Department of Health & Human Services

DHHS

NEBRASKA

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1 Executive Summary

This Executive Summary is from the original SMHP submission:

The State of Nebraska Department of Health and Human Services (DHHS) Division of Medicaid & Long-Term Care (MLTC) plans to participate in the Centers for Medicare and Medicaid Services (CMS) electronic health record (EHR) system incentive payment program for its Medicaid eligible professionals (EPs) and eligible hospitals (EHs) (collectively Providers). The Medicaid EHR Incentive Program (MIP) provides an incentive payment to Providers to adopt, implement, or upgrade an EHR system and meet the Meaningful Use criteria. The incentive payments are part of the American Recovery and Reinvestment Act of 2009 (ARRA) health care initiative to promote the use of health information technology (HIT) to improve health care outcomes and provide cost saving efficiencies in the health care system. This document provides a description of the strategic planning process that DHHS has undertaken to participate in MIP; the business and operational plan for payment of the incentives; and a HIT Roadmap presenting the direction that DHHS plans to take to achieve the HIT vision described in this document.

As part of DHHS's strategic planning effort, it carefully considered the current EHR usage and capacity and completed an Environmental Scan of the State of Nebraska to ascertain the level of readiness of its Providers. DHHS also considered its current data sharing partners and evaluated the level of readiness to expand its current data sharing capacity. This effort resulted in a better understanding of the current HIT landscape within the State of Nebraska. The current HIT landscape is discussed in this document in Section 3 – As-Is HIT Landscape.

Once DHHS achieved a good understanding of the current HIT landscape, its planning effort focused on creating a vision of DHHS's future HIT landscape. Within the next five years, DHHS has specific goals to modernize the Medicaid Management Information System (MMIS). DHHS also plans to achieve greater interoperability with its Providers, improve health record sharing functionality, and promote adoption of EHR technology for its Providers with the goal of achieving better health care outcomes for its beneficiaries. The effort to promote electronic exchange of health care data for the benefit of the patient will be enhanced by the improvement of access to broadband technology for the citizens of the State of Nebraska. Discussion of DHHS's future vision of HIT can be found in this document in Section 4 – To-Be HIT Landscape.

DHHS next defined a HIT Roadmap for achievement of its future vision. The HIT Roadmap articulates the major milestones and activities that DHHS will achieve as it moves from its current environment to its future vision. One of DHHS's first milestones is achieved in the submission of this State Medicaid Health Information Technology Plan (SMHP) to CMS. Additional important milestones include: 1) submitting an Implementation Advanced Planning Document (IAPD); 2) accepting Provider registrations for MIP; 3) making incentive payments to Providers; and 4) sharing data with the Statewide HIE. A description of DHHS's HIT Roadmap is found in this document in Section 6 – HIT Roadmap.

As one of the key elements to this SMHP, DHHS has undertaken a technical, business, and operational planning endeavor in order to be ready to make incentive payments to its Providers. DHHS has carefully considered and incorporated all program integrity elements for MIP and will undertake rigorous

administration and oversight, as well as continue to work hard to promote the adoption of EHR technology for its Providers. This program is designed to ensure that the right payment is made to the right Provider at the right time. A description of the MIP is found in this document in Section 5 – Medicaid EHR Incentive Program Blueprint.

DHHS has begun to implement a communication plan to inform Providers of the availability of the incentives and eligibility criteria. Provider outreach and education sessions will be performed as part of the communication approach. DHHS's Communication Plan is attached hereto as Appendix I.

In conclusion, DHHS is pleased to submit this SMHP as documentation of its activities to plan and implement its future vision as a partner to its Providers and other stakeholders in the adoption of EHR technology and the promotion of HIE.

Respectfully submitted,

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2 Introduction and Overview

DHHS has undertaken a rigorous planning process designed to consider and incorporate all of the requirements for a successful implementation of its HIT initiatives that includes payment of the incentives for adopting, implementing, or upgrading to certified EHR systems and Meaningful Use of EHR technology for Nebraska Medicaid Providers. DHHS carefully considered the current technology, business and operational environment and methodically planned the changes that will be required to effectively administer MIP. This strategic planning process included a series of informational meetings that informed and included all of the necessary DHHS organizational participants, DHHS stakeholders, and coordination with the statewide health information exchange (HIE) planning.

This process has resulted in this SMHP. The SMHP includes all of the elements required by CMS. Specifically, the SMHP includes a description of:

- The current and future vision for the Nebraska DHHS Medicaid Management Information System (MMIS). (Sections 3 and 4)
- A baseline assessment of the current HIT landscape environment in Nebraska through an environmental scan. (Section 3.1)
- The To-Be HIT Landscape. (Section 4)
- The HIT Roadmap and plan. (Section 6)
- How the SMHP was designed and developed and how it will be implemented with Medicaid Information Technology Architecture (MITA) principles. (Section 3.3)
- The Nebraska EHR incentive payment system and how the MMIS has been considered in developing the HIT solution. (Sections 3.4.2 and 4)
- Enhancements that will support the overall goals of DHHS (Section 4)
- The data sharing components of the HIT solution. (Section 4.6)
- The promotion of secure data exchange in accordance with the Health Insurance Portability and Accountability Act (HIPAA). (Section 6, Appendix J)
- How Nebraska will promote the use of data technical standards. (Section 6)
- A process for improvements in health outcomes, clinical quality or efficiency resulting from the adoption of certified EHR technology by DHHS Medicaid Providers. (Section 4)
- How Nebraska will support the integration of clinical and administrative data. (Section 5.10)
- The process for ensuring that any certified EHR technology used as basis for payment incentive is compatible with the MMIS. (Section 4.2)
- How Nebraska will adopt national data standards for health and data exchange and open standards for technical solutions as they become available. (Section 6.1)

- The process to ensure that each Provider meets all Provider enrollment eligibility criteria. (Section 5.2)
- How Nebraska will ensure patient volume requirements are met. (Section 5.8)
- The monitoring and validation of information. (Section 5.8)
- How Nebraska will capture attestations from each Provider that they have met the Adoption, Implementation, or Upgrade (AIU) or are Meaningful Users of certified EHR technology. (Section 5.3)
- How Nebraska will monitor compliance of Providers coming onto the program with different requirements depending on their participation year and a methodology for verifying this information (Section 5.8)
- The list of specific actions planned to implement the EHR incentive program (Section 5)
- The process to ensure that no amounts higher than 100 percent of federal financial participation (FFP) will be claimed by Nebraska for reimbursement of expenditures for State payments to Providers for the certified EHR incentive payment program and a methodology for verifying such information. (Section 5.9)
- The process to ensure that no amounts higher than 90 percent of FFP will be claimed by Nebraska for administrative expenses in administering the EHR incentive payment program. (Section 5.9)
- How Nebraska will ensure that payments made to the Providers are paid directly (or to an employer of facility to which the Provider has assigned payments) without any reduction or rebate, and that incentive payment reassignments to an entity promoting the adoption of certified EHR technology as designated by Nebraska are voluntary for the Medicaid EP involved. (Section 5.5)
- The process to assure that entities promoting the adoption of certified EHR technology do not retain more than five percent of such payments for costs not related to certified EHR technology (and support services including maintenance and training). (Section 5.8)
- The process to ensure the Provider does not receive a duplicate payment; more than one payment for the same year or payment from multiple states. (Section 5.4.2)
- The process for ensuring that each Provider that wishes to participate in the EHR program will receive a National Provider Identification (NPI) number and a description of how the NPI will be used to coordinate with CMS. (Section 5.2)
- The process to ensure that a Taxpayer Identification Number (TIN) will be provided to DHHS for those Providers participating in the EHR incentive program. (Section 5.2)
- How Nebraska will ensure that any existing fiscal relationships with Providers to disburse incentive payments through Medicaid managed care plans does not result in payments that exceed 105 percent of the capitation rate and a verification process. (Section 5.8)
- The process to ensure that only appropriate funding sources are used to make EHR incentive payments and the methodology for verification. (Section 5.9)
- The process in place and the methodology for verifying that information is available to ensure MIP payments are made for no more than a total of six years; that no Provider begins receiving payments after 2016 and that incentive payments cease after 2021 and

that an EH does not receive payments after fiscal year (FY) 2016 unless the hospital has received an incentive payment in the prior FY. (Section 5.5)

- The process to ensure that all hospital calculations are made consistent with the requirements and a method for verification. (Section 5.4)
- The process for timely and accurate payment of incentives (Section 5.5)
- The recoupment process. (Section 5.8)
- The process for combating fraud and abuse (Section 5.8)
- The process for Provider appeals (Section 5.8)

3 As-Is HIT Landscape

DHHS conducted an environmental assessment to evaluate Nebraska Medicaid Providers' readiness to adopt, implement, or upgrade, or meaningfully use EHR and intent to apply for MIP payments. For the purposes of this document, "HIT" refers to health information technology that a Provider may use, including practice management, electronic medical records, EHRs, and electronic billing. This assessment describes the findings regarding Nebraska Providers' HIT and HIE landscape.

This environmental assessment also included an assessment of the legal and regulatory framework for consistency with electronic transaction standards and the privacy and security provisions under HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH). The privacy and security regulatory assessment is attached as Appendix J.

The findings from these assessments serve as source data for the development of the To-Be HIT Landscape and completion of the Provider Incentive Payment Roadmap for the SMHP.

3.1 Health Care Provider-Based Environmental Scan

The environmental assessment was conducted between October 2010 and March 2011. The methods used to conduct the scan included a review of existing documentation on Provider EHR adoption and patient information exchange. Interviews with key stakeholders were conducted to obtain an overall perspective of the Provider HIT landscape, and a Provider survey was conducted to capture additional relevant data. The following sections detail the information collected.

3.1.1 EHR/HIE Adoption Initial Outreach and Data Gathering

DHHS performed documentation research and outreach efforts with key stakeholders to ascertain what information was currently available. DHHS conducted interviews with the following professional organizations:

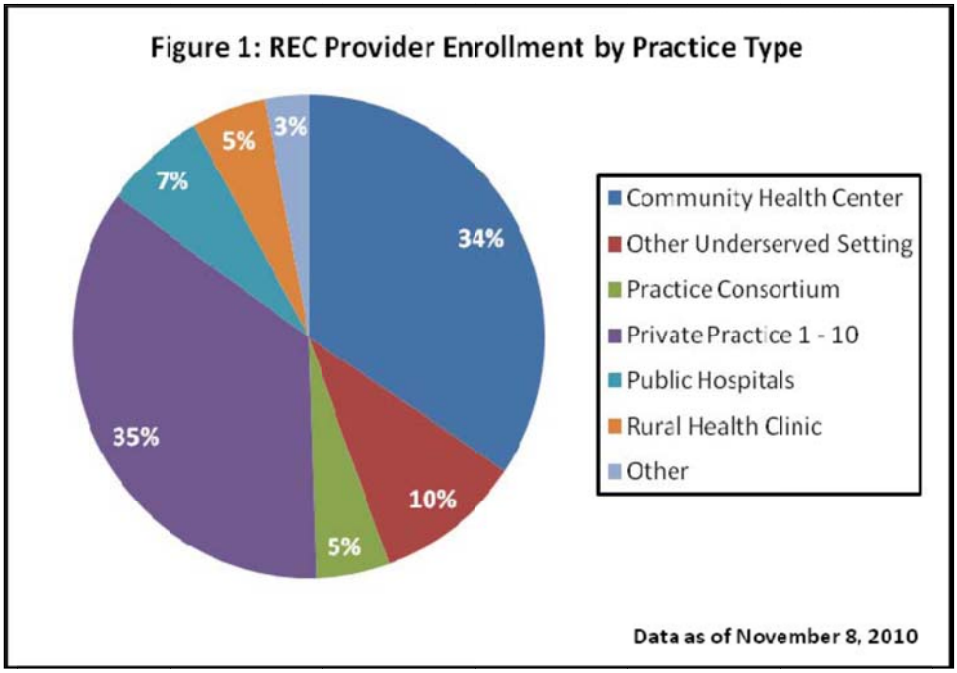
- Nebraska Hospital Association
- Nebraska Medical Association
- Nebraska Nurse Practitioner
- Nebraska Dental Association
- Lancaster County Medical Society
- Nebraska Academy of Physician Assistants

DHHS also reviewed prior efforts to gather data regarding EHR adoption. Wide River Technology Extension Center (Wide River TEC) is Nebraska's designated HIT Regional Extension Center (REC). As Nebraska's designated REC, Wide River TEC's goal is to assist eligible primary care providers and critical access hospitals with becoming Meaningful Users of EHR technology. Wide River TEC provides training and offers support services with the adoption and implementation of EHR systems. Because

Wide River TEC works with Providers to educate and assist in EHR adoption, DHHS initiated contact with Wide River TEC to gather its observations about Nebraska Provider EHR adoption and to identify opportunities for collaboration.

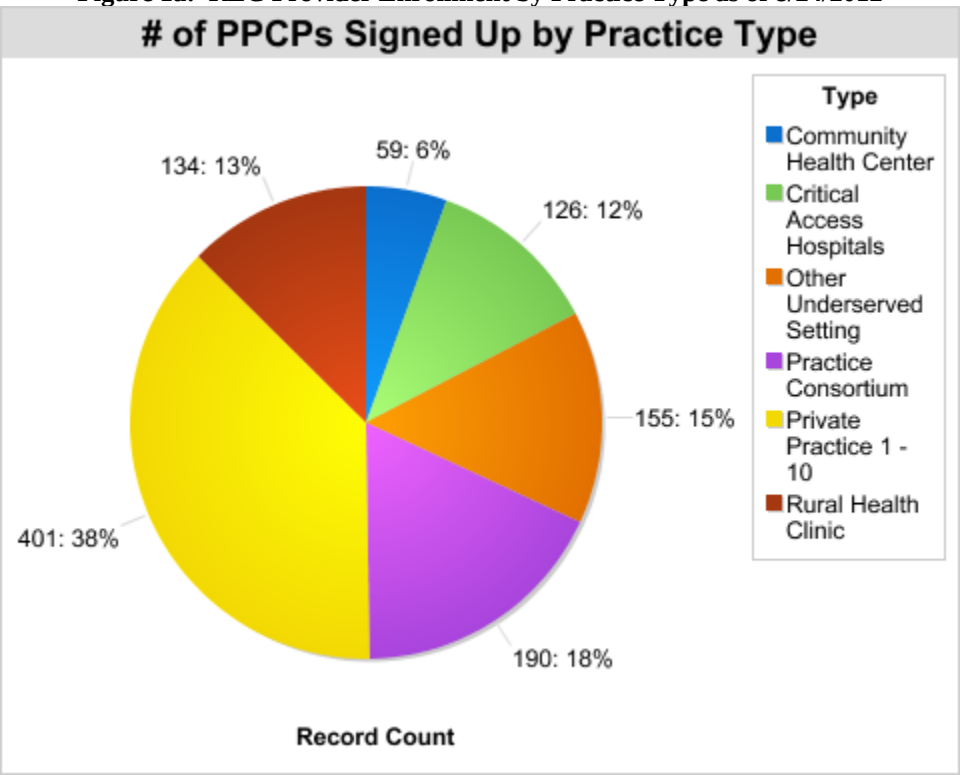
As of November 9, 2010, Wide River TEC was assisting 262 Providers with EHR adoption needs. Figure 1 below displays membership by practice type. The majority of the members are affiliated with small private practices (35 percent) or community health centers (34 percent).

Figure 1: REC Provider Enrollment by Practice Type



As of August 24, 2012, Wide River TEC is assisting 1,065 primary care providers and 54 critical access hospitals with EHR adoption needs. Figure 1a below displays eligible provider by practice type. The majority of providers are affiliated with small private practices (38 percent).

Figure 1a: REC Provider Enrollment by Practice Type as of 8/24/2012



Wide River TEC conducted an EHR survey June through July of 2010. The survey was distributed via email to members of the Nebraska Medical Association and Nebraska Academy of Family Physicians. Approximately 50 percent of respondents indicated that their clinic had an EHR system in place. Of those that had an EHR system in place, 76 percent were satisfied with the system. Of the 50 percent that did not have an EHR system in place, 91 percent intended to adopt one within the next two years. Furthermore, 94 percent of all clinics surveyed planned to meet Meaningful Use criteria and apply for MIP. (Note: Because only a total of 66 clinics responded, these results may not be truly representative of all Nebraska professionals).

Wide River TEC also distributed a hospital survey in April of 2010 to 67 of the more than 100 hospitals in Nebraska. Of the 36 hospital administrators that responded, 33 percent indicated that they have an EHR system in place, while 56 percent indicated that they plan to have an EHR system in place. (Note: While these results provide some insight, because EHR survey respondents tend to be those who have adopted an EHR system and are knowledgeable with HIT, survey results likely do not represent all Nebraska hospitals.)

In addition to Wide River TEC data, DHHS reviewed the Nebraska Strategic eHealth Plan (October 2010), and the results of an EHR survey by the Nebraska Academy of Family Physicians in 2009. Results from this survey indicate that 38 percent of primary care physicians have an EHR system in place and 10 percent plan to adopt an EHR system by end of 2010.

Additionally, DHHS reviewed the results of the EHRNebraska project. This project, funded by the "2006 Excellence in Practice" Grant Program, was a project led by the Nebraska Medical Association. Additional members of this effort included Creighton Health Services Research Program, Stuhr Consulting, DKG Consultants, and PrivaPlan. The primary aim of this program was to facilitate the adoption of EHR systems by Nebraska physicians, and thereby improve patient safety and outcomes.

EHRNebraska distributed a survey to all practicing licensed physicians between February and May 2007 in order to better understand physician-based practice EHR adoption status. Additionally, EHRNebraska wanted to determine the support services that physicians required to effectively adopt and implement an EHR system. The results of the survey were used to develop education efforts to assist physicians with the evaluation, adoption, and implementation of EHR systems.

Approximately 1,300 physicians responded to the survey. Of those that responded, 23 percent indicated that they had an EHR system in place, 17 percent were in the process of implementing an EHR system, 16 percent were in process of selecting an EHR system, 32 percent were evaluating the need for an EHR system, and 11 percent had no plans to adopt an EHR system.

DHHS contacted the National Rural Health Association (NRHA) to discuss the survey it conducted on the readiness of rural hospitals across the country to meaningfully use EHRs. The survey conducted in March 2010 ranked hospital's stages of EHR adoption according the Healthcare Information and Management Systems Society (HIMSS) Analytics EMR Adoption Model Stages. The HIMSS Analytics EMR Adoption Model Stages is attached hereto as Appendix C. Survey results indicated that 26.7 percent were in stage 0, 13 percent were in Stage 1, 19.7 percent were in stage 2, 33.1 percent were in stage 3 and 6.7 percent were in stage 4 or higher. Based on conversations with NRHA, they believe these findings can be extrapolated to Nebraska rural hospitals. (Note: NRHA indicated that this EHR survey, like most others, tends to have a higher response rate from those who have adopted an EHR system. Therefore, while the national results may be representative of the Nebraska respondents, it is important to keep in mind that the Nebraska hospitals that participated may not be typical of all Nebraska hospitals).

The findings from the above outreach efforts and interviews provide valuable information about Nebraska Provider EHR adoption status and activities. However, in an effort to supplement the existing body of available data, DHHS designed a survey to collect more information regarding the level of EHR adoption, Provider education and training needs, and intention to apply for MIP.

3.1.2 Provider Surveys

DHHS distributed surveys to both EPs and EHs to better understand their EHR and HIE adoption status, eligibility, and intent to apply for MIP. The surveys were additionally intended to provide DHHS with information on Provider barriers to EHR and HIE adoption and to identify the education and resource needs of Providers regarding HIT adoption and MIP.

The Provider surveys were developed based on existing EHR surveys conducted in other states and on the national level and were refined to meet Nebraska's specific needs. State stakeholders were involved in the development, distribution, and promotion of the Provider surveys.

The survey results are presented in Appendices D and E. The methodology and significant findings from the surveys are presented in the following sections.

3.1.2.1 EP EHR Survey Methods

The EP EHR survey was launched in February of 2011. The survey consisted of 33 multi-part questions, both in multiple choice and text entry format, concerning the present and planned use of HIT among EPs in the State of Nebraska. To minimize data entry, skip logic was designed into the survey as appropriate.

DHHS contracted with the University of Nebraska Medical Center (UNMC) Health Professional Tracking Services to distribute the notification of the survey to EPs via email. The email included a letter from the Director of Medicaid requesting participation in the survey and providing the survey Web link. The survey was distributed on February 16, 2011 with a follow-up email on March 1, 2011. The following table outlines the total number of EPs by professional type that were provided with the survey by email:

Table 1: Email Distribution of EP Survey by Profession Type

Total Number of Emails Distribution by Profession Type	
Medicine	2,042
Dentist	660
Medicine Dentist	20
Advanced Practice Registered Nurse	464
Physician Assistant	466
Total Number	**3,652**

(Note: A total of 406 emails bounced back; therefore, the total number of EPs that received the email was 3,246).

Additional distribution of the survey included: 1) a cover letter from the Director of Medicaid, along with the survey link, that was faxed to over 1,700 clinics; and 2) coordination with several professional associations and Wide River TEC to post on their internet sites links to both DHHS's EHR Incentive Program Website and the EHR survey. The survey information was also posted in the eHealth Council's newsletter. These efforts resulted in a broad distribution of the survey and promoted inclusion of as many EPs as possible.

3.1.2.2 EP EHR Survey Findings

DHHS cleaned the raw data of the EP EHR survey findings by removing non-EP and clinic-based responses. After this process, the survey resulted in a total of 553 EPs starting the survey and 467 completing it. A completed response was determined by the survey tools to be a response for which the respondent made it all the way through the survey, answered a question and clicked the "Done" button. The survey tool determined that a partial response was for those respondents who clicked on the "next" button but not the "Done" button. The survey tool provided a report for the total number of completed surveys. A survey was considered complete even if the respondent did not complete all survey questions.

Respondents were not presented questions that were not relevant based on previous answers. Finally, after obtaining initial demographic information, EPs were asked if they spent 90 percent or more of their time in a hospital setting. The skip pattern for the 56 of the 553 that responded positively to this question excluded them from all remaining survey questions as they would not be eligible for MIP. Therefore, there was a maximum potential response of 497 to most questions.

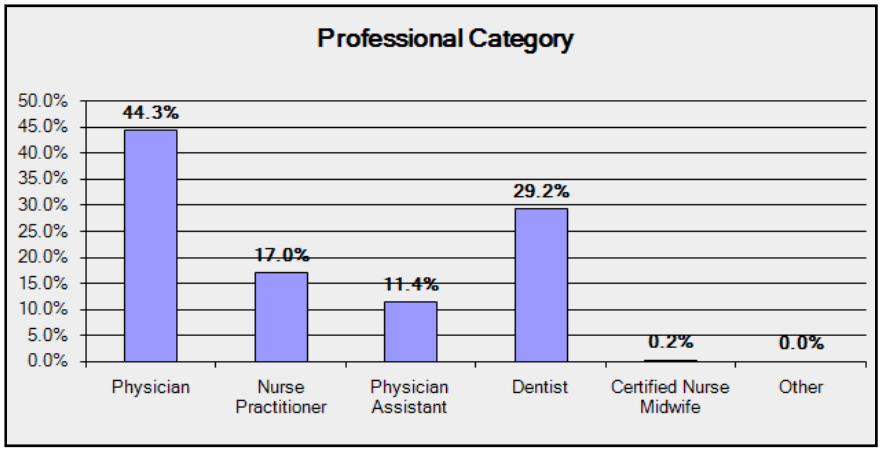
Questions outlined in Appendix D herein that excluded hospital-based professionals had a response range from 415 to 491. Different data sources exist to obtain the number of licensed professionals in the State of Nebraska. UNMC validates licenses semi-yearly with its dataset and tracks professionals with multiple licenses, practice status, and practice location. Therefore, UNMC's dataset likely is most representative of the total number of licensed professionals (with no duplicates for multiple licenses) currently practicing in the State of Nebraska. Based on supporting documentation from the UNMC Health Professional Tracking Services, as of January 2011, there were 6,129 EPs practicing in the State of Nebraska.

Therefore, based on a sample size ranging from 415 to 491 for a population of 6,129, the findings have a 95 percent probability of being true with a confidence interval between 4.24 and 4.65 for the entire Nebraska EP population. Because the EP survey respondents were not random, but rather self-selected, this bias needs to be considered when generalizing survey findings to the overall Nebraska EP population.

Survey Participant Description

Most of the EPs that responded to the survey were physicians or dentists. Figure 2 below outlines the percentage for each of the five EP types that answered this question:

Figure 2: EP Survey – EP Professional Categories



(Note: Respondents had the option to select more than one professional category. Thus, the total number professional category responses are greater than the total number that responded to the question.)

Approximately 45 percent of the 491 EP respondents indicated that their specialty is in general family practice. Because respondents may have more than one area of specialty EPs were given the opportunity to select more than one response.

Table 2: EP Survey – EP Practice Specialties

Answer Options	Response Percent	Response Count
General Family Practice	42.60%	209
Other	17.70%	87
General Pediatrics	9.60%	47
Surgical Subspecialties	6.30%	31
Internal Medicine Subspecialties	5.30%	26
Psychiatry	5.10%	25
Emergency Medicine	3.50%	17
General Internal Medicine	3.10%	15
Obstetrics/Gynecology	2.40%	12
General Surgery	2.40%	12
Ear, Nose and Throat	2.00%	10
Neurology	2.00%	10
Ophthalmology	1.60%	8
Not Applicable	1.60%	8
Cardiology	1.40%	7
Dermatology	1.00%	5
answered question		491
skipped question		62

(Note: The total number practice type responses are greater than the total number that responded to the question as respondents had the option to select more than one practice type).

EPs were also asked about their primary type of practice. Based on 472 responses, the majority of practice types were solo and group medical practices (45 percent). Solo and group dental practice facility types were the next largest at 27 percent.

