal request is 60 calendar days from the date on the notification of the determination. Any appeal received after the 60-day timeframe will not be reviewed and the initial determination will be final. If the appeal is received within 60 days, the case will be reviewed by NY Medicaid. NY Medicaid is responsible for communicating the results of their review of the appeal to the provider within 10 business days of receiving the appeal request.

Appeal Requests are based on the three following adverse determinations: incentive payments, provider eligibility, and demonstration of AIU and MU of CEHRT. It is important to note that the last year for AIU participation was 2016 and therefore the last year where demonstration of AIU may be disputed was in relation to payment year 2016. NY Medicaid may refuse to consider an appeal from a provider who is not properly licensed, has been excluded or terminated, or is not affiliated with their payee.

When a valid Appeal Request is received, NY Medicaid completes a three-level review of all information, including what was supplied by the provider with the appeal, to determine if the original determination will remain or be overturned. Following an appeal determination, the provider is sent electronic communication informing them of the decision and including instructions for moving forward. In addition, when the review has concluded, and the provider has been notified, all appropriate systems will be updated. At that point, the appeal is considered closed.

Post-Payment Audit Appeals

Beginning in each provider's participation year, post-payment audits will be conducted to validate the appropriateness of the payments and to verify the

providers were compliant with requirements to be eligible for the incentive payment. Information submitted by the provider during the registration and attestation processes will be reviewed thoroughly. The audits for the NY Medicaid EHR Incentive Program will utilize the standard processes and techniques already in use for Medicaid claims.

If, following a post-payment audit, a provider seeks to object to an adverse determination and accompanying proposed action presented in the Final Audit Report, the provider will be given the opportunity to request an administrative appeal hearing within 60 calendar days of the Final Audit Report. In accordance with 18 NYCRR Part 519[14], the appeals process for the NY Medicaid EHR Incentive Program follows the standard processes currently employed for Medicaid claims appeals.

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

NY Medicaid reviews and verifies all Federal funding on a quarterly basis, during the completion of the CMS 37 report (request for funds) and the CMS 64 (reconciliation of spent funds). These reports are submitted by the NYS DOH Fiscal Management Group (FMG), which oversees all NYS DOH financials and reporting to CMS. To ensure that funding is accounted for separately, the NY financial system has a separate chart of accounts, which correspond to the percentage for the federal match and usage. For instance, HIT Administration under HITECH, incentive payments, and MMIS are accounted for separately.

24. What is the SMA's anticipated frequency for making the EHR Incentive payments (e.g. monthly, semi-monthly, etc.)?

NY Medicaid payments are made on a weekly basis. There is approximately a two-and-a-half-week time lag between approval for payment and the payment release date. Payments are disbursed in two forms, which include a paper check or an Electronic Funds Transfer (EFT).

Eligible Professionals (EPs)

Below is an overview of the process for disbursement of payment:

1. NY Medicaid uses a series of both manual and automated checks to verify that an EP qualifies for the program and is not excluded from payment. If an EP is deemed to be ineligible, they will not receive an incentive payment.
2. NY Medicaid compiles a list of EPs who qualify for incentive payment and verifies with CMS that the EPs are approved for payment, prior to the payment being issued.

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[14] 18 NYCRR Part 519 (https://regs.health.ny.gov/volume-c-title-18/875084749/part-519-provider-hearings)

3. CMS confirms an EP's eligibility for payment by checking the following:
   a. no duplicate exclusions were allowed;
   b. no payments were already made for the corresponding payment year for the provider; and
   c. the provider has not reached the threshold for the maximum allowable incentive payment reimbursement or $67,500.
4. CMS returns the list of EPs to NY Medicaid indicating if they were denied or approved.
5. The EPs who have been denied for payment by the State or CMS will receive a notice of denial. EPs who do not agree with the findings may appeal.
6. NY Medicaid issues payment to the EPs who were approved for payment during the State review process and by CMS as a single lump sum.
7. NY Medicaid sends CMS a final list of all payments made to EPs.

Eligible Hospitals (EHs)

NY Medicaid issues incentive payments to EHs as early in the payment year as they can, while adhering to the guidelines in the American Recovery and Reinvestment Act of 2009 (ARRA) regarding payment distribution. EHs receive their incentive payment broken into three installments, paid annually over three consecutive years. The following table shows what percentage of the total payment are disbursed during these three participation years.

Exhibit 5. EH Incentive Payment Timeline

Participation Year	Percentage of Incentive Payment Total
1	50%
2	40%
3	10%

EH incentive payment totals are calculated utilizing four years of Institutional Cost Report (ICR) data on file with NY Medicaid. When financial and encounter data elements are compared against the EH's ICR data, there must be an error rate of zero percent; any percentage outside of this would result in EHR program staff contacting the EH to investigate the difference. If additional information cannot be provided by the EH, the attestation for the NY Medicaid EHR Incentive Program will be denied.

To determine percent error, the following calculation is used:

$$Percent\ Error = \frac{MEIPASS\ Application\ Value - ICR\ Value}{ICR\ Value} \times 100$$

25. What will be the process to assure that Medicaid provider payments are paid directly to the provider (or an employer or facility to which the provider has assigned payments) without any deduction or rebate?

EPs assign payment either to themselves or another entity during the CMS registration process with the NLR. Payment assignment cannot be updated via MEIPASS, therefore if a change needs to be made, the provider will need to access the CMS Registration and Attestation System to make the necessary updates. NY Medicaid verifies that the payee is enrolled in NY Medicaid, in addition to the individual EP that is attesting for the NY Medicaid EHR Incentive Program.

When NY Medicaid receives the payment information on the B-6 interface file from the NLR, the system verifies the payee NPI is enrolled with NY Medicaid. In addition, during the pre-payment review process, checks are performed to verify the payment assignment information is valid. Evidence of a contractual agreement (affiliation) between the EP and the payee must be on file either as an affiliation in the eMedNY system or through separate supporting documentation. The validations are completed again at the time of the D-16 interface being processed.

26. What will be the process to assure that Medicaid payments go to an entity promoting the adoption of certified EHR technology, as designated by the state and approved by the US DHHS Secretary, are made only if participation in such a payment arrangement is voluntary by the EP and that no more than 5 percent of such payments is retained for costs unrelated to EHR technology adoption?

Each provider will be allowed to assign NY Medicaid EHR Incentive Program payments only to an employer or entity with which the EP has a contractual arrangement. This contractual arrangement must allow the employer or entity to bill and receive payment for the EP's covered professional services. Providers who choose to assign payments to such an employer or entity will be required to supply the taxpayer identification number (TIN) of the entity and attest that the assignment is appropriate and voluntary. Providers who choose to assign their payment must select a single entity to receive the entire payment, no partial assignment to multiple entities will be allowed.

At this time, NY Medicaid has not chosen to designate any additional entities promoting the adoption of CEHRT to which providers can assign their incentive payments and does not plan to designate any additional entities for the remainder of the program.

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

While NY Medicaid leverages the financial information provided during NY Medicaid enrollment, which is housed in the eMedNY system, for issuance of NY Medicaid EHR Incentive Program payments, the payments are validated separately and kept distinct from other payments. In addition, NY Medicaid disburses NY Medicaid EHR

Incentive Program payments directly to providers, regardless of whether they participate in the Medicaid program through fee-for-service, managed care, or a combination of the two. To receive incentive payments, providers must be enrolled in NY Medicaid with a valid provider ID number, regardless of whether the provider customarily submits fee-for-service claims. Since no payments for the NY Medicaid EHR Incentive Program are disbursed through managed care plans, the restriction that payments to Medicaid managed care plans not exceed 105 percent of the capitation rate does not have any effect on the implementation of this program.

28. What will be the process to assure that all hospital calculations and EP payment incentives (including tracking EPs' 15% of the net average allowable costs of certified EHR technology) are made consistent with the Statute and regulation?

Details on the NY Medicaid EHR Incentive Program payment process and frequency, for both EHs and EPs can be found in question C24. In keeping with the current federal legislation and rulemaking, EPs are not required to demonstrate the actual costs incurred by the EP for the AIU of CEHRT, nor are they required to document payments received from outside sources towards the cost of these activities. During the payment process, MEIPASS limits the total incentive payments for EPs to $63,750 as required per regulation. Adjustments are made to payments, as needed, when a provider participated in other states or switched from the Medicare EHR Incentive Program to the Medicaid EHR Incentive Program. This verification is completed via the interface files that MEIPASS, NY's SLR, exchanges with the NLR.

29. What will be the role of existing SMA contractors in implementing the EHR Incentive Program – such as MMIS, PBM, fiscal agent, managed care contractors, etc.?

Program Support

NY Medicaid has engaged the services of NYSTEC to provide program administration, provider/stakeholder support and outreach, attestation review and remediation, and oversight of MEIPASS DDI - including requirements definition, JAD sessions, documentation development, review and approval of MEIPASS design and development documents, testing review, and user acceptance testing.

NYSTEC is currently under contract for program support services through December 31, 2020.

MEIPASS DDI

At the outset of implementation activities, NY Medicaid executed a contract amendment with its current fiscal agent, CSRA. The amendment covered DDI, and program administration and operational support services for MEIPASS as a contained service within NY Medicaid's MMIS through the end of CSRA's fiscal agent contract, which has been extended through November 30, 2019. NY Medicaid anticipates continuing to utilize CSRA to support the NY Medicaid EHR

Incentive Program DDI efforts coupled with program administration and operational support services beyond this date.

Regional Technical Meaningful Use Support

NY Medicaid previously engaged the New York eHealth Collaborative (NYeC) and New York City Regional Electronic Adoption Center for Health (NYC REACH), the State's two RECs, to coordinate efforts to encourage the adoption and MU of CEHRT. In addition to recruitment and engagement support, these contracts offer a variety of services to assist eligible providers (e.g., educational materials, events).