Table 3: EP Survey – EP Type of Practice

Answer Options	Response Percent	Response Count
Group or Partnership Medical Practice	34.1%	161
Solo Dental Practice	19.3%	91
Solo Medical Practice	10.6%	50
Group or Partnership Dental Practice	8.3%	39
Multi-Specialty Group	7.6%	36
Rural Health Clinic	7.2%	34
Other	5.5%	26
Federally Qualified Health Center	3.2%	15
Group or Partnership Psychiatry Practice	1.9%	9
Nursing Home or Long Term Care facility	0.8%	4
Community-Based Behavioral Health Organization	0.6%	3
Solo Psychiatry Practice	0.4%	2
Indian Health Clinic	0.4%	2
answered question		472
skipped question		81

Finally, of the 481 responses to geographic location, 64 percent were located in an urban setting, whereas 36 percent were located in a rural setting.

EHR Status

Close to half (48 percent) of all the EPs that participated in the survey currently have an EHR system in place. When examining the geographic location of EHR system utilization status, slight differences were identified. About half (51 percent) of urban EPs have an EHR system in place compared to 42 percent of rural EPs.

Of the 219 respondents with an EHR system, 46 percent indicated that the system is certified and 48 percent were unsure if the system is certified or not. When examining these same responses according to geographic location, there are no significant differences.

Approximately 18 percent of all 553 respondents indicated that they currently have a certified EHR system. By 2015, 37 percent of all EPs that responded anticipate having a certified EHR system in place. This question was skipped by 42 percent of the respondents. Based on the above findings (319 responses), there is a 95 percent chance that 31.5 to 42.5 percent of all EPs in Nebraska will adopt a certified EHR system. Again, because the survey responses are not randomly selected, this bias needs to be considered when generalizing to all EPs.

Based on survey results, Table 4 below outlines the total number and percentage of all EP respondents by year that plan to adopt, implement, or upgrade to a certified EHR system:

Table 4: EP Survey - EHR System Certification Status

EHR Certification Status	Total #	Total %
Certified EHR in Place Currently	100	18.08%
Certified EHR in 2011	47	8.50%
Certified EHR in 2012	46	8.32%
Certified EHR in 2013	7	1.27%
Certified EHR in 2014	2	0.36%
Certified EHR in 2015	1	0.18%
Do No Plan	31	5.61%
Unsure	85	15.37%
Skipped Question	234	42.31%
Total	553	100.00%

The top barriers to EHR adoption as indicated by 111 respondents are related to cost, lack of knowledge, and satisfaction with current paper medical record systems.

Meaningful Use Findings

Knowledge of the requirements for Meaningful Use is indicated by 165 respondents (38 percent). When comparing Meaningful Use knowledge by geographic location, no significant differences were apparent. Of those that understand Meaningful Use requirements, a little over 85 percent (140 EPs) intend to become Meaningful Users by 2012.

Medicaid EHR Incentive Program Findings

As 25 percent of 444 respondents indicated that their Medicaid volume is 30 percent or greater, these 110 respondents will likely qualify for MIP based on their Medicaid volume. Of the 413 respondents to Needy Individual volume, 20 percent indicated that they meet the 30 percent or greater threshold. Needy Individual patient volume was defined in the survey as including Medicaid, managed Medicaid, Children's Health Insurance Program (CHIP), furnished uncompensated care, and furnished care provided at no cost or reduced cost using a sliding scale based on ability to pay. Because Needy Individual volume encompasses more than simply Medicaid, this percentage is expected to be higher than Medicaid. The lower number may be due to the fact that some respondents did not understand the criteria for Needy Individual.

When payer volume data was examined only for the 46 EPs whose primary place of practice is at a federally qualified health center (FQHC) or rural health clinic (RHC), the Medicaid and Needy Individual

volume percentages are more in line with expectations. Twenty-six percent of EPs meet the Medicaid volume threshold and forty-two percent meet the Needy Individual criteria.

Almost 50 percent of EPs are unsure if they will apply for MIP payments and 11 percent do not intend to apply. Of the 271 that do not intend to apply or are unsure, 254 responded to the questions pertaining to barriers to seeking Medicare or Medicaid incentive payments. These findings indicate that 53 percent need more information about the incentive programs and 17 percent are unsure which EHR system to purchase.

HIE

About 11 percent of the 433 respondents currently participate in the Nebraska Health Information Initiative (NeHII) and 16 percent intend to join a HIE at a later date. However, 51 percent are unsure about joining a HIE and 21 percent do not intend to join. Ninety-five respondents indicated that cost, lack of knowledge pertaining to HIEs, satisfaction with existing manual process, and security and privacy concerns were the primary reasons for not joining a HIE.

Broadband Accessibility Findings

Based on the survey responses, access to broadband does not appear to be a barrier of EHR adoption and HIE participation. Only 6 of the 437 respondents do not have access to at least 1 Internet service. Only one respondent was unsure of the type of Internet service. Digital subscriber line and cable are the primary types of Internet service utilized. This result may be influenced by the survey delivery methods. The survey was delivered primarily through email and Web-based distribution.

Only 20 percent of the 431 respondents indicated that they have access to redundant or backup Internet service and 41 percent were unsure if this service was available.

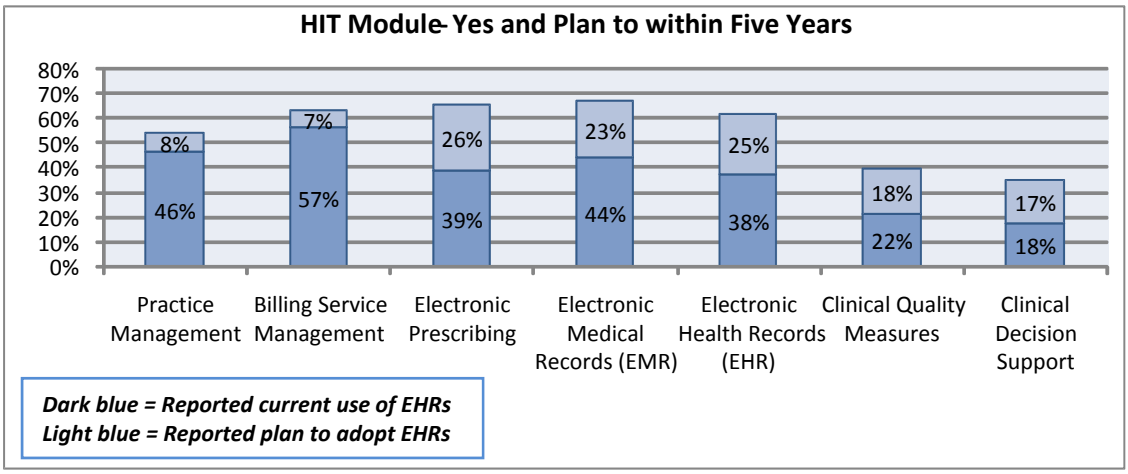
Telemedicine

The majority of EPs (70 percent) do not use telemedicine to provide patient care. However, 13 percent currently use telemedicine and another 9 percent intend to utilize telemedicine in the future.

HIT Module Findings

Figure 3 below represents EP responses to their adoption status for each HIT module listed. Each question was answered by 415 to 423 EPs. There were a number of “unsure” responses for each entry. This may be indicative of the need for Provider outreach and education.

Figure 3: EP Survey – EP HIT Module Adoption Status



Close to half of the professionals currently use Billing Service Management, Practice Management, and electronic medical records (EMRs) HIT modules. Areas of the biggest growth of use include Electronic Prescribing, EHRs and EMRs. Almost half of the respondents were unsure of the status of clinical quality measures (CQMs) and Decision Support modules, and about a quarter of respondents were unsure about Practice Management, Billing Services Management, and EHRs utilization at their primary place of practice.

Notably, there appears to be a greater use of Electronic Prescribing among urban professionals (43 percent) when compared to rural respondents (31 percent).

Findings and Conclusions

The majority (92 percent) of survey respondents are Medicaid enrolled professionals. Most respondents are located in an urban setting (64 percent). Physicians and dentists had the largest representation in the survey. EP respondents primarily specialize in general family practice and work in a group or partnership medical or dental practice facility.

When comparing EHR adoption and HIE and EHR Incentive program participation, minimum variances across Provider types exist. However, physicians appear to have a lower response rate of "unsure" when asked about these topic areas. The survey findings indicate that dentists have the largest variance from other professionals. EHR adoption rates are less than half that of other professionals and about 65 percent are unsure about future EHR purchases

Close to half of all respondents have an EHR system in place and less than 10 percent were unsure. The professionals practicing in an urban setting (52 percent) had a slightly higher adoption rate over those in rural practices (42 percent). About half of those with an EHR system indicated it was certified, whereas the other nearly 50 percent were unsure.

About a quarter of the respondents meet the Medicaid volume threshold. When the data is isolated to only FQHCs and RHCs, the Medicaid volume is similar, whereas Needy Individual volume increases to 42 percent. A total of 20 percent of professionals intend to apply for MIP payments, whereas almost half are unsure about applying to the Medicaid or Medicare Incentive Programs.

Currently, only 11 percent of the EP respondents participate in a HIE and 16 percent plan to join one in the future. As with EHR adoption and MIP participation, about 50 percent are unsure about joining a HIE.

Many of the respondents were unsure about EHR adoption, MIP, and HIE participation. Primary barriers for these areas include cost, lack of knowledge, and satisfaction with existing processes. As the percentage of overall certified EHR adoption and HIE participation is fairly low, targeted outreach and education regarding products and financial benefits may increase these numbers. Additionally, ongoing communication regarding MIP and coordination with other stakeholders may maximize participation.

3.1.2.3 EH EHR Survey Methods

The EH EHR Survey was launched in February 2011. The survey consisted of 31 multi-part questions, both in multiple choice and text entry format, concerning the present and planned use of HIT among EHs in the State of Nebraska. To minimize data entry, skip logic was designed into the survey as appropriate.

Distribution efforts were coordinated with the Nebraska Hospital Association, which maintains a comprehensive email list of all hospitals in Nebraska. The Nebraska Hospital Association emailed 100 of the 105 hospitals in the State. Three Behavioral Health Regional Centers, one Veterans Administration (VA) center, and one Indian Health Service (IHS) hospital did not receive the survey. These institutions are discussed in other areas of the SMHP. The hospitals received an email that included a letter from the Director of Medicaid requesting their participation in the survey and providing the survey Web link. The survey was distributed on February 15, 2011 with follow-up emails on March 2, 2011 and March 7, 2011.

Additionally, DHHS coordinated with Wide River TEC to post a link to DHHS's EHR Incentive Program Website and EHR survey link.

3.1.2.4 EH EHR Survey Findings

A total of 69 hospitals started the survey, 66 hospitals completed most of the questions, two hospitals completed a selected number of questions, and one hospital answered no questions. A response to each survey question was not required; therefore, EHs were permitted to skip survey questions. Additionally, survey questions were skipped if there was a skip pattern.

For questions not following a skip pattern, a range of 61 to 67 hospitals responded to each of the questions outlined in Appendix E, attached hereto.

Therefore, based on a sample size ranging from 61 to 67 for a population of 100, the findings have a 95 percent probability of being true with a confidence interval between 6.91 and 7.88.

Survey Participant Description

Most of the hospitals (95.5 percent) that responded to the survey are Medicaid enrolled Providers. Critical access hospitals (CAHs) accounted for the majority of the hospital type respondents (67.2 percent), with the second largest being noncritical access hospitals (non-CAHs) (22.4 percent). Approximately 74 percent of the hospitals that participated in the survey are located in rural areas and 26 percent are located in urban areas.

When reviewing the different hospital types that participated in the survey by identified geographic location, variances were noted. There were twice as many urban non-CAHs compared to rural non-CAHs. Finally, all three of the children's hospitals that responded are in an urban location.

EHR Status

Close to 60 percent of all the hospitals that participated in the survey currently have an EHR system in place. The majority of urban hospital survey respondents (88 percent) have an EHR system in place compared to about half of the rural hospitals (47 percent). The majority of non-CAHs (87 percent) have an EHR system in place compared to half of CAHs (47 percent).

Approximately 33 percent of respondents indicated that they have a certified EHR system. Of the 34 respondents that answered both hospital type and EHR certification status questions, 44 percent of CAH hospitals have a certified EHR system whereas only 15 percent of non-CAHs have a certified EHR system. Additionally, of the 37 respondents that answered both geographic location and certification status questions, 43 percent of rural hospitals have a certified EHR system whereas only 14 percent of urban have a certified EHR system.

Table 5 below outlines the total number and percentage of all hospital respondents by year that plan to adopt, implement, or upgrade to a certified EHR system based on survey results:

Table 5: EH Survey – EH EHR System Certification Status

EHR Certification Status	Total #	Total %
Certified EHR in Place Currently	22	33%
Certified EHR in 2011	18	27%
Certified EHR in 2012	14	21%
Certified EHR in 2013	6	9%
Unsure	3	5%
Skipped	3	5%
Total	66	100%

Based on the above findings, 84 to 98 percent of hospitals in the State of Nebraska will adopt a certified EHR system by 2013. Again, because the survey responses are not randomly selected, the most conservative estimate would be based on actual responses. Therefore, according to the survey, approximately 60 Nebraska hospitals plan to obtain a certified EHR system by 2013.

Due to the fact that most of the hospitals indicated that they would adopt a certified EHR system and several skipped the question, the number of responses to questions regarding barriers to adoption was limited to three. The top barriers include the following:

- Unsure which EHR system to purchase;
- Cost associated with purchase; and
- Lack of knowledge and understanding about EHR technology.

Because the majority of EH respondents indicated that they would adopt a certified EHR system, it is difficult to say how significant the barriers listed above compare to the hospitals that did not respond to the survey and do not plan to adopt an EHR system. Further outreach to nonparticipating hospitals may provide greater insight.

Meaningful Use Findings

The majority of respondents to the EH survey (93 percent) know the requirements for Meaningful Use and plan to meet Meaningful Use requirements by 2012.

Medicaid Incentive Program Findings

As 52 percent of 62 respondents indicated that their Medicaid volume is greater than 10 percent, these 32 respondents will likely qualify for MIP based on Medicaid volume. Given that only 32 of the 62 respondents indicated that they meet the Medicaid volume criteria, it is difficult to determine why 42 of 66 respondents would apply for MIP, however the responses may be due to lack of understanding of the incentive eligibility requirements. Additionally, the few hospitals that skipped the Medicaid volume question and 6 hospitals that have a Medicaid volume between 8-9 percent may also account for this unexpected variance.

Of the remaining 24 responses to the question about intent to apply to EHR incentive programs, 15 indicated they would only apply for Medicare incentives and 9 were unsure. All 66 hospitals indicated that they would apply to either Medicare or Medicaid.

Based on the fact that the number of hospitals meeting Medicare volume criteria is greater than the number of those meeting the Medicaid threshold, it is likely that hospitals that will only apply for Medicare incentives are doing so because they do not meet the Medicaid volume to apply for this incentive as well. According to the survey, the primary reason for the small number of hospitals being unsure if they would apply for either incentive program is because they need more information about the incentive programs.

All 42 respondents that will seek MIP payments will do so in the State of Nebraska. By 2013, 37 of the 42 hospitals intend to apply for MIP, while 5 are unsure. EHs survey answers indicate the following timeline for incentive payment application:

Table 6: EH Survey – EH Timeline for Incentive Payment Application

Year - Apply Medicaid Incentive Payment	Total #	Total %
2011	18	26%
2012	13	19%
2013	6	9%
Unsure	5	7%
Skipped	27	39%
Total	69	100%

HIE

About 21 percent of survey respondents currently participate in NeHII and close to 5 percent participate in another HIE. Over 50 percent intend to join a HIE at a later date. Therefore, over 80 percent of the 63 respondents are a HIE member or intend to join a HIE. Cost associated with fees, training, implementation, and security and privacy concerns were the primary reasons the three respondents did not plan to join a HIE.

Broadband Accessibility Findings

Based on the survey responses, access to broadband does not appear to be a barrier of EHR adoption and HIE participation. All of the 65 respondents to this question have access to at least one Internet service. Only one respondent was unsure of the type of Internet service. T-1, digital subscriber line and cable were the primary types of Internet service utilized.

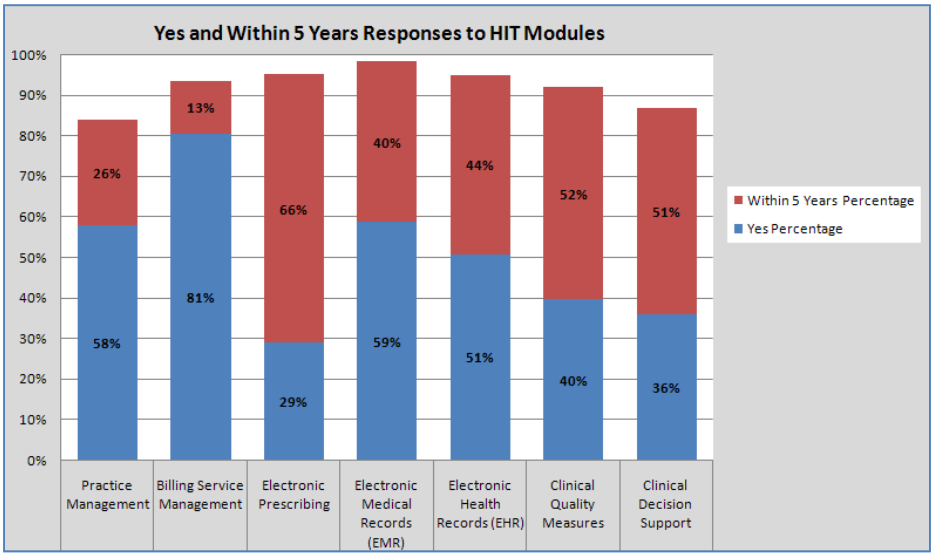
Almost 50 percent of the 64 respondents indicated that they did have access to redundant or backup Internet service. When looking at hospital type, close to 79 percent of non-CAHs hospitals had redundant internet services, whereas only 36 percent of CAHs had this capacity.

The majority of hospitals (68 percent) use telemedicine to provide patient care and an additional 22 percent plan do so in the future.

HIT Module Findings

Figure 4 below represents hospital responses to their adoption status for each HIT module listed. Each question was answered by 61 to 63 hospitals.

Figure 4: EH Survey – HIT Module Adoption Status



While more than 50 percent of hospitals in Nebraska currently utilize Practice Management, Billing Service Management, EMRs, and EHRs modules, over the next five years most hospitals intend to have all HIT applications in place. When comparing urban and rural hospital responses to these questions, a significantly greater percentage of urban hospitals had each of the HIT modules listed above except for billing management and electronic prescribing applications. There was little difference in the use of these two modules when comparing by geographic location.

Conclusions

The majority of EH survey respondents are Medicaid enrolled CAH hospitals located in a rural setting.

Approximately 60 percent of all respondents have an EHR system in place, most of whom are urban non-CAHs. About 30 percent of those with an EHR system indicated that it is certified. More CAH hospitals (44 percent), as compared to non-CAH (15 percent), have a certified EHR system. The same variances occurred when comparing rural (43 percent) to urban (14 percent). Nearly all respondents (90 percent) intend to have a certified EHR system in place by 2013. Primary barriers for the few that do not intend adopt, implement, upgrade or meaningfully use an EHR system are cost and lack of knowledge.

Half of the respondents meet Medicaid volume threshold, yet almost 67 percent intend to apply for MIP payments. This may be due to lack of knowledge, current volume close to threshold, or some respondents may have skipped the Medicaid volume question.

Currently, only about 25 percent of the hospitals that responded are members of a HIE. While this number is lower than EHR adoption, over the next five years over 80 percent intend to join a HIE. The primary barriers to joining are cost, training and implementation, as well as privacy and security concerns.

Broadband coverage does not appear to be a barrier to EHR or HIE adoption as all that responded to this question have at least one form of Internet access. In fact, about 50 percent responded that they have redundant or back-up services.

The EH survey findings suggest that most hospitals will have an EHR system in place by 2013 and all that meet Medicaid volume threshold intend to apply for MIP payments. Additionally, there will be significant increases in participation with HIE, as well as other HIT adoption modules over the next several years. Nebraska hospitals appear to be engaged and actively moving forward with HIT adoption and HIE participation.

3.1.3 Other EHR/HIE Adoption

3.1.3.1 Indian Health Service

Health care services are available to Nebraska Native Americans at IHS and tribal facilities. Winnebago Indian Hospital is an IHS facility, whereas Carl T. Curtis Health Center, Fred LeRoy Health and Wellness Center, Santee Sioux Clinic, and Winnebago Tribal Health Department are tribal-based facilities.

Since both the Nebraska IHS and the tribal health facilities subscribe to the Aberdeen Indian Health Service Area Office for HIT oversight, they all subscribe to the national IHS EHR system Resource and Patient Management System. This is the nationwide IHS EHR system which will be undergoing enhancements to meet Meaningful Use requirements and to connect to the Nationwide Health Information Network (NwHIN). The ability to interface with NwHIN will provide these facilities the means to exchange patient health information across facilities outside the IHS network. In addition to the IHS and tribal healthcare facilities, the Nebraska Urban Indian Coalition also provides services to this population. The Lincoln and Omaha sites in Nebraska and the Sioux City site in Iowa provide services to American Indians that do not reside on a reservation. The Omaha behavioral health site utilizes the AccuCare EMR system. Presently, the Lincoln medical clinic is in the process of implementing the FreeDom EMR and practice management system.

3.1.3.2 Department of Defense

Offutt Air Force Base is the only active military installation in Nebraska. The Ehrling Bergquist Clinic at the base provides comprehensive outpatient care, as well as pharmacy, lab, and radiology services. Military personnel requiring care beyond the capability of Ehrling Bergquist may receive services at the local civilian hospital, Bellevue Medical Center. Offutt clinicians have the opportunity to obtain privileges at Bellevue Medical Center.

Offutt Air Force Base currently uses Composite Health Care Systems and Armed Forces Health Longitudinal Technology Application to support EMR, EHR, and HIE functions. There is an electronic exchange of military health information to civilian-based Providers. Currently, conversations are underway between Offutt Air Force Base and Bellevue Hospital to determine how to best exchange patient data.

3.1.3.3 Veterans Administration

There are approximately 150,000 Veterans in the State of Nebraska who receive health care services from the Veterans Administration Nebraska-Western Iowa Health Care System (VA NWIHCS). Provider members of the VA NWIHCS include the VA Medical Center in Omaha, the Community Living Center in Grand Island and seven community-based outpatient clinics.

The VA NWIHCS uses the Veterans Health Information Systems and Technology Architecture (VistA) EHR system. This technology is used to share patient information among VA facilities only. VistA is a Web-based tool that allows Providers to securely sign in and access patient health records from remote locations.

While patient information is typically not electronically shared outside of the Nebraska VA system, there is the capacity for patient information exchanges on a case-by-case basis when the Interconnection Security Agreement is signed. At the present time, a pilot program is in place at several VA facilities across the country to exchange patient data outside the VA system using NwHIN. The VA NWIHCS is not part of this pilot program.

Currently, VA NWIHCS is pursuing the use of teleconferencing with facilities outside the VA system to provide patient care to veterans who would not otherwise have access to the specialized care they need.

3.2 Stakeholders - HIE/EHR Adoption Planning and Activities

3.2.1 State

The State of Nebraska's HIE/EHR adoption planning and activities are discussed in detail below.

3.2.1.1 Statewide HIE

Nebraska Health Information Initiative

NeHII began as a public and private collaborative initiative between the Nebraska Chamber of Commerce and University of Nebraska in 2005 with the intent of realizing job creation through economic development opportunities created by using innovative technologies to reform the delivery of health care. The goal of this joint effort was to create a common health record for use by all participants across the State. To jump start the planning and development effort, a Decision Accelerator strategy session involving approximately 150 stakeholders took place in March of 2007. In November 2008, NeHII entered into a vendor agreement with Axolotl to provide the technology needed to establish a HIE and offer EMR functionality to physicians without this resource in November 2008. NeHII was successfully piloted March through June of 2009 with the four major Omaha, NE health systems and then was implemented statewide in July 2009. NEHII was designated as the statewide integrator by Governor Heineman in June 2009.

NeHII's governance structure is private sector led with government collaboration. The State acts as the recipient and fiscal agent for the State HIE Cooperative Agreement. The funds for this program were made available through HITECH for the purpose of improving patient outcomes and reducing healthcare costs through the expansion of secure HIEs. NeHII, as the designated statewide integrator for Nebraska, is responsible for the implementation and management of the Statewide HIE. NeHII, Nebraska Information Technology Commission (NITC) eHealth Council, and the State HIT Coordinator work together to facilitate HIE exchange initiatives throughout the State.

NeHII's board of 22 members is made up of a broad representation of Nebraska HIE stakeholders. The four appointed members include an executive director, a government representative, a professional organization representative, and a consumer representative. A list of NeHII's Board of Directors is attached hereto as Appendix F. Two of the elected board members are NeHII Class A members. Class A members pay a yearly membership fee and are permitted one vote to elect two Class A members to the board. The remaining 16 elected members are Class B members. Class B members are typically larger facilities that pay a recommended joining fee based on size referred to as a Class B membership fee. Each Class B member's total number of votes corresponds to the initial one-time fee.

DHHS participates in Statewide HIE efforts. The Medicaid Director holds a seat on NeHII's board and is a member of NITC eHealth Council. As outlined in the Strategic Plan (October 2010), Medicaid is considering plans to become a participating member of NeHII and may undergo the necessary steps to be capable of data exchange.

NeHII's current members include healthcare Providers located throughout the State. Current hospital participants and those hospitals and health systems that have signed a NeHII participant agreement can be found in Appendix F. The majority of those listed plan to start the implementation process by the end of 2012. Please refer to the implementation schedule for the various hospitals found in Appendix F. NeHII also exchanges patient data with members located in the state~~s~~ of Iowa and nearly 26% of those listed in the Master Patient Index (MPI) have addresses outside the State of Nebraska.