NY Medicaid has also engaged NYC REACH to develop and disseminate a statewide curriculum on the NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability program. In addition, NYC REACH is responsible for the delivery of this curriculum within the five boroughs of NYC. NYeC has been engaged to deliver the statewide curriculum throughout the rest of the state.

30. States should explicitly describe what their assumptions are, and where the path and timing of their plans have dependencies based upon:

- **The role of CMS (e.g. the development and support of the National Level Repository; provider outreach/help desk support)**
- **The status/availability of certified EHR technology**
- **The role, approved plans and status of the Regional Extension Centers**
- **The role, approved plans and status of the HIE cooperative agreements**
- **State-specific readiness factors**

NY Medicaid's ability to meet the schedule presented in question C16 and to enable providers to attest and be paid by December 31, 2021, is dependent on the timely release of the eCQM updates, on the eCQI website, for payment years 2020 and 2021. If the eCQMs are not published in a timely manner, there is a risk to NY Medicaid meeting these critical deadlines. Therefore, NY Medicaid will mitigate this risk by making the following assumptions, ensuring the MEIPASS system can be updated in sufficient time for providers to participate in the program by the mandated deadline:

- If the eCQMs for payment year 2020 are not published on the website by March 31, 2020, NY Medicaid will assume there were no changes and utilize the payment year 2019 eCQMs in MEIPASS.
- If the payment year 2021 eCQMs are not published on the website by June 30, 2020, NY Medicaid will assume there were no changes and utilize the payment year 2020, or payment year 2019 if 2020 was not updated, eCQMs in MEIPASS.

Section D
The State's Audit Strategy

The Office of the Medicaid Inspector General (OMIG) plays a pivotal leadership role in the state's mission to eliminate and prevent fraud, waste, and abuse in New York's Medicaid program. OMIG works closely with the New York State Department of Health (NYS DOH) through the Office of Health Insurance Programs (OHIP), which manages New York's Medicaid program, to ensure the integrity and effectiveness of the Medicaid program. For the NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability Program, OMIG[15] integrates the audit requirements of the program into its existing audit processes and work plan to ensure that proper payments have been made.

As the NY Medicaid EHR Incentive Program receives guidance from CMS, OMIG updates its responsibilities and audit strategy accordingly. In this capacity, OMIG will continue to provide program oversight and conduct post-payment reviews of providers to ensure that the CMS eligibility requirements are met. In addition, the post-payment audit team continues to conduct knowledge-sharing and collaboration sessions with stakeholders throughout the state in an effort to keep providers informed of changes in audit requirements and provide updates to the post-payment audit section of the program website as necessary.

OMIG's Division of Medicaid Audit (DMA) conducts audits of Medicaid providers with the goal of ascertaining whether they adhere to applicable federal and state laws, regulations, rules, and policies pertaining to the Medicaid program. These activities are conducted to monitor the cost-effective delivery of Medicaid services and prudent stewardship of scarce dollars; ensure the required involvement of professionals in planning care for program beneficiaries; safeguard the quality of care, medical necessity, and appropriateness of Medicaid services provided; and reduce potential for fraud, waste, and abuse.

OMIG's Division of Medicaid Investigations (DMI) investigates potential instances of fraud, waste, and abuse in the Medicaid program. DMI deters improper behavior by

[15] https://omig.ny.gov/images/stories/work_plan/SFY_2018_OMIG_Work_Plan_FINAL.pdf

inserting covert and overt investigators into all aspects of the program and cooperating with other agencies to enhance enforcement opportunities. Disreputable providers are removed from the program or prevented from enrolling. Recipients abusing the system are not removed from this safety net, but their access to services is examined and restricted, as appropriate. DMI maximizes cost savings, recoveries, and penalties, and improves the quality of care for the state's most vulnerable population.

D. The State's Audit Strategy

1. What will the SMA's methods to be used to avoid making improper payments? (Timing, selection of which audit elements to examine pre or post-payment, use of proxy data, sampling, how the SMA will decide to focus audit efforts, etc.):

To ensure that proper payments are made throughout the life of the NY Medicaid EHR Incentive Payment Program, NYS DOH conducts pre-payment reviews of attestations, performs the checks discussed throughout Section C and in detail in the State's Audit Plan, which is submitted regularly to CMS. In addition to pre-validation checks, OMIG and NYS DOH conduct collaborative meetings to review and discuss any overpayments discovered during the post-payment audit process. Any trends in overpayments will be reviewed and, if necessary, payments will be withheld.

2. Describe the methods the SMA will employ to identify suspected fraud and abuse, including noting if contractors will be used. Please identify what audit elements will be addressed through pre-payment controls or other methods and which audit elements will be addressed post-payment.

OMIG conducts post-payment audits to validate the appropriateness of the payments and to verify the self-attested information provided during the enrollment and registration process. The audits performed by OMIG for the NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability Program, utilize a combination of the standard processes and techniques used by OMIG for their Medicaid audits as well as audit guidance and recommendations from CMS.