Based on the NeHII's Weekly Fact Sheet (September 2012), at that time there were a total of 2,322 physicians and staff using NeHII's Virtual Health Record. Of that number, there are 1,052 physicians participating or nearly 33% of the state's physicians. Additionally, the 17 participating hospitals and those that have signed the participation agreement indicating they intend to join by end of year 2012 make up approximately ~~40~~ 66 percent of the hospital beds in Nebraska. There are 18 hospital-based labs enrolled with NeHII. While NeHII provides e-prescribing services to providers for all of the pharmacies, six independent pharmacies participate as a NeHII member. Blue Cross & Blue Shield of Nebraska is currently the only health plan participating in NeHII. NeHII is in conversations with United Healthcare, Coventry and Humana regarding the values of membership.

NeHII is working with the Division of Public Health to establish the bi-directional exchange of immunization data with NESHS and third party EMRs. NeHII and NESHS are in the final stages of testing with the pilot site Regional West Physician Clinics in Scottsbluff, NE and the NextGen EMR. Planning meetings are being scheduled to implement disease reporting to Public Health followed by syndromic surveillance once the secondary use of data policies have been finalized by the NeHII Privacy & Security Committee.

eBHIN

Electronic Behavioral Health Information Network (eBHIN), is behavioral health specific HIE. eBHIN's goal is to provide HIE services, as well as EMR, billing, and practice management modules to contracted Providers. eBHIN received advisory support from NeHII during the developmental stages and continues to collaborate with NeHII. eBHIN's governance structure is constituency based with nine board members from Region 5 and 1. As additional regions become eBHIN members, stakeholder representation will be revisited. eBHIN has operated a data collection system and ASO upload for 15 months and kicked off the information-sharing portion of the system among Region 5 providers in June of 2012.

The State of Nebraska Division of Behavioral Health (DBH) is made up of six regions that contract with local programs to provide services. Region V, located in southeast Nebraska, is made up of 13 DBH contracted organizations, and will be the first region to interface with eBHIN. The next area of expansion will be Region I which is located in the Panhandle of Nebraska and Region 6 which is the Omaha and Douglas County area. Regions 2, 3 and 4 are currently assessing their readiness for participation based on how to get the most value out of current and future investments.

SENHIE

Thayer County Health Services (TCHS), received a CAH HIT grant to create a HIE across their Provider network. As a result of this funding, South East Nebraska Health Information Exchange (SENHIE) was established to enhance interoperability between TCHS and six long-term care facilities. The governance oversight of SENHIE is maintained by TCHS' CEO and board of directors. SENHIE intends to connect directly to NwHIN rather than interface with the Nebraska Statewide HIE.

Western Nebraska Health Information Exchange

WNHIE ceased operational activities in 2010. Two of the hospitals that were involved in WNHIE have joined or are in the process of joining NeHII.

3.2.1.2 eHealth Council

In 2007, Lieutenant Governor Rick Sheehy and the NITC established the eHealth Council. The goal in forming the council was to foster collaborative relationships between the public and private sector to promote the coordination of HIT initiatives across the State.

The eHealth Council oversaw the completion of the State's eHealth Strategic and Operational Plans. These plans, approved by the Office of the National Coordinator for Health Information Technology (ONC) in November of 2010, will support the execution of the State HIE Cooperative Agreement. The State of Nebraska will act as the recipient and fiscal agent of the $6.8 million award, while NeHII will lead the implementation of the State HIE Exchange Cooperative Agreement program. Funds from the State HIE Cooperative Agreement award will be used to accelerate HIE development Statewide. The award will primarily provide funds to support start-up costs and expansion of new services rather than operational costs.

As outlined in the Nebraska eHealth Strategic Plan (October, 2010), the NITC and eHealth Council, in cooperation with NeHII and the State HIT Coordinator, will be responsible for:

- Developing the State's Strategic and Operational eHealth Plans and application for the State Health Information Exchange Cooperative Agreement Program;
- Coordinating activities with the Statewide integrator, the REC, the State's HIEs, and other stakeholders;
- Working with the NeHII to support implementation efforts of the State Health Information Exchange Cooperative Agreement Program;
- Assisting the State HIT Coordinator in providing oversight over implementation of the State Health Information Exchange Cooperative Agreement Program;
- Establishing a framework for governance and oversight of HIT in the State;
- Developing work groups to address privacy and security, fiscal integrity, interoperability, and business and technical operations;
- Making policy recommendations related to HIT;
- Monitoring programmatic progress through scheduled reports, using approved reporting criteria and measures;
- Complying with all reporting requirements and the terms and conditions of the cooperative agreement to ensure the timely release of funds;
- Ensuring expenses and matching contributions meet all federal requirements;
- Maintaining a fiscal control and monitoring system that meets requirements for federal audits and through which fund expenditures may be tracked in accordance with federal requirements;
- Receiving, reviewing, and monitoring requests for fund advance or reimbursements from subcontractors or other end recipients of funding; and
- Delivering disbursements to subcontractors or other end recipients of funding in a timely manner.

3.2.1.3 DHHS – Division of Public Health

The State of Nebraska Division of Public Health (DPH) is made up of 20 local health departments. The DPH provides oversight of preventive and community health programs and services. Additionally, it is in charge of the regulation and licensure of health-related professions, healthcare facilities, and services.

The DPH is represented on the eHealth Council, and therefore, actively participates in Statewide HIE and EHR adoption initiatives. Also, in 2009 the eHealth Council formed a Public Health Work Group. This group was charged to identify ways to utilize HIE to enhance disease surveillance and other public health efforts. The Public Health Work Group submitted a report to eHealth Council outlining key findings and recommendations, which is attached hereto as Appendix G.

3.2.1.4 DHHS –Division of Medicaid & Long-Term Care

Nebraska's State HIT Coordinator is Lieutenant Governor Rick Sheehy. As the State HIT Coordinator, he works closely with the eHealth Council in facilitating HIE activities across the State. DHHS is also actively involved in Statewide HIE initiatives. The Medicaid Director holds a seat on eHealth Council and the statewide health exchange NeHII. Additionally, DHHS staff participate in State HIE Cooperative Agreement program activities. Participation by both the State HIT Coordinator and DHHS with Statewide Provider adoption and Meaningful Use of EHRs will ensure ongoing coordination of State resources.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), provides funding to continue CHIP, as well as supports additional initiatives. CHIPRA awarded State Demonstration Grants to 10 states to evaluate opportunities for quality improvement in children's health care under Medicaid or CHIP. One of the objectives of these demonstration grants was to determine the impact EHRs have on improving pediatric health outcomes and reducing associated costs.

While the State of Nebraska was not awarded funds from this program, an FQHC – One World Community Health Centers, Inc., located in Omaha – was awarded $706,264 in funding for another CHIPRA initiative. CHIPRA also provided $100 million in funding to enable states to maintain their current CHIP programs and increase enrollment in Medicaid and CHIP between FY 2009 and FY 2013.

3.2.2 Professional Associations

In the fall of 2010, DHHS began outreach and education efforts regarding MIP with the following professional organizations:

- Nebraska Hospital Association
- Nebraska Medical Association
- Nebraska Nurse Practitioner
- Nebraska Dental Association
- Lancaster County Medical Society
- Nebraska Academy of Physician Assistants

Many of these associations participated with DHHS to get the message out about the survey. Efforts are currently underway to continue to foster partnerships with these organizations so that they may serve as another mechanism to communicate with Providers. DHHS anticipates that this collaborative effort will increase the distribution of information regarding MIP, as well as provide an opportunity for the associations to provide feedback.

3.2.3 REC

Wide River TEC is Nebraska's designated HIT REC. CIMRO of Nebraska, the Medicare Quality Improvement Organization for the state of Nebraska, was awarded $6.6 million from the ONC to establish Wide River TEC.

As Nebraska's designated REC, Wide River TEC's goal is to assist Providers with becoming Meaningful Users of EHR technology. As of August 24, 2012, Wide River TEC was working with 1,065 primary care providers and 54 critical access hospitals. Wide River TEC helps Providers with general training and education support, as well as technical services in the following areas:

- Selection and purchase of EHR software;
- EHR implementation and project management support;
- Practice and workflow redesign;
- Functional interoperability and HIE assessment and guidance;
- Privacy and security best practices; and
- EHR optimization and Meaningful Use.

Of the 1,065 primary care providers working with Wide River TEC, 806 have installed an EHR and are using it to report quality measures and e-prescribe, as of August 24, 2012. Also, 192 providers have received payment for meeting meaningful use requriements. Of the 54 critical access hospitals working with Wide River TEC, 27 have implemented and are using an EHR, 15 have received payment for meeting meaningful use requirements.

As part of the environmental assessment, DHHS began to work with Wide River TEC to promote Provider adoption. Wide River TEC helped with the survey distribution by publicizing the survey on their Website. Additionally, DHHS provided Wide River TEC with a list of survey respondents who indicated they were interested in Wide River TEC services. Also, DHHS posted TEC's Website link and provided information for TEC meeting attendees as well as providing referrals to TEC. DHHS anticipates ongoing collaboration with Wide River TEC to support MIP.

3.3 MITA

MITA is a CMS initiative designed to assimilate business and information technology transformation across the Medicaid enterprise in order to improve the administration of the Medicaid program. MITA is a business-centric architectural framework that provides planning guidelines for states to define strategic business goals and objectives, define business processes, and assess current capabilities as a baseline to measure progress towards these goals.

A key activity within the MITA initiative is performing a MITA State Self-Assessment (MITA SS-A). DHHS's MITA 2.0 SS-A .has been completed. MITA 3.0 is in the process. In alignment with the Medicaid vision for MITA, DHHS is planning to modernize the MMIS to obtain a MITA-aligned and HIPAA compliant system, which will aid in exchanging and managing electronic health information.

3.4 Interoperability – Data Sharing

3.4.1 Broadband Internet Access

As found in many states, Nebraska has greater broadband penetration in urban areas than in rural areas of the State. A visual representation of coverage may be found on the National Broadband Map (http://www.broadbandmap.gov/technology), an initiative detailed below. Despite varying levels of geographic coverage, availability to broadband connectivity does not seem to be at issue for health care providers as demonstrated in the survey results detailed in sections 3.1.2.2 and 3.1.2.4.

The State of Nebraska has applied to participate in the National Telecommunications and Information Administration (NTIA) Broadband Mapping program. As part of this award, the Nebraska Public Services Commission will oversee the development of broadband internet access mapping in spring of 2011. The broadband planning component of this initiative will be a collaborative effort led by the NITC's Community Council, the University of Nebraska-Lincoln, and the Nebraska Department of Economic Development. This group's objective is to identify areas in need of greater broadband capabilities and then develop the plans necessary to address them.

A group of companies and associations are working together to coordinate resources and reduce duplication of efforts. The Rural Nebraska Healthcare Network (RHIN), a consortium of nine rural hospitals and related clinics in western Nebraska, is partnering with Zayo Group, a Colorado based Provider of Bandwidth Infrastructure and Network Neutral Colocation Services, to connect nine primary care hospitals and dozens of clinics by deploying a fiber optic medical network. The proposed project, expected to be completed in the fall of 2011, will create a 750-mile fiber network spanning 12 counties in western Nebraska and will connect to national research networks. Funding to support this project was provided by the Rural Health Care Pilot of the Federal Communications Commission and the Zayo Group.

The Nebraska Medical Association and representatives from telecommunication companies are currently discussing statewide broadband needs, specifically addressing pricing and redundancy issues. Additionally, a partnership among a group of Nebraska independent phone companies has organized to discuss a project involving fiber in the ground. The plan would be to work together to create "loops" that would offer redundant services and allow participating companies to better compete with larger carriers.

There are also several Broadband Technology Opportunity Program (BTOP) grants within the State of Nebraska. The following table provides a list of the grants received with links to additional information regarding each of the grants:

Table 7: List of Nebraska BTOP Grant Awards

Grantee	Total Award	Type
Communication Service for the Deaf, Inc.	$14,988,657	Sustainable Adoption
Nebraska Public Service Commission	$5,662,785	Broadband Data & Development
NebraskaLink, LLC	$11,547,866	Infrastructure

Grantee	Total Award	Type
The State of Nebraska	$2,416,403	Public Computer Centers
University Corporation for Advanced Internet Development	$62,540,162	Infrastructure

Nebraska will continue to bring resources together to improve broadband connectivity. Broadband development projects are major initiatives that will be a focus of efforts going forward in the State of Nebraska.

3.4.2 MMIS Interoperability

Nebraska's MMIS consists of batch and online Customer Information Control System (CICS) mainframe components, sixteen subsystems, and a front-end HIPAA-compliant Sybase Translator. Currently, MMIS does not electronically exchange health information with external agencies for health related purposes. Any health related information that may be contained in claims, prior authorization or eligibility data is shared only for administrative and payment purposes.

3.4.3 N-FOCUS Interoperability

N-FOCUS provides eligibility determination for Medicaid and a number of other economic assistance programs and interfaces with the MMIS.

While N-FOCUS obtains patient demographic and health information, as well as makes claim payments, none of the patient health information collected is electronically exchanged with external agencies.

3.4.4 DHHS – Division of Public Health Interoperability

3.4.4.1 State Immunization Registry

The Nebraska State Immunization Information System (NESIIS) is a secure, statewide, web-based system that's been developed to connect and share immunization information among public clinics, private provider offices, local health departments, schools, hospitals and other health care facilities that administer and track immunizations in the State of Nebraska. The primary function of NESIIS is to collect data so that Providers may track and identify required immunizations.

For facilities without an electronic health record (EHR) system, NESIIS offers a user-friendly manual interface that allows a facility to enter, view and track immunizations that have been given, manage vaccine inventory, forecast vaccinations needed, and run reports and reminder-recall notices. For facilities with an EHR, NESIIS is capable of uni-directional and bi-directional electronic data exchange to minimize the amount of manual data entry or double data entry for facilities.

NESIIS utilizes the Public Health Information Network Messaging System (PHINMS) and SOAP Web Services for secure data exchange. NESIIS accepts HL7 2.3.1 and HL7 2.5.1 formatted data. The data

elements collected from Providers include patient demographics, administering facility, immunization type, vaccine trade name, lot number, and immunization date.

NESIIS provides many benefits to the State, the providers who use the system and the clients whose records are stored within the system. It reduces staff time needed to obtain scattered immunization records, reduces expenses and risks incurred by administering duplicate immunizations, reduces missed vaccination opportunities, reduces staff time needed to evaluate which immunizations are due, prevents vaccine waste through better inventory management, reduces staff time needed to produce recall and reminder notices, and provides client level look-up so individuals can view and print their own immunization records whenever they need to.

Data submitted to NESIIS is used to complete the annual surveys sent to the CDC. The Vaccine for Children Providers, a federal vaccine program, use NESIIS to submit their monthly reports to the DPH immunization program. DPH is working towards connecting to NeHII to obtain immunization data.

3.4.4.2 State Public Health Surveillance

Epidemiological Surveillance

DPH utilizes the National Electronic Disease Surveillance System (NEDSS) to track disease patterns and coordinate responses to outbreaks in the State of Nebraska. NEDSS is a secure web-based program that allows healthcare professionals and government agencies to communicate, plan, and respond to such events in a timely manner. The CDC is in charge of maintaining and expanding NEDSS so that the speed, accuracy, standardization and viability of data about diseases are improved. The goal of this surveillance program is to identify trends in reportable diseases and support local health departments' outreach efforts.

NEDSS accepts HL7 2.3.1 and 2.5.1 formatted data. Like NESIIS, NEDSS data is submitted via PHINMS. The State of Nebraska requires labs to report on approximately 70 diseases. Ninety percent of all reportable diseases are submitted electronically. Currently, most labs submit data electronically in HL7 format. While NEDSS captures patient demographic, disease and lab result data, only aggregate data is sent externally. DPH intends to connect to NeHII to collect lab data.

DPH works with the Nebraska Local Health Departments for disease investigations. All responses are submitted to the State's NEDSSS electronic reporting system. These reports are monitored daily for outbreaks so that DPH can develop and implement investigation protocols. The electronic exchange of information to NEDSS allows quick recognition and near real-time responses to disease outbreaks and bioterrorism attacks.

Syndromic Surveillance

To expand the scope of syndromic surveillance, strengthen current surveillance capabilities, and improve the effective practice of public health in Nebraska, DPH created the Syndromic Surveillance Event Detection of Nebraska (SSEDON). The objective of this syndromic surveillance program is to detect,

track and analyze disease events to establish at-risk populations, develop effective prevention plans, monitor trends in morbidity and ultimately improve population health through better, more-timely, disease surveillance.

SSEDON accepts HL7 2.5.1 formatted health information electronically through PHINMS. In 2010 DPH began receiving near real-time data from emergency room (ER) medical record systems. In 2011 this work was expanded to include near real-time data from electronic inpatient record systems. Approximately 25 percent of the emergency room visits across the State are reported to DPH and work has been completed on one in-patient pilot site. Future plans include collecting ED and inpatient data from all hospitals in the State of Nebraska.

While SSEDON accepts HL7 2.5.1 formatted messages, 90 percent of the data received is not submitted in HL7 format therefore DPH must convert it to meet system needs. DPH is working with submitting facilities to reformat data to meet HL7 specifications. This process will, in turn, help the facilities meet the Meaningful Use objectives for data transmission to DPH. It is important to note that that syndromic surveillance data is de-identified before submission therefore it contains no identifiable patient data.

DPH shares aggregate surveillance summaries internally, to reporting hospitals and to facilities for medical research purposes. DPH has installed a system called ESSENCE to help facilitate this data sharing. ESSENCE is a system which compiles data such as emergency room visits to look for early recognition of patterns that could indicate the outbreak of a disease or health situation. DPH plans to interface SSEDON with NeHII.

3.4.5 DHHS – DBH Interoperability

The DBH central office is located in Lincoln. DBH is made up of the Community-Based Services Section and the Regional System Section.

Community-Based Services is organized into six local behavioral health regions that receive funding, oversight, and technical support from DBH. Each region contracts with local clinicians and Provider groups to deliver behavioral health services. These contracted Providers are responsible for maintaining their own medical records, whether they are in paper or electronic format.

There is no centralized EHR system, clinical data repository, or exchange of patient health information. However, Magellan Behavioral Health Services is contracted with Community-Based Services to pay claims, perform authorizations, and collect outcome measures. Therefore, Magellan collects patient demographic and some health related information to carry out these functions. Magellan interfaces with Nebraska's MMIS system for the purpose of eligibility and prior authorization determination.

Magellan provides reports and data extracts in PDF and Excel format to Community-Based Services who then shares them with the local regional agencies and contracted Providers. Contracted Providers also may access standard PDF reports specific to their agency on the Magellan Website. Community-Based

Services also uses Magellan to report Treatment Episode Data Set and State Outcome Measurement and Monitoring System to federal agencies as required.

Electronic Behavioral Health Information Network (eBHIN), is behavioral health specific HIE. eBHIN's goal is to provide HIE services, as well as EMR, billing, and practice management modules to contracted Providers. eBHIN received advisory support from NeHII during the developmental stages and continues to collaborate with NeHII. eBHIN's governance structure is constituency based with nine board members from Region 5 and 1. As additional regions become eBHIN members, stakeholder representation will be revisited. eBHIN has operated a data collection system and ASO upload for 15 months and kicked-off the information sharing portion of the system among Region 5 providers in June of 2012.

The State of Nebraska Division of Behavioral Health (DBH) is made up of six regions that contract with local programs to provide services. Region 5, located in southeast Nebraska, is made up of 13 DBH contracted organizations, and was the first region to interface with eBHIN. The next areas of expansion will be Region I which is located in the Panhandle of Nebraska and Region 6 which is the Omaha and Douglas County area. Regions 2, 3 and 4 are currently assessing their readiness for participation based on how to get the most value out of current and future investments.

The DBH Regional System Section is comprised of three Regional Centers, located in Lincoln, Norfolk and Hastings. The Regional Centers are responsible for providing services to patients committed by mental health boards or the courts. All three Regional Centers currently use Netsmart's Avatar EMR system. Each Regional Center has its own server, and therefore, does not share patient data across entities. There is no external exchange of patient information or immediate plans to join NeHII or eBHIN. The current focus is on the implementation of Avatar's features that are not presently in use. Additionally, plans are underway to purchase Netsmart's Avatar e-Prescribing software.

3.5 Consumer View

In November 2008, the University of Nebraska Public Policy Center conducted a project to research the views of the State of Nebraska's citizens on HIT and electronic sharing of health information. The survey was completed by 168 Nebraskans, 34 of which also participated in a more focused discussion. The findings of this effort suggest that consumers are generally receptive toward HIT and the exchange of patient health information. While perceptions of health technology were positive, some consumers expressed concerns regarding privacy and security.

The results of this research indicate that most participants believed that State government should play a role in ensuring the privacy and security of health information (100 percent), providing information to consumers about health information security and privacy (94 percent), regulating health information networks (91 percent), and facilitating public-private partnerships to exchange health information (88 percent). Findings also reveal that consumers would like to see State government play a role in consumer education and 72 percent of the deliberation participants said it was "very important" for the State government to educate Nebraskans about electronic HIE.

Additionally, Nebraska residents reported that they regularly use the Internet to access health or insurance information. Although consumers would like to, many do not use the Internet to communicate directly with their Providers through email.

According to the Nebraska Strategic eHealth Plan, consumers are satisfied with telehealth services provided through the Nebraska Statewide Telehealth Network.

3.6 State Borders

Iowa, Kansas, Colorado, South Dakota, Wyoming, and Missouri are border states. Based on the State of Nebraska's Medicaid claims data, approximately 10 percent of Nebraska's Medicaid beneficiaries receive care out of the State. The State of Iowa Division of Health Services and the Nebraska DHHS participated in a monthly meeting. Other participants include the representative for the State Health Information Technology Coordinator for Nebraska and NeHII. The purpose of these calls is to share best practices and lessons learned regarding HIE and implementation of MIP.

NeHII collaborates with Iowa, Kansas, Colorado, South Dakota, and Wyoming regarding cross border HIE activities. NeHII has a total of 57 participating physicians that practice in the State of Iowa. Additionally, Mercy Hospital in Council Bluffs, Mercy Hospital in Corning, and Community Memorial Hospital in Missouri Valley, all of which are located in Iowa, are members of NeHII. Jeannie Edmudson Hospital in Council Bluffs, Iowa also plans to connect with NeHII in the near future. In addition to providing HIE services across state borders, NeHII provides business plan development, helpdesk functions, and training services to out-of-state Providers or state HIEs that can use NeHII's expertise.

3.7 MMIS Capabilities Assessment

3.7.1 Medicaid Applications Environment

Applications that support Medicaid programs include the following:

- MMIS – Described in more detail below.
- N-FOCUS – Nebraska's integrated eligibility and case management system (also described below).
- Nebraska Medicaid Case Mix System – This application holds nursing home resident level of care assessment information. It uses information from the Minimum Data Set data base that supports the federally-required interdisciplinary assessments for nursing facility residents.
- Coordinating Options in Nebraska's Network through Effective Communications & Technology (CONNECT) – The system that assists Services Coordinators in their work with children and adults. The Early Development Network, Aged & Disabled Waiver, Early Intervention Waiver, Medically Handicapped Children's Program, Respite Subsidy and the Disabled Persons and Family Support programs are included in the system. CONNECT tracks referrals, verification, diagnosis, and services being provided and services that are needed but not available. CONNECT collects data, but primarily gives

services coordinators access to information on other services the child, or individual is receiving and enables easier coordination. This application supports service authorizations for assisted living services.

- Money Follows the Person – This application supports the program that assists aged individuals and persons with disabilities who want to move out of an institution (such as a nursing facility) and into their own home or apartment.
- Nebraska Aging Management Information System (NAMIS II) – This application supports the activities of the State Unit on Aging. It was developed to enter, edit, monitor, and report services provided by Area Agencies on Aging in Nebraska, track services required by the U.S. Administration on Aging (AoA), and to compile information required by the AoA for the National Aging Program Information System. It is also used to manage programs, track costs in certain services, track program usage, and analyze client demographics.

3.7.2 MMIS

The foundation of the current MMIS technical architecture was developed in 1973. The current MMIS has been fully operational since 1978 and became HIPAA compliant on October 14, 2003. MMIS consists of batch and online CICS mainframe components and a front-end HIPAA compliant Sybase Translator.

The Nebraska MMIS currently consists of the following 16 subsystems:

1. Data Management – The DHHS currently contracts with Truven Health Analytics for data management, housing ten years of Medicaid claims and Provider and client information used to facilitate management reporting, including the Management & Administrative Reporting Subsystem (MARS), the Surveillance and Utilization Review Subsystem (SURS) and the MMIS reporting.
2. Drug Claims Processing – The DHHS currently contracts with First Health Services Corporation (FHSC) for drug claims receipt and adjudication. The FHSC Point of Service (POS) system supports the National Council for Prescription Drug Programs standards, including currently 5.1 (real-time) and 1.1 (batch) formats. The POS sends processed pharmacy claims to the State's MMIS on a daily basis, where the claims are passed into the MMIS weekly payment cycle for final adjudication, payment, and reporting.
3. MARS – Provides system generated reports. DHHS also contracts with Truven Health Analytics to provide management information.
4. Medicaid Drug Rebate – A PC-based extract from MMIS claims history to prepare quarterly invoices for drug rebates from manufacturers.
5. Medical Claims Processing – Edits claims and calculates reimbursement amounts.
6. Medical Non-Federal – Ensures that Title XIX Federal matching funds are not used to pay for health care services otherwise available through Title XVIII (Medicare) funding.
7. Medical Provider Subsystem – Maintains demographic, eligibility, and licensing data for all enrolled Providers.