With respect to the NY Medicaid EHR Incentive Program, OMIG and their associated contractor have worked together to determine the programmatic details of program integrity and audit functions, including the determinants of risk for audit. The team is also responsible for developing programmatic processes for identifying subjects of random (not risk- or event-generated) audits and for developing audit procedures specific to the details of the NY Medicaid EHR Incentive Program. OMIG also receives recommendations for audits from the Office of Inspector General (OIG) within the U.S. Department of Health & Human Services (HHS), as well as oversight agencies. Integral components of the risk selection process include data analysis, provider complaints, and review of prior audit findings. OMIG staff and their associated contractor use the knowledge gained from these activities to determine whether to include additional providers that may not have met the risk criteria.

OMIG uses a variety of analytical tools and data mining techniques to identify providers for audit purposes. OMIG utilizes various tools, including Salient, to uncover fraudulent behavior. Salient is designed to uncover patterns, identify geographic trends, and tie different data points together into usable information. OMIG emphasizes claimants' behavior over claims paid and targets those who make multiple attempts to receive payment and seek ways around the pre-payment controls designed to protect the Medicaid program. OMIG considers successful initiatives in Medicaid program integrity in other states, current academic and public policy organization analyses of health care issues, and program directives from the CMS Medicaid Integrity Program, which has federal responsibility for guidance and oversight of the NY Medicaid program. OMIG works closely with NYS DOH, the NYS Department of Law, and the NYS Comptroller's Office in identifying program vulnerabilities.

OMIG conducts desk audits and field audits as required. Audits follow existing OMIG audit procedures for initiation, execution, and preparation of reports and other correspondence. The number of audits is determined based on the volume of providers receiving NY Medicaid EHR Incentive Program payments and the results of the risk assessment. The type of audit conducted is determined by the rationale used to select the provider for an audit. Most audits will start as a desk audit to determine the provider's adherence with the program requirements. If findings of a desk audit are insufficient to make a conclusive determination, then a field audit may be initiated to further investigate adherence to requirements.

If selected for audit, providers will be sent an Audit Notification Letter by certified mail that outlines the required documentation needed for the audit. For reference purposes, a copy of the provider´s signed attestation for the payment year under audit will be included with the Audit Notification Letter. The Audit Notification Letter will indicate if the provider is under audit for Meaningful Use (MU) or Adopt, Implement or Upgrade (AIU), and for which payment year. Providers are given 35 calendar days to submit documentation from the date of the Audit Notification Letter. After 35 calendar days, providers are expected to submit documentation in support of their attestation. If documentation is not submitted or incomplete, a conference call may be held to explain the findings to the provider, if applicable. At that time, OMIG will accept any additional documentation the provider wishes to submit.

With respect to the NY Medicaid EHR Incentive Program payments, required supporting documentation for post-payment audit may include documents to support AIU of CEHRT, MU of CEHRT, information to support patient volume calculation, and other attestation requirements.

To support attestations for the AIU of CEHRT, providers should be prepared to supply documentation that, at a minimum, demonstrates either a binding financial commitment (such as a contract) or actual expenditures on AIU of the EHR technology. CEHRT documentation should clearly indicate the full name and version of the product in such a way that it can be matched to a specific product, or combination of products, meeting full certification in ONC's web-based Certification HIT Product List (CHPL). Examples of documentation that should be retained and produced upon request for AIU of CEHRT may include, but are not limited to:

- Signed/dated contracts, purchase orders, or receipts for purchase or lease of certified EHR software, or proof of subscription (contracts or paid invoices) to hosted EHR software
- Documentation of expenses incurred in development, testing, maintenance, and upgrade of custom certified EHR systems or modules
- Proof of payment for consulting services related to the selection, acquisition, installation, and setup of certified EHR technology and the successful integration of the certified EHR technology into the clinical workflow
- Purchase agreements or receipts for computer hardware or software required to operate the certified EHR system
- Documentation of expenses incurred in transitioning patient records to the certified EHR system
- Contracts or proof of actual expenditures for testing and/or training for the certified EHR system

To support Stage 1, Stage 2, Modified Stage 2, or Stage 3 attestations for MU of CEHRT, providers should be prepared to supply documentation that demonstrates meeting all measures and objectives attested to, as well as documentation clearly indicating the full name and version of the CEHRT indicated on the provider's attestation. As necessary, providers will need to provide documentation for year-specific exceptions, such as the 2014 Flexibility Rule. Examples of documentation that should be retained and produced upon request for meaningful use include:

- Any EHR or ancillary system reports supporting the criteria for the measures and objectives attested to.
- Documentation to support the conclusion of meeting any exclusion attested to.

OMIG's document requests may also include audit financial statements, related parties, and access to the work papers of independent certified public accountants. This information will facilitate our review and, at times, enable us to reduce our procedure. Additionally, OMIG will review enrollment records and annual certifications for paper and electronic submission of claims. OMIG will remind providers to retain documentation to support all attestations for no less than six years after each payment year against the possibility of post-payment audit.