8. NAMIS II – This application supports the activities of the State Unit on Aging. It was developed to enter, edit, monitor, and report services provided by Area Agencies on Aging in Nebraska, track services required by the AoA, and to compile information required by the AoA for the National Aging Program Information System. It is also used to manage programs, track costs in certain services, track program usage, and analyze client demographics.
9. Nebraska Disability Program – Accounts for the separate funding of health care services for disabled persons who do not meet the SSI disability duration requirements but are eligible for the same medical services as Medicaid.
10. Nebraska Managed Care System – Provides plan and PCP enrollment of Medicaid clients into managed care, and documentation of communications between the client, the enrollment broker, and the managed care plans. Nebraska Managed Care System is a rudimentary case management system.
11. Nebraska Medicaid Eligibility System – An automated voice response system used to verify client Medicaid or managed care eligibility for Nebraska Medicaid. The current Interactive Voice Response Unit also supports the Nebraska's Child Support system, known as Children Have A Right To Support (CHARTS), which serves as Nebraska's statewide Child Support Enforcement system.
12. Recipient File Subsystem – Uses and maintains Medicaid client eligibility data obtained from N-FOCUS.
13. Reference File Subsystem – A database of various reference information that includes, but is not limited to, procedure, diagnosis and drug codes, and fee schedules.
14. Screening Eligible Children – Facilitates comprehensive, preventative health care and early detection and treatment of health problems in Medicaid eligible children.
15. SURS – Provides system generated reports. DHHS also contracts with Truven Health Analytics for reports and tools to support the investigation of potential Provider fraud, abuse, or misuse.
16. Third Party Liability – Stores information on Medicaid clients with private insurance; contains edits and produces reports for coordination of benefits and recovery.

MMIS consists of batch and online CICS mainframe components and a front-end HIPAA compliant Sybase Translator. Batch components consist of 829 COBOL programs and 208 Batch Assembler programs (DRG software). The online CICS consists of 343 COBOL programs and 2 Online Assembler programs. There are 7 COBOL programs that are used both in Batch and Online. There are 406 jobs executed on a scheduled basis and an additional 150 on a request basis. The online CICS component consists of 27 transactions with over 225 on-line screens.

The Sybase translator communicates to a server database (mainframe DB2) through a UDB Gateway utilizing the TCP/IP communications protocol. The translator application consists of 44 VBScripts, 7 VA Cobol programs, 282 Gateway Scheduler Tasks, 272 Gateway Process Scripts, 13 Compliance Maps, 13 in-house developed ECMap maps and 10 CONNECT: Direct processes. There are 359 Trading Partners set up in the Trading Partner server, 115 of which are in production with one or more transactions. A total of six servers are used to support the translator software.

The CICS online and batch components make use of 13 DB2 databases with 523 tables and 505 million rows of data. The Sybase Translator utilizes 79 tables and over nine million rows of data in a Windows server environment.

3.7.3 N-FOCUS

N-FOCUS is an integrated client/server system that automates benefit and service delivery and case management for over 30 Nebraska Health and Human Services System programs, including client benefit determination, Medicaid eligibility and child welfare. N-FOCUS functions include client/case intake, eligibility determination, case management, service authorization, benefit payments, claims processing and payments, Provider contract management, and government and management reporting. N-FOCUS is also the Statewide Automated Child Welfare Information System for DHHS. N-FOCUS was implemented in production in mid-1996 and today is operational Statewide. N-FOCUS interfaces with MMIS.

The application has both batch and online components and stores data in DB2, V9. The DB2 database has over 500 tables, some with a corresponding archive table. There are over 550 relationships between tables, 935 indexes, and over 8700 attributes. There are over 1.3 billion rows of production data with over 200 million rows in one table.

The batch system is coded in Z/OS COBOL and executes in a Z/OS environment. There are more than 700 procedures, over 640 programs, and over 220 stored procedures. The application generates over 540 reports using Crystal Reports that are published to a Web portal through Business Objects Enterprise software.

The online system is an integrated client/server based software system. The client software executes on XP workstations (soon to be upgraded to Windows 7) and resides on Windows 2003/2008 servers located throughout the State. Computer Associates Gen and AION toolsets are used to generate windows and C code, along with custom in-house architecture code written in C. The server components are Z/OS CICS transactions. The CICS programs are Gen-generated COBOL, along with in-house written COBOL and Assembler externals. The CICS programs access DB2 on the Z/OS mainframe. The Gen clients use External Call Interface, IBM's CICS Universal Client to connect to the Z/OS CICS using TCP/IP protocol. The Gen online system consists of over 490 client procedures, 470 server procedures, 475 windows, and 1300 dialog boxes. The AION online system supports the complex eligibility data gathering and automated determination and noticing processes.

N-FOCUS Web applications consist of public applications, including dashboard applications, and applications launched directly from N-FOCUS. Eclipse is the IDE used to generate the Java Server Faces and Facelets code. These Java applications run on Tomcat application servers on the Linux Operating System. The Java applications call stored procedures to access DB2 data and SQL to access SQL Server data.

3.8 Coordination with Medicare and Federally Funded, State Based Programs

There are several HIT and HIE projects underway at DHHS within federally-funded, State-based programs. Specifically, the Division of Public Health is engaged with the CDC to improve interoperability of health data for syndromic surveillance and the immunization registry and other public health preparedness initiatives. Please see Section 3.4.4.1 and 4.4.4.2 for details. Moreover, to streamline and coordinate the public health data projects for Meaningful Use, the Nebraska DPH has reorganized to create a Health Information Exchange/Meaningful Use work group. This group consists of a project coordinator and three help desk coordinators (one for each data element), at this time. This team is working to enhance the public health data initiatives by working on the following:

NESIIS

- Working with facilities to initiate data exchange
- Working with NeHII for data exchange
- Building infrastructure to analyze the data received

NEDSS

- Developing a secondary method for secure data exchange
- Working with facilities to initiate data exchange
- Working with NeHII for data exchange
- Building infrastructure to analyze the data received

Syndromic Surveillance

- Developing a secondary method for secure data exchange
- Working with facilities to initiate data exchange
- Working with NeHII for data exchange
- Building infrastructure to analyze the data received

The Nebraska DPH is also working with other State and Federal programs to determine the best methods to enhance each system. The process is evolving and developing at this time therefore DHHS will continue to investigate and determine the best solutions for Nebraska.

Additionally, The State of Nebraska has received federal funds for broadband initiatives, as well as a United States Department of Health and Human Services' Health Resources and Services Administration

(HRSA) grant to promote the use of HIT. Please see Section 3.9 below for more information related to the HRSA grant.

3.9 FQHCs/RHCs

There are 13 FQHCs and 122 RHCs located in Nebraska and enrolled with Nebraska Medicaid. FQHCs and RHCs are already working together and exchanging health care information. Three initiatives in Nebraska received funding from HRSA to support Provider adoption of HIT and HIE. HRSA is an agency within United States Department of Health and Human Services whose primary goal is to improve access to health care for uninsured, isolated, or medically vulnerable populations.

On June 3, 2010, the United States Department of Health and Human Services announced that $83.9 million in grant funds were available to assist health center networks to adopt and implement HIT. These funds are part of the $2 billion that were assigned to HRSA under ARRA. One World Health Centers, acting as the fiscal agent for the Heartland Community Health Network and as a member of this network, was awarded $1,511,083 from the ARRA Health Information Technology Implementation Grants. Heartland Community Health Network is a collaborative network of the following five FQHCs:

- One World Health Centers, NE
- Charles Drew Health Center, NE
- People's Health Center, NE
- Norfolk Community Health Clinic, NE
- Council Bluffs Community Health Center, IA

Heartland will use this funding for staffing to assist its five participating members and to provide technical support in the adoption of HIT and HIE. Funding from this grant will also be used to customize the NextGen EHR to make it more usable in a community health center setting and to lead performance improvement activities across all five health centers. Finally, Heartland Community Health Network intends to connect to NeHII to for the exchange of patient information. In addition to the federal funding, Heartland Community Health Network members are contributing to the costs of adoption of HIT and HIE.

WNHIE included Panhandle Community Services Health Center, the FQHC serving this region, in its HIT adoption and HIE planning initiative. WNHIE received several grants including: 1) a planning grant from the United States Department of Health and Human Services Agency for Healthcare Research and Quality (AHRQ) in 2004; 2) a three-year implementation grant from AHRQ; 3) a HRSA Rural Network Development Grant, a Rural Health Care Pilot grant from the Federal Communications Commission; and 4) a grant from the Nebraska Information Technology Commission. The primary goal for this collaborative effort to lay the foundation for the development of a HIE for the participating Providers in this region was met. In 2010, WNHIE assessed the need for a HIE in this region and determined not to continue efforts towards this endeavor. WNHIE healthcare Providers are discussing the possibility of joining NeHII. WNHIE decided to utilize their existing HIT and human capital resources to provide HIT

training sessions and through a partnership with Western NE Community College offered HIT training for college credit.

The HRSA Office of Rural Health Policy (ORHP) awarded a $25 million one-time funding to 16 rural grantees to develop and implement HIT pilot networks. In September 2007, Thayer County received $1.6 million in funds from the ORHP MedicAre Rural Hospital Flexibility CAH HIT Network Implementation Program. The goal of this program was to support the implementation of HIT systems in CAHs and their associated network of Providers by allowing the grantee to use the funding in a flexible way. TCHS used this award to establish the State's first HIE –SENHIE. Five RHC satellite clinics located in Bruning, Chester, Davenport, Deshler, and Milligan participated in this project.

4 To-Be HIT Landscape

The To-Be HIT Landscape describes the plan for promotion and adoption of HIT within the DHHS. The plan includes adoption, promotion, and enhancement of certified EHR systems for Providers and promotion of electronic health data exchange for and with DHHS. As part of this plan, DHHS completed an assessment of the current health information privacy and security regulatory framework with a gap analysis and recommendations for changes to the current framework for compliance with HIPAA and HITECH. This detailed discussion is found in Appendix J. This To-Be HIT Landscape section also provides a sustainable plan for participation in MIP with a focus on Meaningful Use. Finally, this section identifies the goals for promotion of MIP and additional functionality planned for the MMIS, other Medicaid information systems, and DHHS systems.

4.1 Future Vision for Providers

The focus of the DHHS HIT strategy and plan is the adoption of certified EHR technology by Providers in the State of Nebraska. Central to DHHS's HIT strategy is the need for clinical information in electronic format. DHHS will encourage Nebraska's Providers to gather clinical information at the time of care through the use of EHRs. DHHS will support EHR adoption through Provider outreach and the administration of MIP.

Informational resources with links to the EHR incentive program page and updates on the State's incentive program have been made available to Providers. Nebraska conducted a survey of the HIT and HIE environments to help define the future vision for health technology in the State of Nebraska. DHHS is coordinating with the REC and the NeHII on the Provider communication and education process to create efficiencies in communication and consistent messaging.

4.2 Future MMIS Capabilities

The State of Nebraska will be modernizing the MMIS to meet the future business needs of DHHS.

The current DHHS MMIS system is approaching the end of its useful life. The foundation for the structure of the current MMIS technical architecture was developed in 1973 and became fully operational in 1978. It consists of batch and online CICS mainframe components, sixteen subsystems, and a frontend HIPAA-compliant Sybase Translator.

The goals for modernization of the DHHS MMIS are to:

- Provide timely and accurate adjudication of Medicaid claims;
- Improve the efficiency and cost effectiveness of the Medicaid program;
- Improve communication between information systems;
- Improve the quality of, and access to, the data for better reports, leading to improved and informed decision making;

- Raise the MITA Maturity Level; and
- Improve information technology systems for increased flexibility and adaptability and increase responsiveness to needs within the DHHS business workflow.

4.3 Future Alignment with MITA

The current MITA status will be determined by the MITA SS-A, has been completed. DHHS plans to advance the MITA Maturity Level over the next five years through modernization of the MMIS system and the addition of clinical interfaces to the MMIS. DHHS is currently considering many options for the addition of clinical interfaces and national interoperability and connectivity, including utilizing standards-based connectivity methodologies, such as NwHIN. DHHS will be pursuing MITA Levels 3-5. MITA 3.0 is currently in process.

4.4 State Repository Level

DHHS considered a number of options for defining and implementing the processes necessary to support MIP.

DHHS used current DHHS systems and current communications channels for implementation of MIP.

DHHS implemented the following functions:

- Interface with the National Level Repository (NLR);
- Registration with the Nebraska State Level Repository (SLR) and review of SLR data;
- Verification of Provider eligibility for MIP;
- Attestation of AIU or Meaningful Use of EHR technology;
- Calculation, review, and approval of Provider payments;
- Initiation of approved payments to the State's enterprise payment system for payment to the Provider; and
- Tracking the payment and verifying that the right payment was made to the right Provider at the right time.

4.5 Future Broadband Initiatives

In the State of Nebraska, broadband Internet access is generally available across the State; however, coverage is lacking in some rural areas. This poses several challenges to Nebraska's rural health care Providers.

Initiatives are underway in the State of Nebraska to both identify gaps in coverage and improve access to broadband connectivity. Focusing specifically on identifying gaps in coverage, the State of Nebraska has applied to participate in the National Telecommunications and Information Administration Broadband Mapping program. Through a component of this program, regional technology committees will be

formed to identify areas in need of greater broadband capabilities. The committees will assist in the development of regional technology plans that will provide a means for underserved Providers to address broadband issues. In addition, the Nebraska Public Services Commission received a grant to create a broadband technology access map in the spring of 2011.

Many efforts are underway that focus on improving access to broadband connectivity. Two specific projects are detailed below:

1. RHIN, a consortium of nine rural hospitals and related clinics in western Nebraska, is partnering with Zayo Group, a Colorado-based provider of Bandwidth Infrastructure and Network Neutral Colocation Services, to connect nine primary care hospitals and dozens of clinics by deploying a fiber optic medical network. The proposed project will create a 750-mile fiber network spanning 12 counties in western Nebraska and will connect to national research networks and is expected to be completed in fall 2011. Funding to support this project was provided by the Zayo Group and federal funds RHIN received under the Rural Health Care Pilot of the Federal Communications Commission.
2. The Nebraska Medical Association and representatives from telecommunication companies are currently having conversations about statewide broadband needs, specifically addressing pricing and redundancy issues. A partnership among a group of Nebraska independent phone companies has organized to discuss a project involving fiber in ground. The plan would be to work together to create "loops" that would offer redundant services and allow participating companies to compete better with larger carriers.

Continuing to coordinate resources to improve broadband connectivity are major initiatives that will certainly be a focus of efforts going forward in the State of Nebraska.

4.6 Future Vision for Medicare and Federally Funded State Based Programs

DHHS intends to have a NwHIN connection and is considering the use of NwHIN standards-based technologies and systems to support clinical and administrative transactions. DHHS is considering the use of a NwHIN gateway for a connection to Medicare and federally funded State-based networks. Additionally, CMS, CDC, and other federal agencies have adopted and supported the use of NwHIN and its standards.

4.6.1 Future Integration Using NwHIN Standards

A number of federal agencies and State-based programs are considering utilizing NwHIN and the Direct Project for interoperable information exchange. Connectivity with these federal agencies will present opportunities in federal agency services and participation in federal projects for DHHS. As such, DHHS intends to have a connection to NwHIN in the future. DHHS is considering NwHIN-based connectivity to multiple federal agencies, including the Department of Defense (DoD), the Department of Veteran Affairs, CMS, CDC, Social Security Administration (SSA), and IHS.

Connection to NwHIN will be provided either through integration with NeHII, who will be on-boarded to NwHIN, or through a DHHS-specific connection.

4.6.2 Connection through Integration with NeHII

The State of Nebraska Strategic plan includes integration of local HIEs with the Statewide HIE, NeHII. The Strategic Plan includes a vision of exchange between DHHS and State-based programs using NeHII as a central point of integration. DHHS understands the importance of connectivity to and with NeHII, allowing for bi-directional exchange of data. DHHS may integrate with NeHII in order to connect to other organizations on the Statewide HIE and to use NeHII's NwHIN gateway. Alternatively, DHHS is considering obtaining a DHHS-specific connection to NwHIN, which could be used to integrate with NeHII.

The State's regional and specialty HIEs were invited to participate in Nebraska's Statewide HIE by connecting through NeHII. Participating exchanges would receive funding based on the characteristics of the population serviced. At this time, only the eBHIN has plans to connect to NeHII.

eBHIN is currently developing an eHealth network to exchange behavioral health information among behavioral health Providers with a focus on the Region V Service area. eBHIN partners have received multiple grants to facilitate the development of the network including:

- A planning grant from AHRQ;
- An AHRQ Ambulatory Care Grant;
- A three-year Rural Health Network Development Grant from HRSA; and
- A Nebraska Information Technology Commission grant.

DHHS will continue to support and work with groups like eBHIN.

DHHS is considering several options for future connectivity with Medicare and State-based programs, including: connection to Medicare, NeHII, and State-based programs via a dedicated DHHS NwHIN Gateway, or through a shared, integrated connection with NeHII (potentially a shared NwHIN Gateway with NeHII).

4.7 Future Vision for the Statewide Health Information Exchange

DHHS intends to leverage the Statewide HIE, NeHII, to support the exchange of clinical and administrative data between State-level HIE stakeholders and DHHS. In the future, clinical and administrative data could be used for DHHS internal analytics and research purposes. The Nebraska Strategic and Operational Plans for HIE include collaboration between DHHS and the Statewide HIE, NeHII.

4.8 Future Vision for the Public Health Initiatives

DHHS includes MLTC as well as DPH. Both divisions under DHHS will continue to work in a collaborative manner. Future NwHIN connectivity will provide a standards-based exchange that could streamline communication with public health initiatives.

MLTC and DPH are members of the NITC eHealth Council. This council was formed to facilitate collaborative opportunities to advance eHealth in the State. The NITC eHealth Council has formed a Public Health Work Group to identify ways to utilize health information exchange to enhance disease surveillance and other public health efforts. In operation since 2009, this Work Group has focused on identifying public health capabilities and gaps and making recommendations regarding the integration of public health information systems with HIE.

4.9 Future Vision for FQHCs/RHCs

There are 13 FQHCs and 122 RHCs located in Nebraska and enrolled with Nebraska Medicaid. FQHCs and RHCs are already working together and exchanging health care information. As DHHS and its Providers move forward with HIT adoption and become Meaningful Users of health care data, DHHS will continue to incorporate clinical quality data elements as part of program initiatives and evaluations. Additionally, FQHC and RHCs serve a high volume of Medicaid clients and DHHS will continue to coordinate with Wide River TEC, as well as NeHII, in the inclusion and education of the FQHCs and RHCs in the State of Nebraska HIE and HIT initiatives.

5 Medicaid EHR Incentive Program Blueprint

5.1 Introduction

5.1.1 Overview

The Medicaid EHR Incentive Program Blueprint (MIP), defined by the ARRA, will provide incentive payments to Providers for efforts to adopt, implement, or upgrade ONC-certified EHR technology or for Meaningful Use of EHR technology in the first year of their participation in the program and for demonstrating Meaningful Use in the second and subsequent years.

This MIP Blueprint describes the high-level process flows and requirements of MIP to interface with the National Level Repository (NLR)to enable Providers to register for MIP and attest to their eligibility. The NLR is the federal database that stores Medicaid and Medicare EHR Incentive Program data. This database supports the Medicaid and Medicare EHR Incentive Program Registration and Attestation System (MEIPRAS), which is the application used to collect and validate the data stored in the NLR.

The MIP Blueprint also describes the administrative processes required to support payment tracking, reporting, Provider appeals, and audits. This MIP Blueprint has liberally borrowed from efforts in other states and documentation from CMS.

5.1.2 Purpose

The purpose of MIP is to capture and track Provider enrollment at the state level, evaluate eligibility, and collect attestations in order to make timely incentive payments to qualifying Providers for the AIU and Meaningful Use of ONC-certified EHR systems. The goal of the MIP is to ensure the right payment is made to the right Provider at the right time.

In Nebraska, the MIP will be realized through a combination of new and existing business processes and systems capabilities which will be referred to as the SLR.

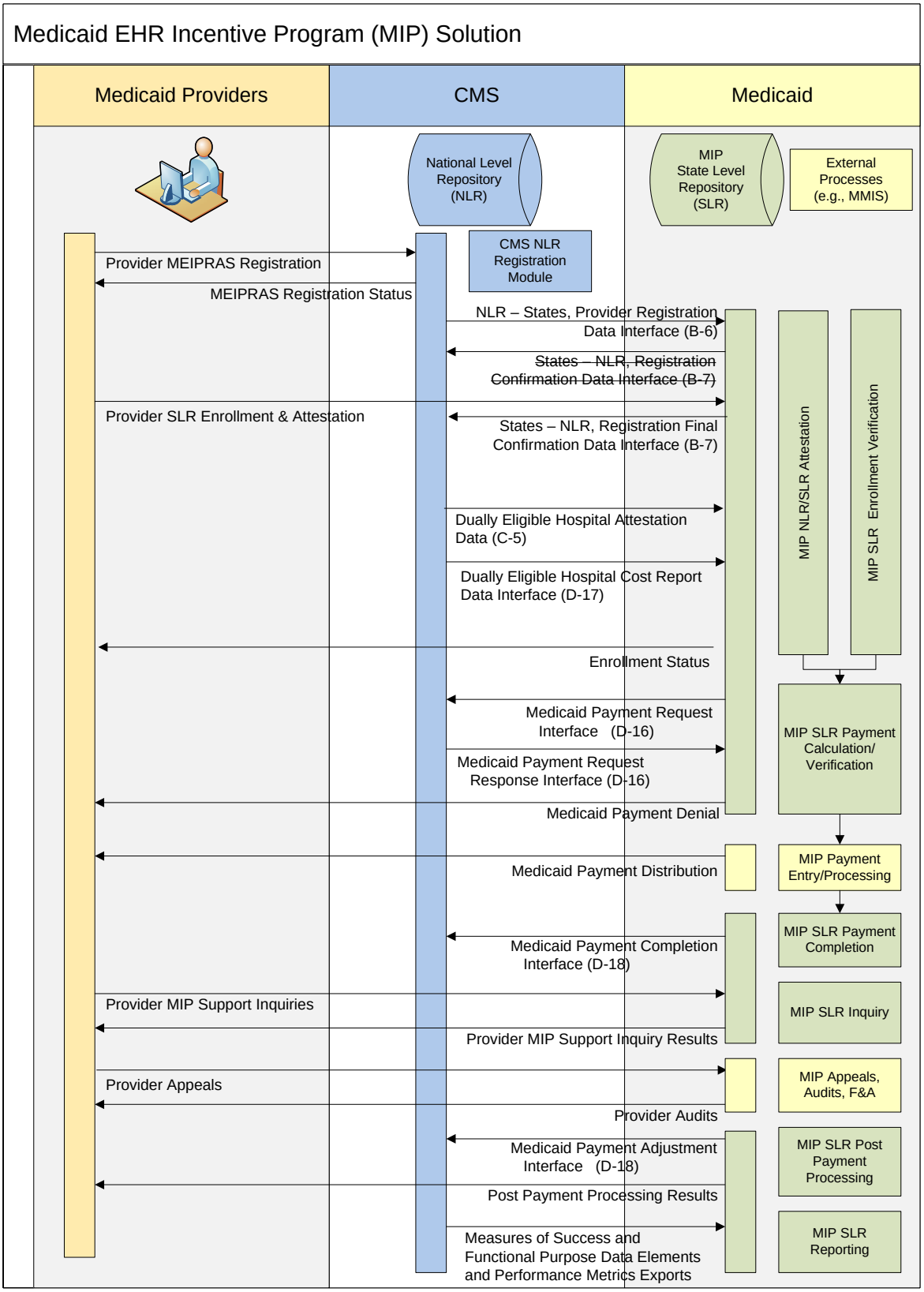
The SLR will interface with the NLR, as well as store and document information regarding the following:

- Current and historical registration information;
- Current and historical eligibility information;
- Current and historical attestation information;
- Current and historical payment information;
- Appeals; and
- Audits.

Inquiry and reporting will be supported on data collected in the SLR, and activity within the SLR will be logged for monitoring, tracking, and audit purposes.

Figure 5 below depicts the high level overview of the necessary components of the MIP. Objects highlighted green represent new business processes the State will develop and support to implement the MIP. Objects highlighted yellow represent business processes the State will modify and/or enhance to implement the MIP. Appendix M attached hereto contains a list of processes and time estimates associated with each.

Figure 5: MIP Solution



5.2 Provider Eligibility Verification

5.2.1 CMS MEIPRAS Registration Module

CMS has ownership of all processes concerning registration at the national level. A brief description is provided here. More detailed information can be found in CMS' document entitled "HITECH Interface Control Document." The most important aspect of the registration process for state Medicaid programs concerns the interface transaction sent from the NLR to the SLR once the Provider has registered with CMS. More detail on this interface is contained herein in Section 5.2.2.1 – Process NLR – States, Provider Registration Data Interface (B-6).

All Providers applying for incentives, whether Medicare or Medicaid, must first register through the MEIPRAS, which stores data in the NLR. The MEIPRAS will capture basic information such as Provider Type and whether the Provider is applying for Medicare, Medicaid, or both (allowed for certain hospitals). If the Provider chooses Medicaid or both Medicaid and Medicare, the Provider must identify the state selected for application. The MEIPRAS will check for valid NPI, CMS Certification Number (CCN), and TIN (if on record), and for any federal level sanctions. Providers opting for Medicaid who are not included in the SSA Death Master File will be passed through to the Medicaid state the Provider selected. If registration checks complete successfully, the new Provider information will be written to the NLR and sent in the NLR – States, Provider Registration Data (B-6) to the State for validation.

MEIPRAS registration status is communicated back to the Provider.

5.2.2 MIP SLR Enrollment Verification

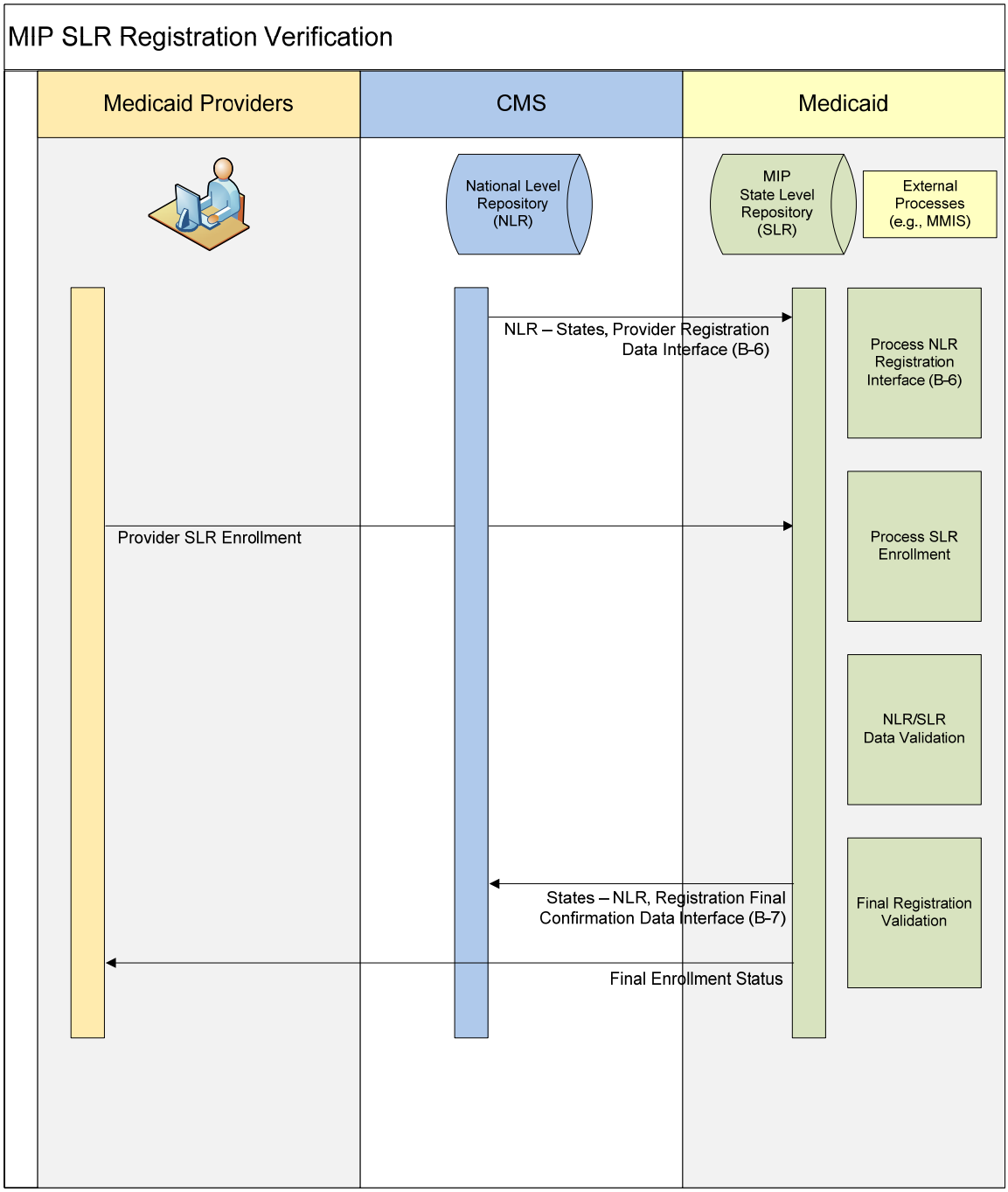
The MIP process supports Provider enrollment with the State to allow for processing of eligibility determination. The Provider submits enrollment information that is compared to data obtained via the NLR interface and supplies additional information the State may require to determine eligibility. Areas of focus within the SLR for Nebraska enrollment and eligibility verification include:

- Medicaid enrollment, where available;
- Provider type;
- For professionals, any hospital, FQHC or RHC affiliation;
- Provider sanctions and/or exclusions;
- Provider licensing; and
- Provider Medicaid/Needy Individual patient encounter volume.

An Interface (B-7) notifying CMS of the Provider's final eligibility status with Nebraska is sent when eligibility has been determined. Status of eligibility is also communicated back to the Provider.

Figure 6 below depicts the overview of the necessary components of the enrollment verification. The processes themselves are described in more detail following the diagram.

Figure 6: MIP SLR Registration Verification

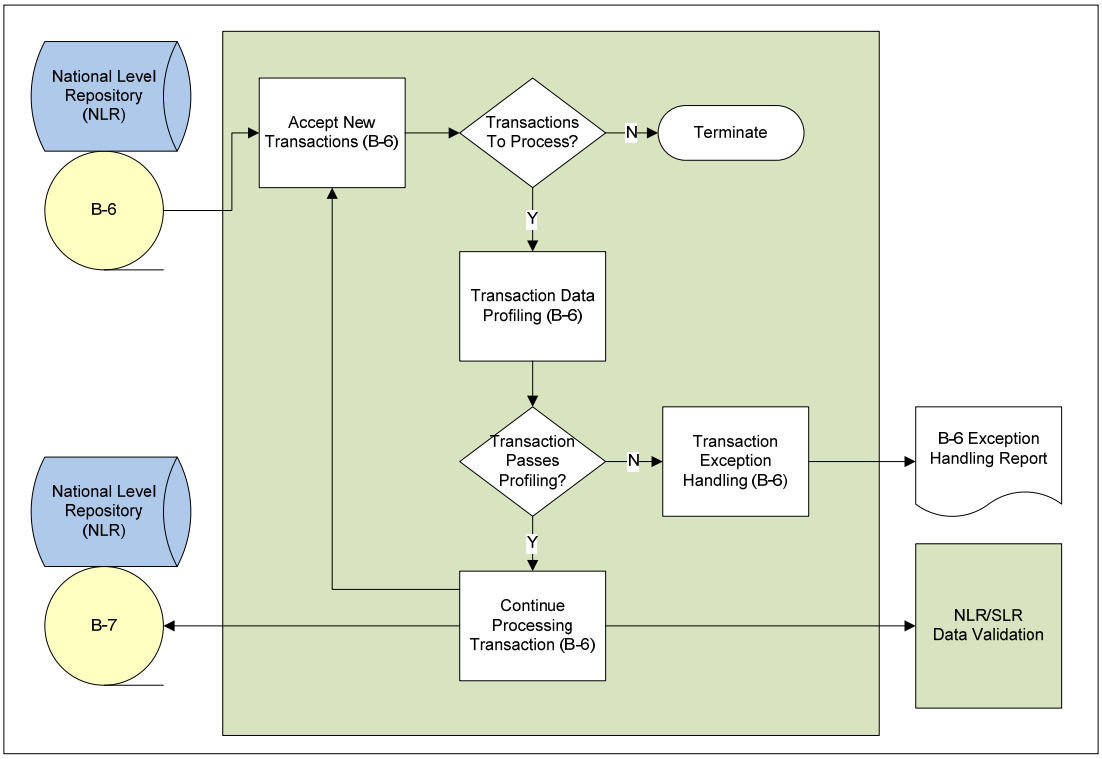


5.2.2.1 Process NLR – States, Provider Registration Data Interface (B-6)

The purpose of the B-6 Interface is to inform Nebraska of new, updated, and inactivated Medicaid registrations. The NLR will send the State batch feeds of new Providers that signed up for MIP payments

and selected or switched to Medicaid. Also included in the data are any updates and changes to the Provider entries and any registration inactivation events. A detailed description of this interface can be found in CMS' document entitled "HITECH Interface Control Document."

Figure 7: Process NLR – States, Provider Registration Data (B-6)



The NLR Registration Interface process will perform the following actions:

- Accept transactions from the NLR;
- Perform Data Profiling, based on CMS Interface requirements
- Perform Exception Handling on B-6 transactions not passing Data Profiling quality controls;
- ~~For accepted data, create the States – NLR, Registration Confirmation Data Interface (B-7) with an initial Eligibility Status;~~ and
- Allow processing to continue for accepted data.

Processes to manage transactions that do not pass Exception Handling are not described because the HITECH Interface Control Document states that CMS does not expect any exceptions from the B-6 interface. Nebraska will create a report of B-6 transactions that cannot be parsed and work directly with CMS to resolve issues.

If the transaction passes Data Profiling processing, the process named "NLR/SLR Data Validation" (described later in this section) is executed.

5.2.2.2 Process SLR Enrollment

The SLR enrollment process will accept enrollment requests from eligible providers as specified by the final rule. In Nebraska, this includes Providers enrolled in the Medicaid program and some Providers not required to enroll in Medicaid through a state policy exception. The enrollment process will ensure that registration has occurred with the MEIPRAS and obtain any necessary information to initiate eligibility determination. In addition, the provider will have the opportunity to perform attestation at this time.

A fillable PDF registration document is published on ~~to~~ the MLTC web site that providers may download and complete. This enrollment document will be accepted by:

- Fax
- Mail
- Email

All accompanying documentation is requested at time of registration.

Documentation needed for a provider

- Patient volume report with accompanying methodology
- Supporting AIU documentation
- A completed ACH/EFT application and W-9 for direct deposit information, if one is not already on file

Documents received will be entered into the State Level Repository, a data storage facility that will store data, maintain a historical record of changes, and track application status. All Provider-specific information required to validate eligibility and attestation details is collected. The data listed below is described in more detail in the process named "Final Enrollment Validation."

- NPI
- Data required to ensure current licensing
- Data required to check against Death Records
- Data required to ensure exclusion from sanctions
- Provider Type
- Patient Volume
- EP-specific enrollment data

The SLR enrollment process will perform the following functions

- Accept SLR Enrollment data;
- Store validation checks ;

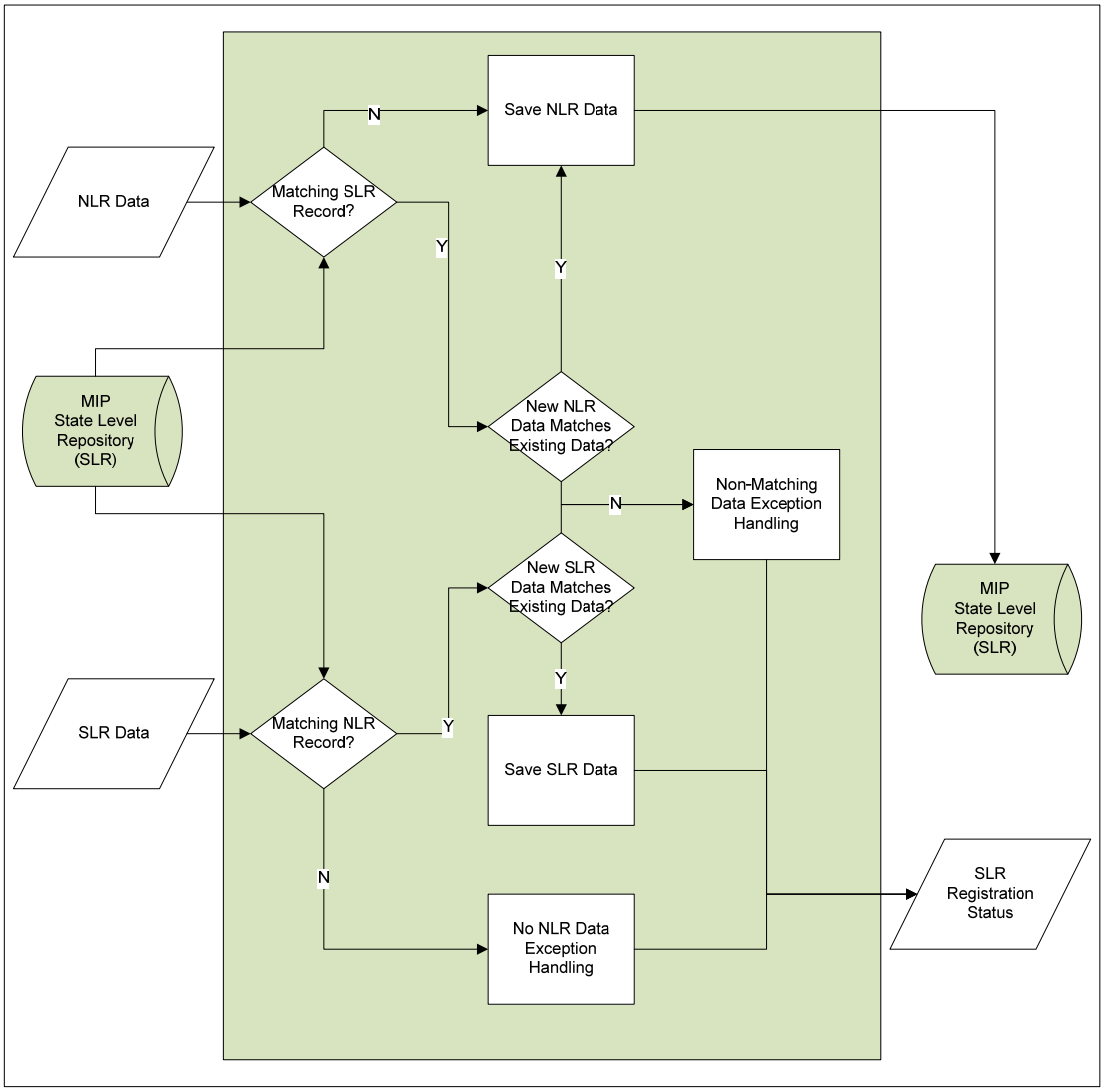
The State has the option to request data elements from a Medicaid Provider, in addition to those required by the NLR B-6 Interface. Nebraska will require the Provider to include its Nebraska Medicaid Provider Number when the Provider is a Nebraska Medicaid Provider.

5.2.3 NLR/SLR Data Validation

The NLR/SLR data validation processes support the requirements that Provider data in the B-6 Interface be verified. Process execution logic depends on different scenarios described after the diagram.

Figure 8 below depicts the overview of the necessary components of NLR/SLR data validation. The processes themselves are described in more detail following the diagram.

Figure 8: NLR/SLR Data Validation



The MIP will prohibit Providers from enrolling with the SLR before the B-6 Interface is processed by the State.

- <u>NPI from a B-6 Interface being processed does not match a SLR Provider Enrollment</u>: The B-6 Interface data is stored in the SLR awaiting SLR Provider Enrollment using the same NPI. The provider is informed via an e-mail so the NPI can either be corrected at the NLR or a new enrollment form completed to correct at the SLR. If registration has not yet occurred at the NLR, an e-mail is sent to the provider with a link to the CMS registration site.
- <u>NPI from a B-6 Interface being processed does match a SLR Provider Enrollment</u>: In this case the Provider may have made a change to existing NLR registration data. The data from the B-6 Interface is matched against the data input by the Provider during SLR Provider Enrollment. If all data matches the process named "Final Enrollment

Validation" (described later in this section) is performed. If data does not match, the Provider is informed via an e-mail advising of the mis-matched information. The Provider must update the NLR or comlete a new Enrollment Form to make all data match.

- NPI from a SLR Enrollment being processed does not match a B-6 Interface: The Provider is not allowed to enroll with the SLR. The Provider is informed via an e-mail so the NPI can either be corrected at the NLR or a new enrollment form completed to correct at the SLR.
- NPI from a SLR Enrollment being processed does match a B-6 Interface: The processor views and confirms the NLR registration data received via the data B-6 Interface. If all data matches, the process named "Final Enrollment Validation" (described later in this section) is performed. If data does not match, the Provider is informed via an e-mail advising of the mis-matched information. The provider must update the NLR or re-submit their enrollment with the corrected NPI#. The Provider is not allowed to enroll with the SLR.

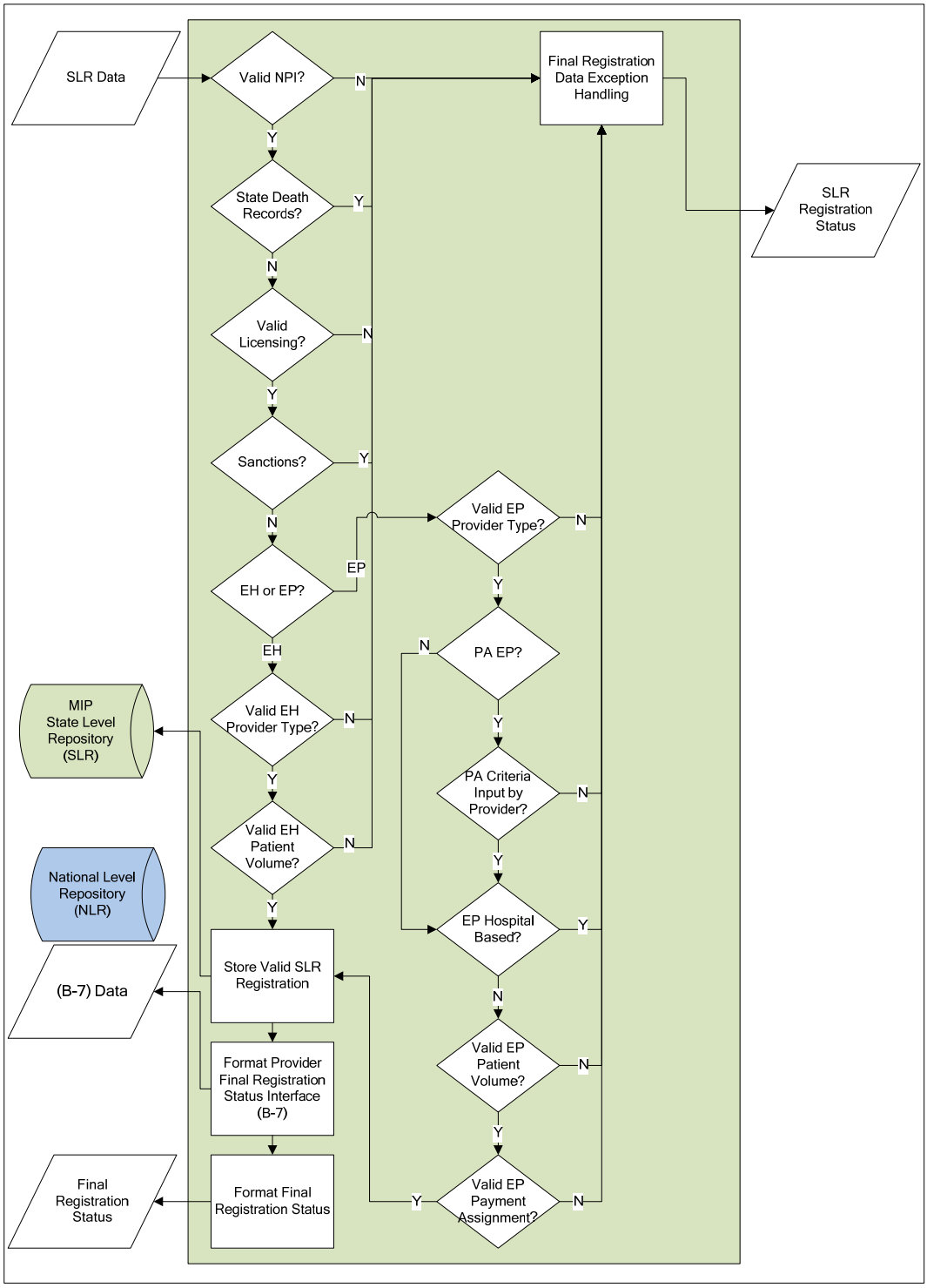
All new activity, NLR or SLR, is inserted with data elements identifying the chronology, via date/time stamps, of record insertion. Existing data are not updated. This is done to maintain a complete auditable history of data changes.

5.2.3.1 Final Enrollment Validation

The Provider will attest to the accuracy of the NLR and SLR data. The State will access electronically stored data from sources other than the data submitted to the SLR by the Provider to ensure data accuracy during the enrollment process.

Figure 9 below depicts the overview of the necessary components of the final enrollment validation. The processes themselves are described in more detail following the diagram.

Figure 9: Final Enrollment Validation



SLR Registration Validation includes the following:

- NPI is valid.

  EHR Program staff will validate the NPI using the MMIS and confirm against the Medicaid Provider ID where available. Validation will be done pre-payment.

- Nebraska will verify the Provider is not listed on a death registry.

  EHR Program staff will include pre-payment validation that a provider record does not appear on the Social Security Death Master File (SSDMF), the process consistent with enrollment of Medicaid FFS providers. MIP operations staff will ~~manually~~ check this file at the time of eligibility determination and prior to issuing payment to a provider.

  This process will depend on data elements that identify the Provider that may include:

  - Social Security Number
  - Name
  - Address
  - Date of Birth

- Providers have current licenses issued by the state in which they are located.

  For in-state Providers, EHR Program staff will ~~manually~~ perform a pre-payment validation of appropriate licensure based on data available on the License Information System.

  License validation for out-of-state Providers will also be performed pre-payment by contacting the appropriate department or accessing the licensure verification web site of the state in which the Provider practices.

  Data elements to capture:

  - Provider type
  - Licensing state
  - License number
  - Effective date range
  - Timestamp when data captured

- Provider is not sanctioned.

  Sanctioning validation will be completed ~~manually~~ by the EHR Program staff pre-payment. This effort will be completed at the time of eligibility determination and prior to issuing payment to a provider.

  For Providers located in Nebraska, the data source is a list maintained by Nebraska's Program Integrity. Both the SAM and the OIG websites are checked pre-payment. The D-16 Response file is also checked to determine if any Federal sanctions occurred directly before the payment is issued. Nebraska interprets "sanction" as meaning Provider enrollment is terminated.

- Provider Type is valid. (This is described in more detail and separated by EH and EP requirements below under "EH/EP Specific Requirements.")

The validation of the appropriate provider type is completed pre-payment.

The Provider Specialty used in the B-6 and B-7 Interfaces is based on the Provider Taxonomy codes used in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS). They are the standard X12 EDI (electronic data interchange) codes maintained by Washington Publishing Company and referenced at the URL http://www.wpc-edi.com/codes/taxonomy. The taxonomy code used from NPPES is used to validate pediatricians as pediatricians in Nebraska are licensed as MDs.

- Provider Patient Volume meets program requirements.

  For purposes of calculating patient volume, a Medicaid encounter means services rendered to an individual on any one day where the patient is enrolled in the Medicaid program (either through fee-for-service or managed care) at the time of service without the requirement of Medicaid payment liability. This change is due to the Federal rule change. Nebraska will implement this change effective 1/1/2013.

For the purpose of this program, Medicaid is defined as any program administered by the State authorized under Title XIX of the Social Security Act. This includes both fee-for-service and managed care. It does not include any other program such as CHIP or State-Only funded programs.

Beginning in 2013, the patient volume criteria is expanded. Nebraska has both a CHIP expansion as well as a stand-alone CHIP. The CHIP expansion will be included in the Medicaid encounters effective 1/1/2013 when determining the patient volume. The stand-alone CHIP (599 CHIP) as well as State-only funded and federal grant funded Medicaid will continue to be excluded from the Medicaid encounters. The requirement that Medicaid must have paid all or part of the individual's premiums, co-payments and cost sharing has also been removed. Beginning with Payment Year 2013, if a patient was enrolled in a Medicaid program (with the exception of stand-alone CHIP and State-only funded Medicaid) and had an encounter, it will be considered toward the Medicaid patient volume.

This is described in more detail and separated by EH and EP requirements below under "EH/EP Specific Requirements."

Nebraska will use Medicaid claims and managed care organization (MCO) encounter data to capture the volumes needed for pre-payment validation of the numerator of the patient volume calculation.

EH/EP Specific Requirements

EPs and EHs must meet different eligibility criteria for final validation.

For EHs, EHR Program staff will verify CCN numbers ~~manually~~ against data maintained in the MMIS provider file. Average length of stay, for applicable hospitals, will be calculated from the most recently filed Medicare Cost Report.

Medicaid EH criteria include the following:

Provider Type

- Acute Care Hospital:
  - The average length of patient stay is 25 days or fewer; and
  - CCN (previously known as the Medicare Provider number) has the last four digits in the series 0001 – 0879.
- CAH:
  - The average length of patient stay is 25 days or fewer; and
  - The CCN has the last four digits in the series 1300 – 1399.
- Children's Hospital:
  - The hospital is separately certified as a children's hospital - either freestanding or a hospital within hospital; and
  - The CCN has the last four digits in the series 3300 – 3399.

Patient Volume

The numerator of the Patient Volume will be validated pre-payment during registration.

Acute Care and CAHs must meet a 10 percent patient volume either over a 90-day period or 3 month period in the 12-month period prior to attestation to qualify for the program. Children's hospitals have no patient volume requirements.

As stand-alone CHIP beneficiaries as well as State-Only funded programs cannot be counted in the Medicaid volume, DHHS will assist Providers in identifying their allowable encounters. All Medicaid ~~and CHIP~~ beneficiaries utilize the same identification cards so there is no way for a Provider to distinguish the Medicaid funding source. DHHS recognizes the complications this creates for calculating patient volume. To assist EHs in the determination of program qualification, DHHS will furnish upon provider request, a history of Medicaid allowable and non-allowable encounters for inpatient discharges and emergency department visits (each shown separately) reported daily for the requested Fiscal year.

At the time of program enrollment, EHs will be asked to supply the following:

1. The date range selected for patient volume calculation (any continuous 90-day period or 3-month period in the 12 months prior to attestation).
2. The number of Medicaid encounters for the selected ~~90-day~~ period
3. The number of total encounters for the same period.
4. A system-generated report from the software system from which the calculation was made.
5. A description of the query criteria used to generate the report.
6. A description of the source from which the data is obtained. This source must be auditable and available for review upon request.

DHHS will review, verify, and reconcile submitted patient volume submissions by providers with data drawn from the Medicaid Management Information System (MMIS) at the time of enrollment/attestation submission. The methodology used to develop reported numbers will be reviewed for soundness and staff will verify that the volume percentage calculation meets appropriate qualifying threshold. The patient volume numerators from the report submitted will also be compared to those generated from the MMIS/encounter system extract. Those submissions exceeding a 10% variance from MMIS/encounter system extract will be reviewed more thoroughly to identify reason. EHR Incentive staff will contact and resolve volume issues with providers as necessary.

The same period must be used in both the numerator and denominator of the equation.

- (Total Medicaid patient encounters / total patient encounters) x 100 = n%.

Medicaid EP criteria include the following:

Provider Type and Provider Specialty

Provider Type is defined by CMS and is specific to the B-6 Interface. Provider Specialty will be validated using standard X12 EDI Provider Taxonomy Codes for pediatricians. EHR program staff will confirm provider type and specialty information ~~manually~~ against data in the MMIS provider file. For providers not enrolled with Fee-For-Service Medicaid, verification of additional documentation (such as Specialty Board Certification or Training Documentation) may be required.