If a provider is determined to be in non-compliance with one or more program requirements, a Draft Audit Report will be issued. The Draft Audit Report will reiterate the objective and scope of the audit and identify the program requirements that were determined to be in non-compliance. The Draft Audit Report will also include the regulatory citations related to program requirements not met. The provider will have 35 calendar days from the date of the Draft Audit Report to respond. If the provider fails to reply within that time frame, OMIG will issue a Final Audit Report. If the provider responds to the Draft Audit Report, OMIG will consider the provider's response, including any supporting documentation, before issuing a Final Audit Report.

3. How will the SMA track the total dollar amount of overpayments identified by the State as a result of oversight activities conducted during the FFY?

If any overpayments are identified (for example, via post-payment audit), they will be reported on OMIG's Fraud Activity Comprehensive Tracking System (FACTS), and all existing processes will be followed for the tracking of such recoveries.

FACTS is a proprietary tracking system for OMIG's audit activities, fraud investigations, compliance effectiveness reviews, system edit reviews, and self-disclosure reporting. The application is web-based and is accessible in real time by users across the state in four state agencies (OMIG, NYS DOH, Medicaid Fraud Control Unit, and the Office of the State Comptroller). FACTS is a web-based application that was developed using .NET and Oracle. The hardware architecture consists of a fail-over database/application cluster that is located in a controlled server environment at an off-site state office. Full backups are performed on a daily basis, with incremental backups occurring approximately every two minutes. A log of every transaction is kept ensuring the integrity of the system.

FACTS is an electronic drawer, composed of numerous and varying databases, data sources, modules, and interfaces that permit efficient access to current and historical information on OMIG activities involving Medicaid providers and/or recipients. The system centralizes information from OMIG reviews, providing a current, accurate, and reliable data source by building a complete history of any prior provider- or recipient-related activity and making it immediately available to auditors and investigators. Users can collaborate on assignments, and OMIG managers can obtain the most recent activity.

FACTS also enables fraud/audit managers statewide to better identify, track, and coordinate Medicaid audits and investigators across NYS. Cases are entered by each regional office and updated by audit supervisors. Each region is responsible for its reviews. Imaged case documents are placed in each respective case, which allows OMIG staff real-time access.

Significant Medicaid Program savings are generated through better identification of provider fraud and abuse and through more timely and efficient coordination of activities by audit and investigative staff. Additionally, coordination of some inter-agency and local district reviews can be achieved through the use of FACTS.

As stated above, FACTS serves as the central tracking mechanism for audits. A new project type called "Medicaid EHR Incentive Program" has been created in FACTS in an effort to track HIT activity distinctly. For the EHR Incentive Program, the obligation to repay the federal government 100% for overpayments will be met consistently with current procedures.

The reporting of an overpayment in FACTS will also trigger the appropriate notifications to NYS DOH and to the CMS Research and Support (R&S) system. NYS DOH will set up a recovery account for this provider recoupment with full repayment made to CMS on a quarterly basis. OMIG collections will then continue to follow its normal collections process to recoup the funds from the provider. Standard collection policy is that these debts should be repaid within one year. Providers requesting reduced collection percentages may be accommodated,

assuming the principal component of the debt can still be recovered within one year. Providers requesting financial hardship may be granted different repayment terms, based on a review of specific financial information. If the provider becomes an inactive Medicaid biller, the State takes additional collection actions, including assigning the debt to another active provider with the same federal tax ID, or eventually referring the debt to the State Attorney General's office for recovery

4. Describe the actions the SMA will take when fraud and abuse is detected.

Any fraud identified may be referred by OMIG to the New York State Attorney General's Medicaid Fraud Control Unit or prosecutor, if deemed appropriate. Suspected cases of fraud and abuse (e.g., unacceptable practices under State regulations) will be handled similarly to all other current allegations of fraud and abuse, including the conduct of investigations, issuance of warning letters, imposition of penalties or other sanctions, exclusions and terminations from the Medicaid Program, etc.

5. Is the SMA planning to leverage existing data sources to verify meaningful use (e.g. HIEs, pharmacy hubs, immunization registries, public health surveillance databases, etc.)? Please describe.

MU measures are evaluated based on requirements outlined in 42 CFR 495.6, depending on the stage and year the provider is attesting to. Measures are reviewed for reasonableness and, when possible, existing data from sources like the Medicaid Data Warehouse (MDW), NYS Public Health Agencies (PHAs), and New York City (NYC) PHAs are leveraged along with responses from like provider types. However, after analyzing existing data sources, it was determined that few additional data sources exist for verification of MU data, given that much of the information collected constitutes new data types. For example, the ability to perform some rudimentary verification checks (such as confirming that an eligible professional was an active Medicaid participant over the reported time frame) can be accomplished using the existing data found in the MMIS and MDW; however, the ability to collect data supporting the verification of measures and objectives outside of the Medicaid system(s) is limited.