- The Provider is one of the following:
  - A physician;
  - A dentist;
  - A certified nurse-midwife;
  - A nurse practitioner; or
  - A physician assistant practicing in a FQHC or a RHC, which is so led by a physician assistant.

Pediatrician Criteria

Nebraska has no statutory requirements defining practice as a pediatrician. For the purpose of this program, DHHS defines a pediatrician as a physician whose reported provider type is either Physician, MD or Physician DO; specialty is identified as Pediatrics; and the taxonomy code associated with his/her NPI is one identified as a Pediatrics classification in the Health Care Provider Taxonomy Code set.

Physician Assistant Criteria

Physician Assistant Criteria requirements will be validated pre-payment.

- Physician Assistants (PA) eligible to participate in the EHR Incentive Program must practice in an FQHC or RHC that is so led by a physician assistant. The EHR Incentive Program defines a facility is ‘so led’ when any one of the following three criteria is met:
  - When a PA is the primary provider in a clinic

- When a PA is a clinical or medical director at a clinical site of practice; or
- When a PA is an owner of an RHC

- The EHR Program staff will check the following sources to verify eligibility upon receipt of registration:
  - Primary Provider – DHHS will review the most recent Human Resources Services Administration (HRSA) - Data Warehouse Report Tool (http://datawarehouse.hrsa.gov/HGDWReports/RT_App.aspx?rpt=P8).

    If the number of FTE listed for Physicians and Nurse Practitioners is each less than one (<1) and the listed FTE for Physician Assistant FTE exceeds each that of Physicians and Nurse Practitioners, PAs in this facility would be deemed as to have met so-led criteria. Other documentation to substantiate this can be accepted also.

PA as a Medical Director – DHHS will review the most recent CMS-29, "Request to Establish Eligibility to Participate in the Health Insurance for the Aged and Disabled Program to Provide Rural Health Clinic Services", on file with the department to validate Medical Direction. If a PA is listed under the field II. Medical Direction, PAs in this facility would be deemed as to have met so-led criteria

- PA ownership – DHHS will review the most recently filed MLTC-62, "Nebraska Ownership/Controlling Interest and Conviction Disclosure". If a PA is listed under the section A. Ownership, PAs in this facility would be deemed as to have met so-led criteria.

In the event that a PA is identified as not being an eligible provider, the facility will be responsible for correction of source documentation from which the determination is made.

<u>Provider is Not Hospital Based</u>

- Not Hospital Based - A Provider who furnishes less than 90 percent of his or her covered professional services in the calendar year preceding the payment year in a hospital setting. A setting is considered a hospital setting if it is identified by the codes used in the HIPAA standard transactions that identifies the site of service as an inpatient hospital (code "21 or emergency room (code "23"). This will be verified by EHR Program staff running a pre-payment query against Medicaid Fee-for-Service claims and Medicaid Managed Care encounter data. As it is expected that the distribution of where a patient is seen is relative regardless of payer, this will be based on Medicaid data. Note: A physician is considered not hospital based if they have a certified EHR system which is separate from the one the hospital uses even if they had 90% or more encounters in a hospital or emergency room setting.

  Data elements to capture for each EP:

  - Place of Service
  - Encounter/Service volume

<u>Patient Volume</u>

Professionals have the option to report patient volume individually or by clinic or group practice where they render medical services. However, to employ group proxy volume reporting, EPs must adhere to the following requirements:

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP. For instance, use of this methodology would be inappropriate if an EP does not accept Medicaid clients.
- There is an auditable data source to support the clinic's or group practice's patient volume determination.
- All EPs in the group practice or clinic must use the same methodology for the payment year.
- The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way.
- If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice.

EHR Program staff will verify that those EPs reporting patient volume by group proxy have done so properly. This will entail ensuring that:

- All EPs within a practice, if reporting volume by group proxy, have reported using group proxy
- All EPs within a practice, if reporting volume by group proxy, have reported the same volume

Verification will be performed using data from the MMIS Provider file to identify all EPs associated with a group. When the body of EPs is identified, these will be reviewed against the SLR to confirm that both the group volume and reported volume figures are consistent.

Patient Volume Calculation Methodology

Medicaid patient volume calculations are based on encounters for which Medicaid paid any part. For purposes of this calculation beginning in 2013, a Medicaid encounter means services rendered to an individual on any one day where the patient was enrolled in the state's Medicaid program (either through fee-for service or managed care) at the time of the service without the requirement of Medicaid payment liability. Medicaid volume calculations are not to include the stand-alone CHIP program (599 CHIP) or State-only funded programs for 2013.

To offer flexibility and support for both the Medicaid fee-for-service and managed care model, DHHS has opted to make available both EP patient volume calculations listed in the Final Rule: Patient Encounter and Patient Panel. MIP will also allow patient volume to be aggregated from multiple locations for EPs reporting individually. In these instances, information from each location will be captured. MIP will require the Provider to attest to the fact that the same 90-day or three-month period is used in both the numerator and denominator of the equation.

- The first option is that EPs must have a minimum of 30 percent of all patient encounters attributable to Medicaid during a consecutive 90-day or three month period in the 12 months preceding attestation, with the exception of pediatricians who must only reach a 20 percent patient volume.

(Total Medicaid Individual Encounters / Total Encounters) x 100 = n%.

- The second option is that EPs must have a minimum of 30 percent of the total Medicaid patients assigned to the EP's panel in a continuous 90-day or three-month period, with at least one encounter taking place during 24-month period preceding the start of the 90-day period, plus unduplicated Medicaid encounters in the same 90-day period. Pediatricians must only reach a 20 percent patient volume. DHHS believes only MCO and Medical Home EPs will qualify for Option 2 in Nebraska.

  ((Medicaid Panel + Unduplicated Non-panel Medicaid encounters) / (Total Panel + Non-panel Total encounters)) x 100 = n%.

  The numerator of the patient volume calculation will be manually validated, based on data from the MMIS system and MCO Encounter data, during eligibility determination.

Practicing Predominantly

An EP for whom the clinical location for over 50 percent of his or her total patient encounters over a period of six months in the most recent calendar year occurs at a FQHC or RHC may be identified as practicing predominantly. As it is expected that the distribution of where a patient is seen is relative regardless of payer, EHR Program staff will verify this using information only on Medicaid data from the MMIS and MCO encounters.

Needy Individuals

EPs that perform over fifty percent (>50%) of patient encounters in a FQHC or RHC over a six month period in the most recent calendar year are deemed to 'practice predominantly' in such a location. EPs that 'practice predominantly' may utilize Needy Individuals to calculate patient volume.

Needy Individuals include Medicaid Fee-For-Service patients, patients enrolled in Medicaid managed care, patients for whom services were furnished at no cost, and services paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay. EPs using needy individual volumes to qualify for the EHR Incentive program must meet a 30% volume threshold. Needy Individuals can only be included when an EP wishes to qualify as practicing predominantly in an FQHC or RHC.

Note: EPs qualifying for inclusion of Needy Individuals would simply substitute Needy Individual volume in either the patient encounter or patient panel formula where "Medicaid" is indicated. These formulas are shown in the section "Patient Volume Calculation Methodology"

Patient Volume Process

As stand-alone CHIP and state-only beneficiaries cannot be counted in the Medicaid volume, DHHS will assist Providers in identifying their Medicaid allowable encounters All Medicaid ~~and CHIP~~ beneficiaries utilize the same identification cards, so there is no way for a Provider to distinguish the Medicaid funding source for a beneficiary. DHHS recognizes the complications this creates for calculating patient volume. To assist EPs in the determination of program qualification, DHHS will furnish upon provider request, a history of Title XIX and other patient volume (each shown separately) reported daily for the requested calendar year. Due to timely

filing requirements and the selected period, DHHS recognizes that variations may exist in the volume supplied at time of inquiry (if a report is requested) and the volume determined at the time of eligibility determination. Medicaid suggests that these reports be used solely as a guideline for understanding the patient volume calculation.

At the time of enrollment, providers will be asked to supply the following:

~~1.~~ The date range selected for patient volume calculation

2. The number of Medicaid encounters (needy patient volume, if appropriate) for the selected ~~90 day~~ period in the previous calendar year.
3. The number of total encounters for the same period.
4. The methodology used for performing calculations (i.e. encounter or panel)
5. The basis on which the calculation is performed (i.e. individual, individual at multiple locations, or group calculation).
6. A system-generated report from the software system from which the calculation was made.
7. A description of the source from which the data is obtained. This source must be auditable and available for review upon request.

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It is expected that most enrollees to the NE EHR Incentive Program will not have significant out of state provider volume..If the required patient volume percentage cannot be obtained from Nebraska Medicaid encounters, the provider will list the other States along with the percentage of Medicaid patient volume from each state. DHHS will request the other state validate the Medicaid encounter number.

EHR Program staff will review, verify, and reconcile patient volume submissions by providers with data drawn from the Medicaid Management Information System (MMIS) at the time of enrollment/attestation submission. The methodology used to develop reported numbers will be reviewed for soundness and staff will verify that the volume percentage calculation meets appropriate qualifying threshold. The patient volume numerators from the report submitted will also be compared to those generated from the MMIS/encounter system extract. Those submissions exceeding a 10% variance from MMIS/encounter system extract will be reviewed more thoroughly to identify reason (e.g. OBGYN). EHR Program staff will contact and resolve volume issues with providers as necessary. Upon completion of the review of enrollment and eligibility information, providers will be supplied with a summary of verified information.

EHR Incentive Payment Assignment

When registering for Medicaid Incentive payments, Providers may assign their incentive payments to their employer or other entity if the employer or other entity has a valid contractual arrangement allowing the entity to bill and receive payment for the Provider's professional services. Such assignment of payments must be entirely voluntary for the Provider. EHR Program staff will validate assignment relationship to ensure that those payments assigned to another entity have an appropriate contractual relationship. This will be identified ~~manually~~ using data from the MMIS provider file to ensure that a

service rendering/group billing relationship exists with the NPI to which a payment has been assigned.

DHHS does not plan to designate any "Entities for Promoting EHR Adoption." Therefore, the option for providers to assign incentive payments to such entities will not be available. However, DHHS may designate promoting entities in the future. If so, DHHS will obtain CMS approval before proceeding and the SMHP will be updated accordingly.

Data elements to capture:

- Provider TIN
- Provider NPI
- Payee TIN
- Payee NPI

If the Provider meets all enrollment and eligibility validation checks, the NLR interface (B-7) is formatted and sent to the NLR informing CMS that the Provider qualifies for MIP payments. The provider is informed of their eligibility via an e-mail from EHR Program staff as well as an automated e-mail from the NLR.

If the Provider does not meet all enrollment and eligibility validation checks, the NLR Interface (B-7) transaction is formatted and sent to the NLR, informing CMS of the reason the Provider does not qualify for ~~MIP~~incentive payments using standard reject reason codes defined by CMS. The Provider is informed that they are not eligible via a standard form letter which explains their rights regarding appeals. Every attempt is made to work with the provider prior to sending a notice of denial.

5.3 MIP NLR/SLR Attestation

Attestation details of the Provider's AIU or Meaningful Use of ONC-certified EHR technology will be captured at the time of SLR enrollment.

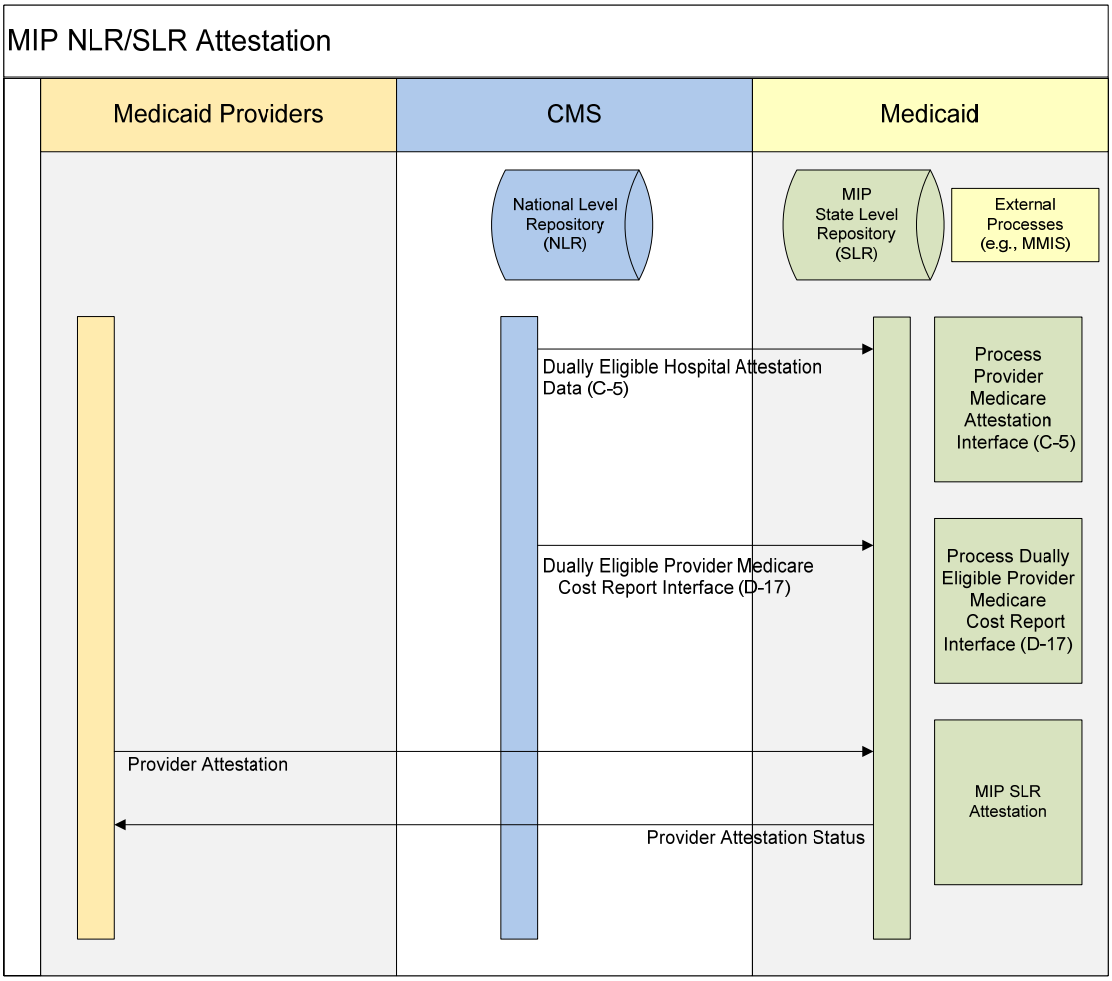
Once the Provider has completed and submitted the required final attestation data, Nebraska will verify (along with remaining attestation data described below) before issuing the NLR payment request. Nebraska will accept provider attestations up to 60 days beyond the end of the associated payment year.

The NLR is sending Medicare hospital attestation data to the State for EHs that are dually eligible via the Dually Eligible Hospital Attestation Data (C-5). The C-5 Interface Transaction attestation data will be evaluated, if available, to determine if the hospital has been approved for Medicare payment. If the hospital is eligible for Medicare payment, then the hospital will be deemed eligible for Medicaid payment, specific to the Meaningful Use criteria contained in the C-5 Interface Transaction.

The NLR will also send hospital Cost Report data to the State for EHs that are dually eligible via the Dually Eligible Hospital Cost Report Data Interface (D-17). The Medicare Cost Report may be useful as an aid to use in computing the Medicaid payments.

Figure 10 below depicts the overview of the necessary components of Attestation. The processes themselves are described in more detail following the diagram.

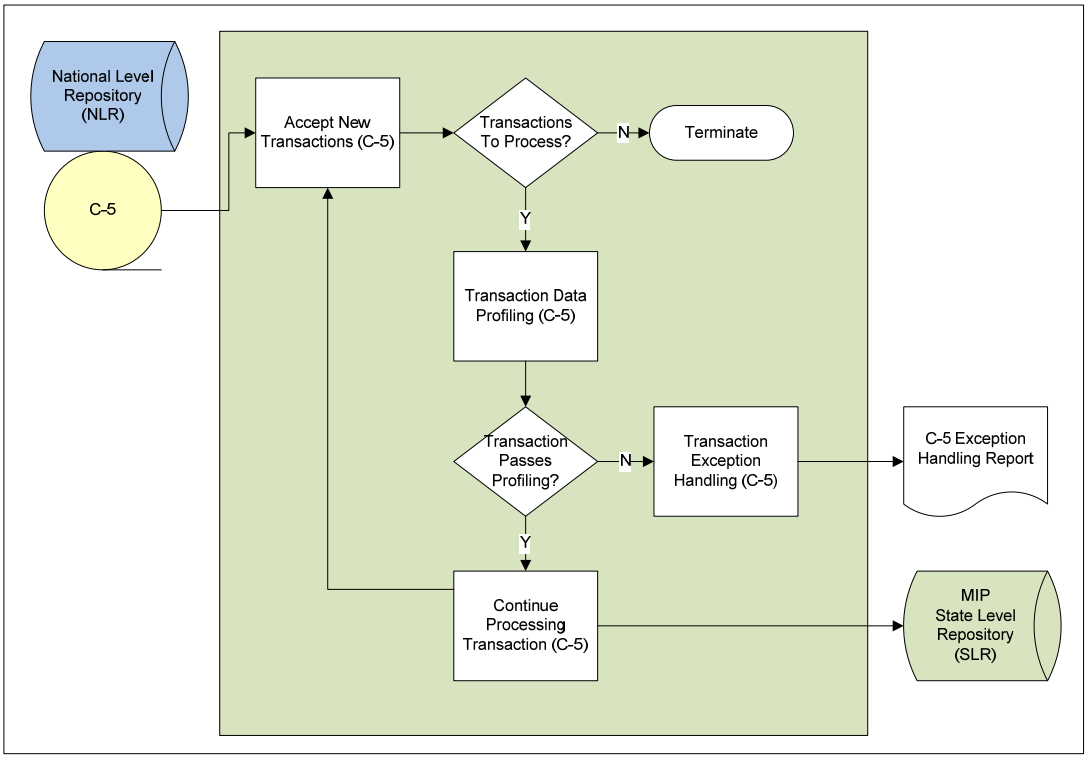
Figure 10: MIP NLR/SLR Attestation



5.3.1 Process Dually Eligible Hospital Attestation Data Interface (C-5)

The Process Provider Medicare Attestation Interface process will accept and parse the C-5 Interface from the NLR. The purpose of the C-5 Interface is to inform Nebraska of Medicare attestation data (Meaningful Use) for EHs that are dually eligible. If the hospital is eligible for Medicare payment, then the hospital will be deemed eligible for Medicaid payment, specific to the Meaningful Use criteria contained in the C-5 Interface Transaction. A detailed description of this interface can be found in CMS' document entitled "HITECH Interface Control Document."

Figure 11: Process Dually Eligible Hospital Attestation Data Interface (C-5)



The Process Provider Medicare Attestation Interface process will perform the following actions:

- Accept new transactions;
- Perform Data Profiling, based on CMS Interface requirements; and
- Perform Exception Handling on C-5 transactions not passing Data Profiling quality controls.

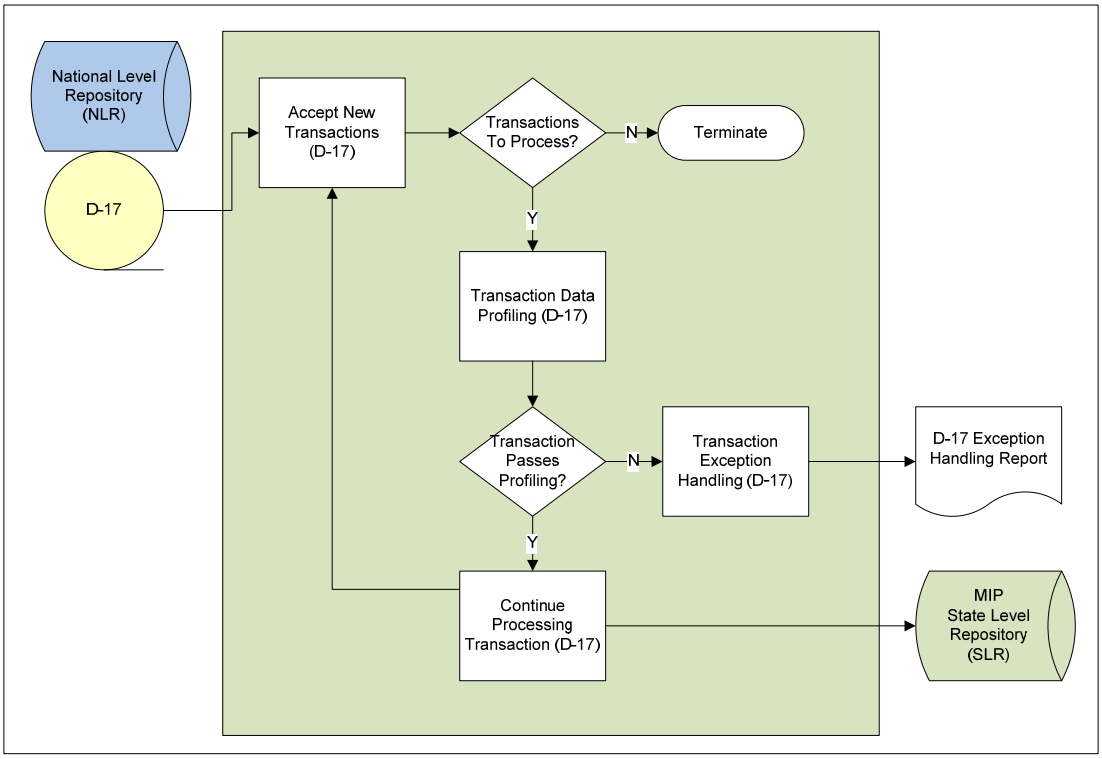
Processes to manage transactions that do not pass Exception Handling are not described because the HITECH Interface Control Document states that CMS does not expect any exceptions. Nebraska will create a report of C-5 transactions that cannot be parsed and work directly with CMS to resolve issues.

If the transaction passes Data Profiling processing, the data will be stored in the SLR.

5.3.2 Process Dually Eligible Hospital Cost Report Data Interface (D-17)

The Process Dually Eligible Hospital Cost Report Data Interface process will accept and parse the D-17 Interface from the NLR. The purpose of the D-17 Interface is to send hospital Cost Report data to State for dually EHs. The Medicare Cost Report may be useful as an aid to use in computing the Medicaid payments. A detailed description of this interface can be found in CMS' document entitled "HITECH Interface Control Document."

Figure 12: Process Dually Eligible Hospital Cost Report Data (D-17)



The Process Dually Eligible Hospital Cost Report Data Interface process will perform the following actions:

- Accept new transactions;
- Perform Data Profiling, based on CMS Interface requirements; and
- Perform Exception Handling on D-17 transactions not passing Data Profiling quality controls.

Processes to manage transactions that do not pass Exception Handling are not described because the HITECH Interface Control Document states that CMS does not expect any exceptions. Nebraska will create a report of D-17 transactions that cannot be parsed and work directly with CMS to resolve issues.

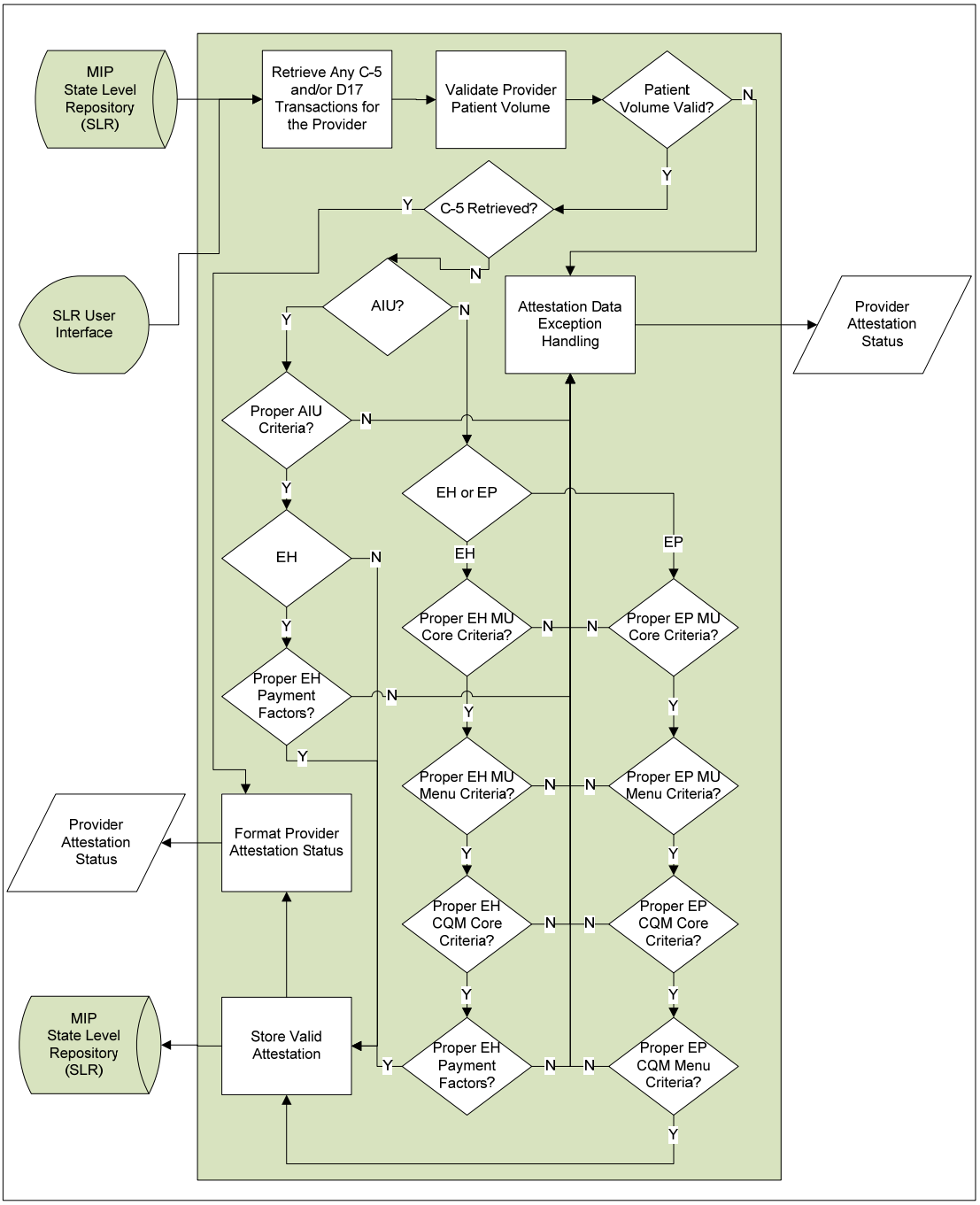
If the transaction passes Data Profiling processing, the data will be stored in the SLR.