6. Will the state be using sampling as part of audit strategy? If yes, what sampling methodology will be performed?* (i.e. probe sampling; random sampling)

OMIG uses statistical sampling to target providers that may pose an elevated risk of improper payments and noncompliance with the federal and state requirements. For NY Medicaid EHR Incentive Program Payment audits, OMIG performs a risk assessment on all EPs and EHs and stratifies them into one of five different risk pools, based on their calculated risk scores. Each risk pool will have a percentage of providers to be selected for audit based on various sampling techniques, including random sampling and stratified sampling conducted by OMIG's Division of Systems Utilization and Review (DSUR). Within this stratification, 100% of providers in risk pool 1 will be selected for audit. Risk pools 2 through 5 will have a

percentage of providers to audit, and this percentage will decrease as the level of risk decreases for each risk pool.

7. What methods will the SMA use to reduce provider burden and maintain integrity and efficacy of oversight process (e.g. above examples about leveraging existing data sources, piggy-backing on existing audit mechanisms/activities, etc.)?

Existing data sources will be used, in particular the MMIS, to assist OMIG in the validation of provider participation and Medicaid Patient Volume (MPV) in the Medicaid program. OMIG also continues to evaluate lessons learned and conduct evaluation of processes to improve, streamline, and standardize the audit process and reduce provider burden, when possible. Potential process improvements are identified based on continued experience and feedback from providers, best practices shared in HITECH Communities of Practice (CoP) meetings, and collaboration sessions with other states. As an example, through these efforts, OMIG has identified areas that reduce unnecessary provider burden such as:

- Documenting proven methods by EHR vendors to validate audit requirements related to the EHR system. This knowledge is then shared in future communications for new provider audits using similar software.
- Organizing audits by group so that one auditor is assigned to all providers within a group. Data that applies to all providers within the group, such as patient volume, is requested only once, and a consolidated data request is sent out at one time to the contact person.
- Continued coordination between NYS DOH and OMIG on sharing provider communication and documentation submitted at the time of attestation. This allows OMIG to leverage previously submitted documentation to reduce provider burden and prevent duplicative efforts during post-payment audit.

8. Where are program integrity operations located within the State Medicaid Agency, and how will responsibility for EHR incentive payment oversight be allocated?

Program Integrity with respect to the NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability Program, is a coordinated effort between NYS DOH, which conducts screening of applicants prior to the issuance of NY Medicaid EHR Incentive Program payments and OMIG, which is charged with detecting fraud, abuse, or waste in the Medicaid system and recovering improper payments.

Within OMIG, each division plays a significant role in the program integrity function, including the Division of Medicaid Audit (DMA), which conducts audits and reviews of Medicaid providers to ensure compliance with program requirements and, where necessary, recovers overpayments; the Division of Medicaid Investigations (DMI), which investigates potential instances of fraud, waste, and abuse in the Medicaid Program; the Division of System Utilization and Review (DSUR), which supports the data needs of OMIG through data mining and analysis, and system match and recovery through the use of commercial data mining products and procurement of expert services consultants; and the Office of Counsel, which promotes OMIG's

overall statutory mission through timely, accurate, and pervasive legal advocacy and counsel.

Section E
The State's HIT Roadmap

E. The State's HIT Roadmap

1. Provide CMS with a graphical as well as narrative pathway that clearly shows where the SMA is starting from (As-Is) today, where it expects to be five years from now (To-Be), and how it plans to get there.

NY Medicaid EHR Incentive Program

As touched upon in question B1, the overarching goal of the New York (NY) Medicaid Electronic Health Record (EHR) Incentive Program, a CMS Promoting Interoperability Program, is to maximize provider participation in the program and encourage Eligible Professionals (EPs) to complete all six years of the program or to participate consecutively through payment year 2021, if the EP is unable to complete six years before the end of the program. In addition, payment year 2018 is the final year for Eligible Hospitals (EHs) to participate and it is NY Medicaid's goal to ensure all EHs participate during this final year. The rationale behind this goal is that as providers continue to meaningfully utilize Certified EHR Technology (CEHRT), they will be able to achieve other health care transformation initiatives and improve quality outcomes.

Exhibit 6. EHR Incentive Program Strategy

Adopt, Implement, or Upgrade (AIU) → Meaningful Use (MU) → Improved Outcomes & Health Care Transformation
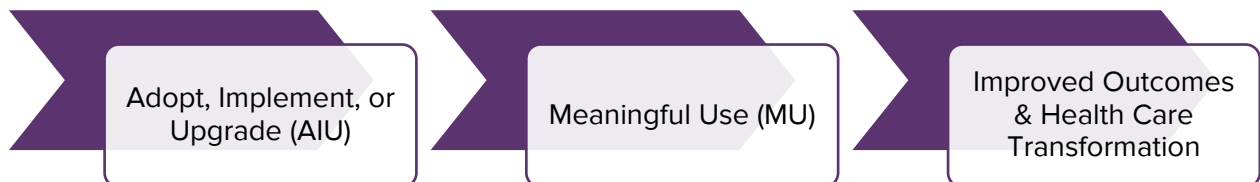
In order to meet this goal, NY Medicaid is continuing and enhancing the activities detailed in question A9, which consist of provider outreach, development and enhancement of comprehensive educational materials, coordination with New York State (NYS) trade organizations and professional associations, and collaboration and support of NY's two Regional Extension Centers (RECs). Details on how and with what frequency NY Medicaid will assess their progress towards this goal, are found in question E3.