5.3.3 ~~MIP~~ SLR Attestation

The Provider will attest to AIU and Meaningful Use of ONC-certified EHR technology. If the C-5 transaction was received from the NLR for a dually eligible hospital, the EH will not have to submit Meaningful Use information as part of the Nebraska Attestation process. Patient volume will still have to be validated as well as other eligibility factors. After the Provider completes and submits their attestation data, Nebraska will verify the information. This will be done before issuing the payment request to the NLR via the Medicaid Payment Request Interface (D-16).

Figure 13 below depicts the overview of the necessary components of Attestation. The processes themselves are described in more detail following the diagram.

Figure 13: MIP SLR Attestation



5.3.4 Dually EH Data Retrieval

Any existing Dually Eligible Hospital Attestation Data Interface (C-5) data and any Dually Eligible Hospital Cost Report Data Interface (D-17) data will be stored in the SLR.

5.3.5 Adoption, Implementation, or Upgrade

Along with the attestation information described above, the Provider also must attest, at a minimum, in the first year to the AIU of an ONC-certified EHR system. The Provider must supply the code from its EHR vendor to identify the EHR system.

The definition of AIU in 42 CFR 495.302 allows the Provider to demonstrate AIU through any of the following: (a) acquiring, purchasing or securing access to certified EHR technology; (b) installing or commencing utilization of certified EHR technology capable of meeting Meaningful Use requirements; or (c) expanding the available functionality of certified EHR technology.

The Provider supplies the following attestation information to qualify for AIU:

- Criteria:
  - An indication of whether the provider has Adopted, Implemented, or Upgraded;
  - Attachment of external documents supporting AIU of EHR Technology.

EHR Program staff will review documentation to assure compliance with promulgated requirements.

Acceptable verification of AIU of a certified EHR system will include the following information:

- Provider name and location of EHR
- Vendor name and contact information
- Certified system name, version, and ONC certification number
- CMS EHR Certification ID
- Date and term of provider contractual arrangements

Typically, appropriate documentation to verify AIU will be a copy of the signed contract between the provider and EHR vendor.

Attestation	**Example of acceptable source documentation**
Adopt	A signed purchase order or signed EHR vendor contract
Implement	Contract with REC or other entity with whom implementation exercises are planned, documented implementation work plan

	And EHR vendor contractual arrangement
Upgrade	Signed EHR vendor contract And Signed vendor letter

- Certified EHR Technology:

  The Provider must enter the EHR Certification Number from its EHR vendor to identify the EHR. EHR Program staff will validate AIU with the documentation supplied by the provider.

5.3.6 Meaningful Use

In the first year, all Medicaid Providers have to attest to AIU, rather than Meaningful Use. In the second and subsequent years, DHHS will verify Meaningful Use of a certified EHR technology through attestation. Each year thereafter, Providers will be required to confirm that all registration and eligibility information is correct.

For EPs, there are a total of 23 Meaningful Use objectives: 13 core objectives and 5 of 10 menu set objectives. A total of 23 of the objectives must be completed to qualify for an incentive payment: 13 required core objectives; and 5 objectives may be chosen from the list of 10 menu set objectives.

For EHs, there are a total of 19 Meaningful Use objectives: 14 core objectives and 5 of 10 menu set objectives. A total of 19 of the objectives must be completed to qualify for an incentive payment: 14 required core objectives; and 5 objectives may be chosen from the list of 10 menu set objectives.

Subject to 42 CFR Part 495.332, the State may propose a revised definition of Meaningful Use of certified EHR technology, subject to CMS prior approval, but only with respect to the following objectives:

1. Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.
2. Capability to submit electronic data to immunization registries or immunization information systems and actual submission in accordance with applicable law and practice.
3. Capability to provide electronic submission of reportable (as required by State or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice; and

4. Capability to provide electronic syndromic surveillance data to public health agencies and actual transmission in accordance with applicable law and practice.

To simplify processes and to encourage EHR adoption, Nebraska will not require any additional Meaningful Use measures.

Some Meaningful Use objectives are not applicable to every Provider's clinical practice, eliminating any eligible patients or actions for the measure denominator. In these cases, the EP will be excluded from having to meet that measure. Examples of exclusions include dentists that do not perform immunizations.

The Providers will attest to CQMs. EPs are required to attest to 3 core or alternate core plus 3 additional CQMs. EHs are required to attest to all 15 CQMs. This is described in more detail in Sections 5.3.6.3 – EP Clinical Quality Measures and 5.3.6.4 – EH Clinical Quality Measures.

5.3.6.1 Stage 1 Meaningful Use Core Criteria

All Meaningful Use core objectives must be met, unless an exclusion applies. Stage 2 Meaningful Use and 2014 Stage 1 changes will be included with a future SMHP update.

1. Core Objective: Use computerized physician order entry (CPOE) for medication orders directly entered by any licensed health care professional who can enter orders into the medical record per state, local, and professional guidelines.

   Measure: More than 30 percent of unique patients with at least one medication in their medication list seen by the EP or admitted to the EH's or CAH's inpatient or emergency department (place of service 21 *Inpatient hospital* or 23 *Emergency room – hospital*) have at least one medication order entered using CPOE. An option is added to this beginning 2013. For the denominator, providers can either use unique patients with at least one medication in their medication list or the number of orders during the EHR reporting period.

2. Core Objective: Implement drug/drug and drug/allergy interaction checks.

   Measure: The EP/EH/CAH has enabled this functionality and has access to at least one internal or external formulary for the entire EHR reporting period.

3. Core Objective: Maintain an up-to-date problem list of current and active diagnoses.

   Measure: More than 80 percent of all unique patients seen by the EP or admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that no problems are known for the patient) recorded as structured data.

4. Core Objective: Maintain active medication list.

   Measure: More than 80 percent of all unique patients seen by the EP or admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data.

5. Core Objective: Maintain active medication allergy list.

   Measure: More than 80 percent of all unique patients seen by the EP or admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry

(or an indication that the patient has no known medication allergies) recorded as structured data.

6. Core Objective: Record and chart changes in vital signs, including: height, weight, blood pressure, calculation and display of body mass index (BMI), and plot and display growth charts for children 2-10 years (including BMI).

   Measure: For more than 50 percent of all unique patients age two and over seen by the EP or admitted to EH's or CAH's inpatient or emergency department (POS 21 or 23), height, weight, and blood pressure are recorded as structured data. These optional changes are added for 2013: Age limit changed from age 2 to age 3 for blood pressure. No age limit on height/weight. Providers can either exclude all three elements if not in the scope of practice or can exclude blood pressure sseparately and report on height/weight.

7. Core Objective: Record smoking status for patients 13 years-old or older.

   Measure: More than 50 percent of all unique patients 13 years-old or older seen by the EP or admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded.

8. Core Objective: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies) upon request.

   Measure: More than 50 percent of all patients of the EP or the inpatient or emergency departments of the EH or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within three business days.

9. Core Objective: Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.

   Measure: Conduct or review a security risk analysis, as required under the HIPAA Security Rule, and implement security updates as necessary and correct identified security deficiencies as part of its risk management process. There are no exceptions to this requirement.

10. Core Objective — EP only: Generate and transmit permissible prescriptions electronically (eRx).

    Measure: More than 40 percent of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology.

11. Core Objective — EP only: Record demographics, including: preferred language, gender, race, ethnicity, and date of birth.

    Measure: More than 50 percent of all unique patients seen by the EP have demographics recorded as structured data.

12. Core Objective — EP only: Implement one clinical decision support rule relevant to specialty or high clinical priority, along with the ability to track compliance that rule.

    Measure: There are no allowable exclusions for this objective.

13. Core Objective — EP only: Provide clinical summaries for patients for each office visit.

Measure: Clinical summaries provided to patients for more than 50 percent of all office visits within three business days.

14. Core Objective — Hospital/CAH only: Record demographics, including: preferred language, gender, race, ethnicity, date of birth, and date and preliminary cause of death in the event of mortality in the EH or CAH.

    Measure: More than 50 percent of all unique patients admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data.

15. Core Objective — Hospital/CAH only: Implement one clinical decision support rule related to a high priority hospital condition, along with the ability to track compliance with that rule.

    Measure: There are no exclusions for this objective and its associated measure.

16. Core Objective — Hospital/CAH only: Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.

    Measure: More than 50 percent of all patients who are discharged from an EH or CAH's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.

17. Core Objective — Hospital/CAH only: Report hospital CQMs to CMS or states.

    Measure: For 2011 through 2013, provide aggregate numerator, denominator, and exclusions through attestation. For 2014 2012, electronically submit CQMs.

18. Core Objective — Hospital/CAH only: Provide patients with an electronic copy of their discharge instructions at time of discharge, upon request.

    Measure: More than 50 percent of all patients who are discharged from an EH or CAH's inpatient department or emergency department (POS 21 or 23) and who request an electronic copy of their discharge instructions are provided it.

5.3.6.1 Stage 1 Meaningful Use Menu Set Criteria

Five of ten menu objectives must be met, unless exceptions apply. One of the five objectives chosen must be a population health-related objective, which are the first three objectives listed below.

1. Menu Objective: Capability to submit electronic data to immunization registries or Immunization Information Systems and actual submission in accordance with applicable law and practice.

   Measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP, EH, or CAH submits such information have the capacity to receive the information electronically).

2. Menu Objective: Capability to submit electronic syndromic surveillance data to public health agencies and actual submission in accordance with applicable law and practice.

Measure: Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP, EH, or CAH submits such information have the capacity to receive the information electronically).

3. Menu Objective — Hospital/CAH only: Capability to submit electronic data on reportable (as required by state or local law) lab results to public health agencies and actual submission in accordance with applicable law and practice.

   Measure: Performed at least one test of certified EHR technology's capacity to provide electronic submission of reportable lab results to public health agencies, and follow-up submission if the test is successful (unless none of the public health agencies to which EH or CAH submits such information have the capacity to receive the information electronically).

4. Menu Objective: Implement drug formulary checks.

   Measure: The EP/EH/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period.

5. Menu Objective: Incorporate clinical lab-test results into certified EHR technology as structured data.

   Measure: More than 40 percent of all clinical lab tests results ordered by the EP or by an authorized Provider of the EH or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period, whose results are either in a positive/negative or numerical format, are incorporated in certified EHR technology as structured data. The percentage is based on labs ordered for patients whose records are maintained using certified EHR technology.

6. Menu Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.

   Measure: Generate at least one report listing patients of the EP, EH, or CAH with a specific condition. Specific conditions are those conditions listed in the active patient problem list.

7. Menu Objective: Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient, if appropriate.

   Measure: More than ten percent of all unique patients seen by the EP or admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources.

8. Menu Objective: The EP, EH, or CAH that receives a patient from another setting of care or Provider of care or believes an encounter is relevant should perform medication reconciliation.

   Measure: The EP, EH, or CAH that performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP or admitted to the EH's or CAH's inpatient or emergency department (POS 21 or 23).

9. Menu Objective: The EP, EH, or CAH that transitions its patient to another setting of care or Provider of care or refers their patient to another Provider of care should provide summary of care record for each transition of care or referral.

Measure: The EP, EH, or CAH that transitions or refers its patient to another setting of care or Provider of care, provides a summary of care record for more than 50 percent of transitions of care and referrals.

10. Menu Objective — EP only: Send reminders to patients per patient preference for preventive/follow up care.

    Measure: More than 20 percent of all unique patients 65 years or older or five years old or younger were sent an appropriate reminder during the EHR reporting period.

11. Menu Objective — EP only: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP.

    Measure: More than ten percent of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information.

12. Menu Objective — Hospital/CAH only: Record advance directives for patients 65 years old or older.

    Measure: More than 50 percent of all unique patients 65 years old or older admitted to the EH's or CAH's inpatient department (POS 21) have an indication of an advance directive status recorded.

5.3.6.2 EPs Clinical Quality Measures

EPs must report from the table of 44 CQMs that includes three Core, three Alternate Core, and 38 additional CQMs.

- Core CQMs: EPs must report on three required core CQMs
- Alternate Core CQMs: If the denominator of one or more of the required core measure is zero, then EPs are required to report results for up to three alternate core measures.
- Additional CQMs: EPs also must also select three additional CQMs from a set of 38 CQMs (excluding the core/alternate core measures). It is acceptable to have a '0' denominator provided the EP does not have an applicable population.

In sum, EPs must report on six total measures: three required core measures (substituting alternate core measures where necessary) and three additional measures. A maximum of nine measures would be reported if the EP needed to attest to the three required core, the three alternate cores, and the three additional measures. Reporting will require a numeric value for each numerator, denominator, and exclusion required by a given CQM, if applicable.

The EP Core CQMs (alternative core measures marked with *) are provided in Table 8 below:

Table 8: EP Clinical Quality Measures

NQF #	PQRI #	Developer	Description
0421	128	CMS/QIP [1]	Patients more than 18 years old whose BMI[2] was calculated within six months,

			and who have a documented follow-up plan if BMI falls outside parameters.
0013	n/a	AMA-PCPI[3]	Patients more than 18 years old who have a diagnosis of hypertension seen in at least two office visits, with blood pressure recorded.
0028	n/a	AMA-PCPI	Patients more than 18 years old who were seen at least twice and asked at least once about tobacco use in 24 months, and who received cessation intervention if they are users.
0038	n/a	NCQA[4]	*Two-year-old children who received DTaP[5], polio, MMR[6], flu, hepatitis B, chicken pox, PCV[7], hepatitis A and rotavirus vaccines by their second birthday.
0041	110	AMA-PCPI	*Patients more than 50 years old who received a flu vaccine (September to February).
0024	n/a	NCQA	*Patients from 2 to 17 years old who visited a primary care provider (PCP) or ob-gyn physician, had evidence of BMI percentile documentation, and received counseling for nutrition and physical activity.

EPs must choose three from the 38 among the clinical areas of: diabetes, heart conditions, women's health, cancer, asthma, or miscellaneous.

5.3.6.3 EH Clinical Quality Measures

EHs must report all 15 CQMs listed below.

Table 9: EH Clinical Quality Measures

NQF #	Developer	Description
495	CMS/OFMQ	Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department.
0497	CMS/OFMQ	Median time from admit decision time to time of departure from the emergency department of emergency department patients admitted to inpatient status.
0435	The Joint Commission	Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge.
0436	The Joint Commission	Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.
0437	The Joint Commission	Acute ischemic stroke patients who arrive at this hospital within two hours of time last known well and for whom IV t-PA was initiated at this hospital within three hours of time last known well.
0438	The Joint Commission	Ischemic stroke patients administered antithrombotic therapy by the end of hospital day two.
0439	The Joint Commission	Ischemic stroke patients with LDL ! 100 mg/dL, or LDL not measured, or, who were on a lipidlowering medication prior to hospital arrival are prescribed statin medication at

		hospital discharge.
0440	The Joint Commission	Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow-up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke.
0441	The Joint Commission	Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services.
0371	The Joint Commission	This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.
0372	The Joint Commission	This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer).
0373	The Joint Commission	This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they must be discharged on both medications. Overlap therapy must be administered for at least five days with an international normalized ratio (INR) ! 2 prior to discontinuation of the parenteral anticoagulation therapy or the patient must be discharged on both medications.
0374	The Joint Commission	This measure assesses the number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.
0375	The Joint Commission	This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, to home with home health, home hospice or discharged/transferred to court/law enforcement on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions/interactions.
0376	The Joint Commission	This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present on arrival) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.

~~The Provider is informed about attestation status via the Provider Attestation Status communication channel.~~

5.3.7 Proper EH Payment Factors

EHs need to supply several factors that go into the EH EHR Incentive Payment calculation. These are based on the hospital FY that ends during the federal FY prior to the hospital FY that serves as the first payment year. Hospitals which begin participation in FFY 2013 or later, will use the most recent

continuous 12 month period for which data are available prior to the payment year. EHs will be requested to supply information for payment calculations based on data submitted on Medicare **cost report**, Form CMS 2552-96 until the implementation of the new Medicare cost report, Form CMS 2552-10. Data from the following fields should be reported:

Table 10: EH Payment Calculation Data Sources

Total Acute Inpatient Discharges – Current year and 3 preceding fiscal years	Worksheet S-3, Part I, Column 15, Line 12
Medicaid Acute Inpatient Bed Days	Worksheet S-3, Part I, Column 5, Lines 1, 6-10
Medicaid Managed Care Acute Inpatient Bed Days	Worksheet S-3, Part I, Column 5, Line 2
Total Acute Inpatient Hospital Bed Days	Worksheet S-3, Part I, Column 6, Lines 1, 2, 6-10
Total Charity Charges (Total Hospital Uncompensated Charges (less Bad Debt).	Worksheet S-10, Line 30
Total Hospital Charges	Worksheet C, Part I, Column 8, Line 101

This data will be collected for all EHs and compared to that on file with DHHS. In the event that a data reported does not match that on file, EHR Program staff will work with EHs to reconcile any discrepancies. If any of this data are available from an NLR Dually Eligible Provider Medicare Cost Report Interface (D-17) transaction, DHHS will use that data as well.

5.4 MIP SLR Payment Calculation/Verification

The payment process involves a number of important activities:

- Verifying the Provider qualifies for a payment based on all the attestation information;
- Parsing the Dually Eligible Provider Medicare Cost Report Interface (D-17) that are used as part of the hospital payment calculation;
- Calculating the payment;
- Verifying with CMS, via the NLR, the Provider should not be denied payment; and

- Tracking the payment and verifying that the right payment was made to the right Provider at the right time.

5.4.1 Payment Calculation

Payments are calculated differently for EPs and EHs. There are also some cost report data elements passed to the State from the NLR via the Dually Eligible Provider Medicare Cost Report Interface (D-17) that are used as part of the hospital payment calculation.

5.4.1.1 EP Payment Calculation

Nebraska recognizes that, as of December 29, 2010, CMS revised the EP Payment Calculation methodology. CMS has decided to use a fixed amount each year for the 85 percent of the net average allowable cost considered for the EHR incentive payment and the 15 percent cost responsibility of the EP. EPs will no longer have to enter or attest to their cost data or money they receive from other funding sources related to EHR implementation and use. The State will no longer have to verify or audit the EP cost figures. The State will determine the fixed EP MIP payment, based on EP's year of participation, from Table 11 below.

Table 11: Medicaid EP Payment Table

Year	Medicaid EP Adoption Year					
	2011	2012	2013	2014	2015	2016
2011	$21,250					
2012	$8,500	$21,250				
2013	$8,500	$8,500	$21,250			
2014	$8,500	$8,500	$8,500	$21,250		
2015	$8,500	$8,500	$8,500	$8,500	$21,250	
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017		$8,500	$8,500	$8,500	$8,500	$8,500
2018			$8,500	$8,500	$8,500	$8,500
2019				$8,500	$8,500	$8,500
2020					$8,500	$8,500
2021						$8,500
Total	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Note: The total for pediatricians who meet the 20 percent patient volume but fall short of the 30 percent patient volume is $14,167 in the first year and $5,667 in subsequent years. This adds up to a maximum MIP payment of $42,500 over a six-year period.

5.4.1.2 EH Payment Calculation

DHHS will verify the hospital's calculation of their overall EHR amount. EHR Program staff will verify information submitted against filed cost reports, calculate EH payment amounts, and obtain agreement of amounts with the EH. Through HITECH Act Regulation 42 CFR: Part 495 Subpart D § 495.310 (g), the calculation of the hospital payment is defined as follows.

The overall EHR amount is the sum over four years of (a) the base amount of $2,000,000 plus (b) the discharge related amount defined as $200 for the 1,150 through the 23,000 discharge for the first payment. Transition factors are applied to years one through four in the following amounts; Year One - 1; Year Two - .75; Year Three - .5, and Year Four - .25.

For the first payment year, data on hospital discharges from the hospital FY that ends during the federal FY prior to the hospital FY that serves as the first payment year will be used as the basis for determining the discharge-related amount. To determine the discharge-related amount for the three subsequent payment years that are included in determining the overall EHR amount, the number of discharges will be based on the average annual growth rate for the hospital over the most recent three years of available data. Note: If a hospital's average annual rate of growth is negative over the three-year period, the rate should be applied as such.

Auditable data sources will be used to calculate the aggregate hospital payments. DHHS will request that EHs submit data from Medicare cost reports as specified in Section 5.3.7. In the event that data is unavailable from indicated source, as such may exist with Charity Care, DHHS will consider submissions from other auditable sources such as: 1) payment and utilization information from MMIS (or other automated claims processing systems or information retrieval systems); and 2) hospital financial statements and accounting records. Greater detail concerning EH calculations may be found in Appendix L.

The Medicaid Share, which is applied against the aggregate hospital MIP payment, is essentially the percentage of a hospital's inpatient non-charity care days that are attributable to Medicaid inpatients.

The numerator of the Medicaid Share is the sum of:

- The number of Medicaid acute inpatient-bed-days; and
- The number of Medicaid managed care acute inpatient-bed-days.

The denominator of the Medicaid Share is the product of:

- The total number of acute inpatient-bed-days for the EH during that period; and
- The total amount of the EH's charges during that period, not including any charges that are attributable to charity care divided by the estimated total amount of the hospital's charges during that period.

The estimated total charges and charity care charges amounts used in the formula must represent inpatient hospital services only and exclude any professional charges associated with the inpatient stay. *Note: The reduction of EH charges attributable to charity care in the formula, in effect, increases the Medicaid*

Share resulting in higher incentive payments for hospitals that provide a greater proportion of charity care.

States have options in setting a payment schedule, but no annual payment can exceed 50 percent of the total calculated hospital ~~MIP~~ payment and cannot exceed 90 percent of this total over two consecutive years. Therefore, the full amount of the total incentive payment cannot be made to a hospital in fewer than three payment years beginning in 2011, and the full amount could be spread out over a maximum of six payment years by the State.

A hospital cannot receive payments after 2016 unless the hospital received a payment for the previous year. Prior to 2016, ~~MIP~~ payments to EHs can be made on a non-consecutive annual basis.

Due to the high cost of hospital software and to encourage the early adoption of the EHR technology in hospitals, Nebraska will pay the overall EH ~~MIP~~ payment over the minimum three-year period and at the maximum allowable percentages in each year which the EH qualifies for payment: Year 1 = 50 percent, Year 2 = 40 percent, Year 3 = 10 percent.

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

1. Calculate the average annual growth rate over three years using the Medicare/Medicaid Cost Reports prior to the most current Cost Report.
2. Calculate the total discharges. Only discharges between and including 1,150 and 23,000 per CCN will be allowable discharges.
3. Calculate each of the next four year's total discharges by multiplying the previous year's discharges times the average computed growth rate.
4. Calculate the Aggregate EHR Amount for each year by multiplying (total eligible discharges times $200) plus the $2,000,000 base.
5. Apply the appropriate transition factor to each year's Aggregate EHR Amount. (Year 1 = 100 percent, Year 2 = 75 percent, Year 3 = 50 percent, Year 4 = 25 percent).
6. Calculate the total Overall EHR Amount by adding the total of each year with the transition factor applied.
7. Apply the Medicaid Share percentage to the Overall EHR Amount. (See Medicaid Share calculation below). <u>This is the hospital's Medicaid Aggregate EHR Incentive amount.</u>

Calculation of the Medicaid Share percentage:

1. Total Medicaid days includes both the total Medicaid Days and total Medicaid health maintenance organization (HMO) days. Nebraska will use the State MMIS system to determine Medicaid days. Medicaid HMO days will come from the Cost Report.
2. Calculate the non-charity percentage. Subtract uncompensated care from total hospital charges. Divide the result by the total hospital charges.
3. Calculate the non-charity days by multiplying the non-charity percentage times the total hospital days.

4. Calculate the Medicaid Share percentage by dividing the Medicaid days by the non-charity days.

For new hospitals which do not have the required four years of discharge information, Nebraska will require they attest after they have two full years of data for the initial payment. A new calculation will occur in the next two years after the initial payment with the subsequent year's Medicare cost report and payments will be adjusted.

5.4.1.3 Managed Care Payment Calculation

Nebraska will disburse payments directly to the providers or their requested assigned payee. Managed care entities will not be used to disburse incentive payments eliminating the need to calculate an impact to capitation rates.

5.4.2 CMS Verification

Before payment can be distributed, a final CMS check must be performed to validate that the Provider can receive payment. The validation is done via the Medicaid Payment Request Response Interface (D-16) to the NLR. The NLR will return a batch interface transaction via the Medicaid Payment Request Response Interface (D-16) authorizing the payment or denying it with a Denial Reason, such as a duplicate payment.

5.5 MIP Payment Entry/Processing

Upon confirmation of final determination of eligibility and attestation details and approval for payment, EHR Program staff will enter a payment request into Nebraska's existing Accounts Payable system, known as EnterpriseOne.

EnterpriseOne, as Nebraska's Accounts Payable system, handles all payments made by the State, including Medicaid claims. EnterpriseOne provides the MIP Program with the ability to process payment requests, track expenditures, and maintain and analyze provider payment information. It supports the program's need for accurate and timely payables that follow standardized procedures.