Health Information Exchange (HIE)

The New York State (NYS) Department of Health (NYS DOH) plans to continue to invest in HIE initiatives to support providers' efforts to improve the health of their patients while lowering health care costs by reducing redundancy and improving care coordination. Moreover, these initiatives are integral to the long-term success of the NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability Program, by creating the governance and technology infrastructure to enable providers to share data to meet their MU objectives and increase the value of the program, thereby increasing providers' willingness to meet MU requirements and maintain participation in the program.

Medicaid providers' use of HIE capabilities and their participation in the NY Medicaid EHR Incentive Program will be driven in large part by the quality and quantity of data they can locate on Medicaid beneficiaries, and the sophistication and ease of use of the HIE services. The work underway to expand the availability of Medicaid beneficiary data and the robustness of services available via the Statewide Health Information Network for New York (SHIN-NY) and Qualified Entities (QEs), as well as its overall usability, will thereby increase and sustain EH and EP participation in the NY Medicaid EHR Incentive Program.

The ultimate vision for HIE in NYS is to establish an infrastructure of technology and policies that allow multiple stakeholders to access high-quality data that represents a complete picture of the care delivered to a patient and enables measurement of the health outcomes of a population. To achieve this, NYS DOH is continuing to invest in the SHIN-NY, supporting providers in connecting to the QEs, and planning for future interoperability.

As of January 2019, use of the SHIN-NY to access patient information is associated with approximately:

- 50% reduction in the rate of hospital readmissions,
- 26% reduction in the rate of emergency department admissions,
- 35% reduction in the rate of repeat imaging procedures, and
- 10% lower 30-day readmission rate among Medicare fee-for-service beneficiaries.[16]

This demonstrates that efforts being undertaken are driving NYS towards their ultimate goals and demonstrate that the desired outcomes are possible, with continued focus and effort.

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[16] https://www.nyehealth.org/shin-ny/value-of-hie/

2. What are the SMA's expectations re provider EHR technology adoption over time? Annual benchmarks by provider type?

As discussed in question B1, Medicaid Promoting Interoperability Program requirements stipulate that the last year for providers to begin participation was 2016. Therefore, there is a set universe and the number of providers who may continue participation in the program is finite. In addition, MU Stage 3 requires providers to utilize 2015 Edition CEHRT. Based on these two requirements, NY Medicaid is focusing efforts on encouraging providers to upgrade or adopt EHR technology that meets the MU Stage 3 requirements and maximizing continued provider participation in the NY Medicaid EHR Incentive Program, a CMS Promoting Interoperability Program. Please see details on the specific benchmarks in question E3 below.

3. Describe the annual benchmarks for each of the SMA's goals that will serve as clearly measurable indicators of progress along this scenario.

NY Medicaid EHR Incentive Program

As discussed throughout this document and in question E1, NY Medicaid's goals, regarding the NY Medicaid EHR Incentive Program, will be reviewed and measured as they pertain to Program Participation and Outreach, Education, and Resources.

i.   Program Participation

To assess the program participation of providers, the following goals have been set for EPs.

Exhibit 7. EP Program Participation Goals

Total Unique EPs: 18,613	Payment Year			
	2018	2019	2020	2021
Attesting Unique EPs	3,630	2,792	3,164	2,885
Percent of Total Unique EPs	19.5%	15.0%	17.0%	15.5%

The goals for EP participation are reviewed after each payment year is completed, to determine if provider participation aligned with expectations or deviated. After review, NY Medicaid refines the goals, ensuring the program is striving for accurate and realistic goals. Therefore, goals for future payment years are subject to change following the review of the closing of a prior payment year.

In addition, there is a population of 8 EHs that are eligible to attest and be paid for payment year 2018. This is the final year in which EHs are eligible to participate in the program and NY Medicaid is striving for the entire population of 8 EHs to successfully achieve MU and participate in the program.

ii. Outreach, Education, and Resources

Aligned with NY Medicaid's goal to continue provider education, outreach efforts, and provision of resources for the NY Medicaid EHR Incentive Program (discussed throughout Section A and Section B), NY Medicaid has identified four areas pertaining to outreach, education, and resources which review is conducted at varying frequencies. The review and assessment of each area is instrumental to ensuring providers are satisfied with the support offered by the program. Review of the following four areas of outreach, education, and resources will support meeting the goals of the NY Medicaid EHR Incentive Program:

Exhibit 8. Outreach, Education, and Resources Review Schedule

Outreach, Education, and Resource Area	Review Frequency
Provider Satisfaction/Feedback Survey Results	Monthly
Cumulative Tutorial Views	Monthly
Webinar Participation	Monthly
Targeted Outreach	Quarterly

After review of each area, NY Medicaid adjusts outreach, education, and resources to better support providers to further encourage continued participation in the program. Monthly, NY Medicaid reviews the results of the Provider Satisfaction/Feedback Survey to gain insight into areas where providers need assistance, how the program can make improvements to support providers, and to ensure that providers are satisfied with the support offered and received by the program. Review of the Provider Satisfaction/Feedback Survey results in NY Medicaid creating new outreach and educational resources to better support providers. These resources may include but are not limited to updates to the program website, creation of tutorials, hosting of webinars, MU Objective highlights, and fact and tip sheets. Similarly, NY Medicaid also reviews the cumulative tutorial views and webinar participation rates monthly, for the program to identify any adjustments in the offerings. An example of this would be if there are a large number of attendees, NY Medicaid will consider hosting additional sessions of that webinar. On the contrary, if there are minimal attendees, the number of sessions may be reduced, or the webinar recorded and posted to the website for as-needed viewing only. Quarterly, NY Medicaid reviews the cumulative payment amounts received by participating providers to send targeted outreach informing providers of the maximum potential amount of incentive funds available to them if they successfully achieve MU and participate in the NY Medicaid EHR Incentive Program. The targeted outreach effort is designed to encourage providers to continue to participate and inform those who have not participated consecutively, of the incentive funds still available.

The establishment and review of annual benchmarks for the NY Medicaid EHR Incentive Program will directly support and enable the program's goal of maximizing provider participation in the program and limit provider attrition for future payment years.

Health Information Exchange (HIE)

To promote meeting the overarching goals for HIE, discussed in question E1, NYS has identified a roadmap for SHIN-NY activities and set goals for connecting providers to the QEs.

i. SHIN-NY Roadmap

The SHINY-NY 2020 Roadmap[17] identifies top priorities to be addressed to ensure long-term sustainability of the public infrastructure. The Roadmap uses a variety of tools for execution including performance-based contracting, policy changes, and advocacy. The following five strategies will support its priorities and goals:

1. Ensuring a strong HIE foundation (the basics) across the State for providers, health plans, and public health:
    a. 100% of hospitals participating and contributing full data, common-clinical dataset (C-CDA) by 2020
    b. 70% of all other providers participating and contributing full data (C-CDA) by 2020
2. Aggressively supporting patient-centric, value-based care, and certain tools, supports and services desired by stakeholders:
    a. Develop basic alerts without written consent option
    b. Apply integrated SHIN-NY consent form option
    c. Achieve consent for 95% of all adult New Yorkers (this target will be adjusted if NYS does not move to an opt-out model)
3. Enabling interoperability and innovations using HIE as a foundation:
    a. Develop and implement a new innovation pool program
    b. Select and fund the best innovation proposals that are consistent with state priorities
4. Promoting efficiency and affordability of the SHIN-NY system:
    a. Develop and implement new core infrastructure payments and measure efficiency
    b. Develop and implement performance payments based on key metrics
    c. Implement "wire once" / "pay once" strategy
5. Advocating collectively for the SHIN-NY and its stakeholders:
    a. Collectively and effectively organize around EHR vendor issues
    b. Participate in interoperability and standards work
    c. Ensure continuous feedback loop from stakeholders

The Roadmap will promote and maximize the SHIN-NY's support of a learning health system, public health, patient engagement, and patient-centered, value-based care.

ii. Provider Connection to Qualified Entities (QEs)

To have success with the SHIN-NY and interoperability, it is essential that NYS DOH continue to connect providers to the QEs. Therefore, the following projection goals

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[17] https://www.nyehealth.org/shin-ny/2020-roadmap/

for adoption figures for Medicaid MU eligible and supportive providers for FFY 2019 and future years are outlined below:

Exhibit 9. Projected Rate of Medicaid MU Eligible and Supportive Provider Connectivity to QEs

Late Stage Implementation	Q2 FFY 2019	Q2 FFY 2020	Q2 FFY 2021
Number of Medicaid MU Eligible and Supportive Provider Organizations at end of FFY Q2 that have a Participation Agreement in place with a QE	8,632	9,972	11,162
Total Number of Medicaid MU Eligible and Supportive Provider Organizations	14,883	14,883	14,883
Percentage of Medicaid MU Eligible and Supportive Provider Organizations that are connected to a QE	58%	67%	75%

4. Discuss annual benchmarks for audit and oversight activities.

As described in Section D (The State's Audit Strategy), OMIG integrates the audit requirements of the program into their existing audit processes and work plan to ensure that proper payments are made. OMIG plays a pivotal leadership role in the state's mission to eliminate and prevent fraud, waste, and abuse in NY's Medicaid program. OMIG conducts post-payment audits to validate the appropriateness of the payments and verify the self-attested information provided during the enrollment and registration process. Based on the contents of the Audit Strategy, OMIG will continue to develop benchmarks that measure the success of the Audit approach in keeping Medicaid EHR Incentive Payment Program payments accurate and consistent with federal rules. The team reports on audit progress in the quarterly CMS report and on the HITECH user support interface.