Payment process:

1. Create and disburse payments through EnterpriseOne;
2. Issue payment to Providers within 45 days of completing all eligibility verification checks;
3. Ensure duplicate payments are not made;
4. Business Units/Object Codes are used to distinguish incentive payments from any other payments made to the provider.
5. Payments are made without reduction or rebate and are paid directly to a Provider or to an employer, a facility, or an eligible third-party entity to which the Medicaid Provider has assigned payments;

6. Satisfy the CMS defined periodic reporting requirements specific to incentive payments
7. Send D-18 to CMS when payment has been disbursed

5.6 MIP SLR Payment Complete

As stated above, the Nebraska SLR will send a Medicaid Payment Completion Interface transaction (D-18) to the NLR when the payment is distributed to the Provider.

5.7 MIP SLR Inquiry

Existing inquiry processes will allow Providers to check the progress of their incentive payments with EHR Program Staff. The inquiry process may also be used by Providers to receive guidance regarding registration, AIU, and Meaningful Use. Providers may inquire by phone, ~~or~~ email or by reviewing information posted on the EHR website.

5.8 MIP Appeals, Audits, and Fraud and Abuse

Appeals, audits, and fraud and abuse administration and work will be supported by processes external to MIP and may take place at any point described above (Enrollment, Attestation, etc.). "Historical log" information will be stored that documents the initiation, progress, and results of each appeal, audit, and fraud and abuse case. This documentation will simplify reporting and assist in answering Provider questions.

DHHS developed the criteria for pre-payment, payment, and post-payment audits and the method for payment recovery. The MIP SLR Post Payment Process will be notified of any payment adjustments.

Nebraska will request CMS complete meaningful use audits for EHs. All other audits will be conducted by Nebraska Medicaid staff. See Audit Plan for further details regarding the audit.

5.8.1 Oversight

Oversight for the incentive program will be managed through the Medicaid IT Initiatives area that falls under the Operations section of MLTC. The level of oversight and monitoring includes the tracking and verification of the activities necessary for a Medicaid Provider to receive an incentive payment for each payment year as well as administration of Provider appeals. Financial oversight of Providers and DHHS EHR related activities are also included. As part of the oversight program, the Audit Plan provides the specifics of the pre-payment and post-payment verifications and audits. In addition to the Audit Plan, oversight activities include the collection and reporting of data on Provider AIU in the first year and Meaningful Use in subsequent years.

Eligibility oversight and verification ensures each Provider meets Provider enrollment criteria upon enrollment and re-enrollment. In addition, the verifications will assess patient volume, as well as the non-hospital based physician eligibility requirement.

The DHHS oversight program also addresses financial requirements of MIP. As the first line of financial oversight of Providers, DHHS plans pre-payment verifications that will be completed through the SLR and NLR.

DHHS will use existing budgeting personnel and processes to facilitate the efforts of forecasting and reporting for MIP. DHHS used several different estimating methodologies to estimate the number of EPs and EHs participating in MIP:

- CMS methodology as defined in the preamble to 42 CFR Part 495;
- Qualitative comparisons with other states;
- DHHS February 2011 Survey Data Results; and
- Analysis of MMIS data.

Based on a review and comparison of the estimating methodology results, DHHS plans to use an initial estimate of 600 EPs and the initial estimate of EHs is 50.

DHHS will use EnterpriseOne to make the incentive payments to Providers. Unique accounting codes will be used to distinguish MIP payments from any other payments going to a Provider.

DHHS plans to claim federal reimbursement in accordance with all applicable federal laws, regulations, and policy guidance. More specifically, DHHS has a process in place to ensure that its expenditures for administration of the MIP will not be claimed at amounts higher than 90 percent of the cost of such administration. DHHS will establish a separate reporting category to identify all direct costs related to MIP. DHHS will allocate indirect costs related to MIP by applying allocation methodologies that will be in the approved Cost Allocation Plan. Administrative costs will be reconciled at the end of each quarter to ensure no administrative expenditures are charged as both direct and indirect costs.

Administrative expenditures related to MIP erroneously claimed at an amount higher than 90 percent will be discovered during the preparation of the quarterly CMS-64 report and corrected.

DHHS also has a process in place to ensure that it does not claim amounts higher than 100 percent of the cost of such payments to Providers. This control process will be supported by reports based on data extracted from EnterpriseOne and the SLR solution.

DHHS uses SLR functions and the NLR, as well as the CMS systems of Research and Support User Interface and MicroStrategy reports, to assure that no duplicate MIP payments are paid by more than one state or between the Medicaid and Medicare programs. The SLR processes will also ensure that the incentive payments are made accurately, without reduction or rebate, and made directly to a Provider or to an eligible third-party entity to which the Provider has assigned payments.

DHHS uses a comprehensive attestation document that ensures the Provider meets MIP payment eligibility requirements. DHHS will audit the Provider attestations as identified ~~herein~~ in Section 5.3.3 – MIP SLR Attestation. Additionally, DHHS plans to include statements on the attestation that the Provider attests to having completed the forms correctly and is subject to an audit. DHHS plans to require the following:

- The Provider's signature
- A statement that the information is true, accurate, and complete;
- A statement that: "I understand that Medicaid EHR incentive payments submitted under this Provider number will be from federal funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws";
- The above statements to appear directly above the Provider's signature or, if they are printed on the reverse of the form, a reference to the statements will appear immediately preceding the Provider's signature;
- Provider attestation is resubmitted upon a change in the Provider's representative; and
- Provider attestation is updated as needed.

DHHS recognizes the need to repay to CMS all inappropriate payments received by Providers regardless of whether DHHS has received recoupment. Nebraska will take corrective action regarding any improper MIP payments, so a robust pre-payment process will be implemented for verification and audit to minimize the need for the manual recoupment process. Nebraska will follow its current recoupment process provided in Title 471 Chapter 3 Section 3-002.

DHHS works with its vendors and Wide River TEC, Nebraska's REC, to continue provider outreach and education plan. Providers are able to access the Medicaid Inquiry Line to address Provider questions regarding MIP. Additionally, the Communication Plan will take advantage of the existing Provider communication infrastructure and will incorporate the timeline and rollout of incentive payments. The Communication Plan is attached ~~hereto~~ as Appendix I.

The redetermination and appeal processes will proceed in accordance with Nebraska Rules and Regulations, Title 471 Chapter 2 section 2-003 Provider Hearings. This process is fully described in Section 5.8.2 – Administrative Redetermination and Appeal Plan. Prior to invoking the formal Administrative Redetermination and Appeal Plan, EHR Program staff will work with providers to correct errors. DHHS will work with Providers to resubmit registrations and attestations if appropriate. In the event the registration and attestation data is not able to be corrected, and the application is ultimately denied, the formal Administrative Redetermination and Appeal process as defined in Title 471 NAC Chapter 2 Section 2-003 will be invoked.

DHHS continues to evaluate methods for MIP payments and will continue to review and revise its oversight responsibilities as risks emerge. This approach allows for flexibility and amendment to the verifications and Audit Plan. DHHS will perform periodic MIP risk assessments and will make adjustments based on the results.

MIP payments from EnterpriseOne are completed daily. DHHS will make the payments to the Provider, the employer, or a facility assigned the payments without any reduction or rebate.

5.8.2 Administrative Redetermination and Appeal Plan

This section of the SMHP describes the DHHS appeals process regarding MIP appeal rights. This section specifies the valid reasons for appeal and the types of Providers that can apply. Through HITECH Act

Regulation 42 CFR: Part 495 Subpart D § 495.370, CMS defined the following process requirements for Medicaid Providers registering to receive MIP payments.

EHR Program staff will work closely with providers during eligibility determination and review of attestation documentation to resolve discrepancies prior to final eligibility determination. The Medicaid agency will provide an appeals or exception procedure that allows individual Providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as:

- Provider eligibility determinations;
- Demonstration of AIU and Meaningful Use eligibility for incentives;
- Incentive payments; and
- Incentive payment amounts.

The State's process will ensure the following:

- The Provider (whether an individual or an entity) has an opportunity to challenge the State's determination under this Part by submitting documents or data or both to support the Provider's claim; and
- The process employs methods for conducting an appeal that are consistent with the State's Administrative Procedure law(s).

Specifically, Providers can appeal if they believe that they have been denied an incentive payment, or have received an incorrect payment amount because of incorrect determinations of eligibility, including but not limited to the following DHHS decisions:

- Measuring patient volume;
- Demonstrating Meaningful Use; and
- Efforts to adopt, implement, or upgrade to certified EHR technology.

As stated above, DHHS has determined that Providers will be able to invoke an initial data correction process that will afford them opportunity to make changes to their SLR information. If the informal resolution process results in a denial decision, DHHS will provide a written notification of the denial action to the Provider. The Provider may challenge the DHHS action, by request of a hearing within 90 days of the date of the action through the formal process stated in Title 471 Chapter 2 Section 2-003 and Title 465 Chapter 6.

DHHS will update its appeals process after MIP begins and lessons are learned from the number and type of appeals being filed and processed.

5.8.3 Audit Plan and Fraud and Abuse

See detailed audit plan attached.

Through HITECH Act Regulation 42 CFR: Part 495 Subpart D § 495.368, CMS defined the following audit and fraud and abuse prevention process requirements for a Provider receiving MIP payments.

The State will comply with federal requirements to:

- Ensure the qualifications of the Providers requesting MIP payments;
- Detect improper payments; and
- Refer suspected cases of fraud and abuse to the Medicaid Fraud Control Unit.

Nebraska will use auditable data sources in calculating the MIP payments.

The State will take corrective action in the case of improper MIP payments to Providers. Nebraska will repay to CMS all inappropriate payments received by Providers identified as an overpayment regardless of recoupment from such Providers, Nebraska will comply with all federal laws and regulations designed to prevent fraud, waste, and abuse.

The DHHS audit plan for MIP is designed to be timely and targeted and balance risk with available resources. The plan is also designed to provide assurance that the right incentive payments will be made to the right Provider before initiating MIP.

5.8.4 Verification and Audit Plan

See Detailed Audit Plan attached.

5.9 Reporting

5.9.1 MIP SLR Reporting

Information submitted to CMS annually includes:

- Reports on Provider AIU of certified EHR technology activities and payments;
- Aggregated, de-identified Meaningful Use data;
- Aggregated data on AIU; Meaningful Use; CQMs and payments for unique needs (e.g. children);
- Volume statistics on type, practice locations, and Providers who qualified for MIP payments; and
- Audit payment history from the NLR and SLR (which must be reconciled).
- DHHS plans to implement a SLR that supports reporting capabilities for MIP. The initial reporting capability of the SLR for internal DHHS may use includes but is not limited to:
- Incomplete registration applications;
- NLR applications waiting on SLR registration;
- Active registration applications with CMS;

- Active registration applications attached to a group;
- Attestation applications currently pending;
- Active registrations not meeting eligibility threshold;
- Applications pending payment; and
- Completed application payments.

Using the above referenced SLR, and the CMS systems of Research and Support User Interface and MicroStrategy reports, DHHS is planning to manually prepare and submit the following regular annual reports to CMS:

- Provider AIU activities and payments;
- Aggregated and de-identified Meaningful Use of certified EHR technology and payments. (This table is not anticipated in the first annual report because Providers are only required to demonstrate AIU.);
- Number, type, and practice locations of Providers who qualified on the basis of AIU;
- Aggregated data tables representing Provider AIU;
- Number, type, and practice locations of providers who qualified on the basis of demonstrating Meaningful Use. (This table is not anticipated in the first annual report because Providers are only required to demonstrate AIU.);
- Aggregated data tables representing the Providers' Meaningful Use and CQMs data; and
- Description and quantitative data on how the DHHS MIP addressed individuals with unique needs, such as children. (This information is not anticipated in the first annual report because this information may not be collected during the first year of the program.)

Additional financial oversight reports DHHS may use internally include:

Table 12: Additional Financial Oversight Reports

Report	Frequency
Reports showing payments pending to EP or EH.	Weekly and Monthly
Reports showing payments made to EP or EH.	Weekly and Monthly
Payment reconciliation reports to track payment by NPI/Provider ID from SLR to EnterpriseOne to SLR to NLR. • Dollars in the payment calculation of SLR by Provider. • Dollars input in to the EnterpriseOne system. • Payments made by EnterpriseOne to Provider. • Payments reported to the SLR by Provider. • Payments reported to the NLR by Provider.	Weekly and Monthly.
Reports tracking the status of all applications in the redetermination or appeals processes.	Weekly and Monthly
CMS Report with number of Providers by type and location using AIU.	Monthly

Report	Frequency
Aggregated Tables for AIU.	Monthly
CMS Report with number of Providers by type and location using Meaningful Use.	Monthly
Aggregated Tables for Meaningful Use.	Monthly
Quantitative data on how MIP addressed individual with unique needs, such as children.	Monthly

DHHS will create additional reports as necessary to administer, manage, and monitor MIP. CMS is creating Measures of Success and Functional Purpose Data Elements and Performance Metrics Exports from the NLR for states to use for reporting. CMS expects these files will be in a simple CSV format. DHHS will use these files, as well as the CMS systems of Research and Support User Interface and MicroStrategy reports, to support reporting.

5.9.2 CMS Required Financial Reporting

CMS required financial reporting will be supported by existing Medicaid processes external to MIP.

Under the Recovery Act, states have the option to participate in MIP. The Recovery Act provides 100 percent FFP to states for MIP payments to eligible Medicaid providers to adopt, implement, upgrade, and meaningfully use certified EHR technology, and 90 percent FFP for state administrative expenses related to the program.

DHHS will receive 90 percent FFP for reasonable administrative expenditures incurred in planning and implementing the program, subject to CMS prior approval. (Note, as required by 42 CFR § 495.358, all costs are subject to cost allocation rules in 45 CFR Part 95).

DHHS will estimate the expenditures for MIP on the DHHS's quarterly budget estimate reports via Form CMS-37. These reports are used as the basis for Medicaid annual grant awards that would be advanced to DHHS for MIP. These forms are submitted electronically to CMS via the Medicaid and State CHIP Budget and Expenditure System (MBES/CBES). On Form CMS-37, states should include any projections of administration related expenditures for the implementation costs. On Form CMS-64, a state submits on a quarterly basis actual expenses incurred, which is used to reconcile the Medicaid funding advanced to Nebraska for the year made on the basis of the Form CMS-37.

To assist DHHS in properly reporting expenditures using the MBES/CBES, the CMS-37 and CMS-64 reports include a new category for reporting the 90 percent FFP match for State administrative expenses associated with MIP. The new category will be called "Health Information Technology Administration." This reporting category is located on the 64.10 base page lines 24A and 24B for Administration. Implementation expenditures are included on lines 24C and 24D.

5.9.3 Additional Required CMS Reporting

Reporting requirements of 42 CFR Section 495.352 mandate each state must submit to the CMS on a quarterly basis a progress report documenting specific implementation and oversight activities performed during the quarter, including progress in implementing the state's approved Medicaid HIT plan. DHHS will submit the quarterly report that includes the specific implementation and oversight activities performed.

6 HIT Roadmap

6.1 Major Activities and Milestones Moving from "As-Is" to "To-Be"

The following table shows the major activities and milestones to move DHHS from "As-Is" to "To-Be" status. It illustrates the HIT Roadmap and Activities, including milestones for DHHS. Some activities may occur every quarter and be shown in the activity list, but only appear as a milestone in its first occurrence.

Table 13: HIT Roadmap and Activities

Date	Activity
2011 – 4th Quarter October/November/December	• Continue provider outreach through professional association meetings and conferences. • Finalize revisions to submitted SMHP and IAPD, obtain CMS approval. • NLR interface testing with CMS. • Begin reporting of quarterly MIP forcasted expenditures (CMS 37). • Further develop Communications Plan. • Continue to develop roles and responsibilities with the State HIE network. • "As-Is" portion of MITA SS-A completed.
2012 – 1st Quarter January/February/March	• Hire and train MIP operations staff. • Finalize provider manual materials. • Finalize internal staff manual materials. • Refine MIP Provider training materials. • Conduct MIP Provider training sessions. • Re-test with NLR in preparation for launch. • Complete and submit MIP audit plan to CMS.

Date	Activity
2012 – 2nd Quarter April/May/June	• Perform Provider testing. • Continue Provider training and outreach. • Launch program. • Begin accepting AIU MIP applications from Providers. • Begin reporting of quarterly MIP Provider payment actual expenditures (CMS 64). • Begin making MIP payments for AIU. • Begin readiness planning for MU payments. • Finalize an agreement on roles and responsibilities with State HIE. • Begin quarterly SMHP progress reporting. • Complete MITA SS-A.
2012 – 3rd Quarter July/August/September	• Review and update SMHP and IAPD documents to CMS as necessary. • Submit Audit Plan to CMS for approval • Review and revise program training materials and manuals. • Submit MU attestation process documentation for CMS review and approval. ◆ Begin design discussion with IS&T for system changes for MU
2012 – 4th Quarter October/November/December	• Review and revise MIP audit plan. • Begin post payment audit activities • Finalize IS&T system changes to incorporate MU • Test system changes • Add MU to enrollment/attestation • Revise training materials to incorporate MU
2013 – 1st Quarter January/February/March	• Review and revise MIP program requirements. ◆ Begin accepting MU attestations ◆ Begin analysis of system changes to accept CQM data and prepare for Stage 2 ◆ If analysis supports an RFP, submit proposed RFP to CMS for approval ◆ Update SMHP and IAPD to allow for new system if determined appropriiate
2013—2nd Quarter April/May/June	• Publish RFP for new system if determined appropriate
2013 – 3rd Quarter July/August/September	• Review and revise MIP program requirements. • Review and update SMHP and IAPD documents to CMS as necessary. • Review and revise program training materials and manuals. • Sign/award contracts for new system if determined appropriate • System design requirements finalized if appropriate

Date	Activity
2013—4th Quarter October/November/December	• New system testing if appropriate
2014 – 1st Quarter January/February/March	• Review and revise MIP program requirements. • Review and update SMHP and IAPD documents to CMS, as necessary. • Implementation of new system if appropriate
2014 – 3rd Quarter July/August/September	• Review and revise MIP program requirements. • Review and update SMHP and IAPD documents to CMS, as necessary. • Review and update audit plan as necessary

6.2 Provider Adoption of EHR Technology

DHHS conducted an analysis for estimating the number of EPs and EHs. DHHS was conservative in its approach by undertaking an analysis that included consideration of several different estimating methodologies:

- CMS methodology as defined in the preamble to 42 CFR Part 495;
- Qualitative comparisons with other states;
- DHHS February 2011 Survey Data Results; and
- Analysis of MMIS data.

The initial estimate of EPs is 600 and the initial estimate of EHs is 50.

In order to determine the most cost efficient method for making incentive payments to its Providers, DHHS evaluated three strategies:

1. Whether to invest in an automated Provider registration and attestation system;
2. Whether to incorporate a manual set of processes; or
3. Whether to initially use a manual set of processes while conducting a parallel planning process for automated registration and attestation.

At this time, DHHS plans to initially pay Providers using a manual process and may conduct a parallel planning process for automated registration and attestations based on findings during the operation of the program.

The following table shows the initial Performance Measures that DHHS used to gauge progress toward Meaningful Use using the estimated numbers of EPS and EHs listed above. As Nebraska launched the program in 2012, the 2011 estimates in Table 15 do not apply. A second table below shows the Actual Performance measures as of 9/27/2012 along with the revised estimates. The original projection that 600 EPs and 50 EHs will apply before the end of the Medicaid Incentive Program is still an accurate projection.

Table 14: Performance Measures

Table 15: Actual Performance Measures with revised estimates

	Actual through 9/27/12 2012	Estimates for remainder of calendar year 2012	Estimated number of new providers requesting EHR incentives 2013	Estimated number of providers requesting a program year 2 payment 2013	Estimated number new providers requesting EHR incentives 2014	Estimates number of providers requesting a year 2 or subsequent year payment 2014
Hospitals	**27**	**12**	**15**	**39**	**5**	**50**
Physicians	**73**	**60**	**80**	**44**	**200**	**175**
Dentists	**3**	**3**	**20**	**3**	**20**	**10**
Nurse Practitioners	**17**	**5**	**1**	**10**	**1**	**10**
Certified Nurse Midwives	**0**	**1**	**1**	**1**	**1**	**1**
PA (FQHC/RHC)	**2**	**1**	**1**	**1**	**1**	**1**
TOTALS	**122**	**82**	**118**	**98**	**228**	**247**

As previously stated, the State of Nebraska estimates that approximately 600 EPs and 50 EHs will participate in MIP. When viewing Table 15, there are two items to bear in mind:

1. The numbers shown in the "Adopt Certified EHR" column show the expected number of Providers applying in that year.
2. The numbers shown in the "MU of EHR" column represents the cumulative number of Providers qualifying in that year.

Additional information related to Table 15:

- The 600 EPs have been broken out into the categories on a percentage basis relative to their overall numbers.
- It is assumed that not all the EPs will achieve Meaningful Use.
- Achievement of Meaningful Use by the EPs may not occur in the next year after their AIU.

6.3 Assumptions and Dependencies

The following assumptions and dependencies may affect the MIP as described in this document:

Assumptions:

1. The SLR will be ready for test and implementation with the NLR according to the current schedule as presented by CMS; and
2. Certification and implementation of certified EHR systems will be timely in keeping with the MIP schedule.

Dependencies:

1. Testing of the SLR is dependent on the availability and functionality of the NLR being as described by CMS; and
2. The incentive payments activities as listed in Table 14 – HIT Roadmap and Activities – above are dependent on the capacity of the certified EHR vendors to meet the demands of the Provider marketplace for their product.

6.4 Participation in the State Health Information Exchange

Nebraska DHHS intends to leverage the Statewide HIE, NeHII, to support the exchange of clinical and administrative data between State-level HIE stakeholders and DHHS. In the future, clinical and administrative data could be used for DHHS internal analytics and research purposes. The Nebraska Strategic and Operational Plans for HIE include collaboration between DHHS and the Statewide HIE, NeHII. Nebraska Medicaid and NeHII have held regular meetings in an effort to define joint roles and responsibilities. Activities and accomplishments include:

- Developing use cases describing interaction between the SMA and Statewide HIE
- Exploring financial viability and potential models for Medicaid investment in HIE
- Examining multiple upcoming initiatives (e.g., CHIPRA, CQM, Meaningful Use, etc.) with an awareness of their dependence upon SMA's ability to obtain/receive data from providers.

6.5 Participation in NwHIN

A number of federal agencies and State-based programs are considering utilizing NwHIN and the Direct Project for interoperable information exchange. Connectivity with these federal agencies will present opportunities in federal agency services and participation in federal projects for DHHS. As such, DHHS intends to have a connection to NwHIN in the future. DHHS is considering NwHIN-based connectivity to multiple federal agencies, including the DoD, the Department of Veteran Affairs, CMS, CDC, SSA, and IHS.

Connection to NwHIN will be provided either through integration with NeHII, which will be on-boarded to NwHIN, or through a DHHS-specific connection. Ongoing collaborative work between Nebraska

Medicaid and NeHII, defining roles and responsibilities, will inform and determine choices about connectivity to NwHIN.

6.5.1 Alignment with MITA Mission, Goals, and Objectives

Nebraska DHHS intends to align with MITA's mission, goals, and objectives in support of DHHS internal goals. DHHS will also be in alignment with the Federal Health Architecture (FHA) and NwHIN initiatives by utilizing national industry-standards for interoperability. DHHS understands the CMS expectation for states to bring their business and technical capabilities up to MITA levels 3, 4, and 5.

It is the intention of DHHS to achieve those levels of MITA maturity through utilization of standards-based technologies, including NwHIN connectivity.

6.5.2 NwHIN

NwHIN is made up of the standards and protocols required to facilitate the exchange of electronic health information exchange of information between disparate organizations. NwHIN can facilitate the exchange of both clinical and administrative transactions, including the necessary security and interoperability standards for advanced information exchange. NwHIN is a central component of the FHA and other national priorities in healthcare, including clinical decision making capabilities and analytics. Focus on NwHIN from federal agencies, including ONC and CMS, increases the importance of NwHIN compliance as part of the DHHS HIT Roadmap for the Nebraska SMHP.

Some common NwHIN use-case examples are provided below:

- Provider to Provider: allowing for referrals, exchange of patient medical history, and sending messages for the administrative coordination of care.
- Provider to Pharmacy: allowing for electronic prescriptions, and drug-drug, drug-allergy, or drug-formulary checks.
- Provider to Patient: allowing for patient reminders, sending patient medical information to a Personal Health Record (PHR), and to provide information directly to patients.
- Provider to Payer: allowing for eligibility checks, submitting claims, prior authorization, and submitting patient information.
- Laboratory to Provider: allowing for lab result exchange and submission of reportable lab results.
- Provider to Federal Agencies: allowing for quality reports and surveillance reports.

As DHHS is primarily focused on exchange between state agencies, federal agencies, and the Statewide HIE, there will be a focus on NwHIN Exchange standards using a NwHIN CONNECT-compliant gateway. However, DHHS may also support the Direct Project standards and protocols for exchange between organizations without NwHIN gateways.

6.5.3 NwHIN Gateways

NwHIN Gateways are required for connection the NwHIN exchange network. A NwHIN Gateway is a set of interfaces and adapters facilitating the interaction with the NwHIN network. NwHIN Gateways can be classified as one of two basic categories:

1. CONNECT-compliant gateways; and
2. Proprietary NwHIN gateways.

Nebraska DHHS intends to use a CONNECT-compliant NwHIN Gateway for coordination with the federal NwHIN initiative and interoperability with appropriate exchange organizations such as NeHII and CMS.

6.5.4 Coordination with NwHIN

Connection to NwHIN will be provided either through integration with NeHII, which will be on-boarded to NwHIN, or through a DHHS-specific connection.

6.5.5 Connectivity

Nebraska DHHS's vision includes NwHIN connectivity to allow for a standards-based exchange with NeHII, neighboring HIEs, state agencies, and federal agencies. Specific organizations with which DHHS may use the NwHIN Gateway to exchange information are listed below:

- NeHII and the Provider organizations within NeHII, including the Provider locations receiving Medicaid reimbursement from DHHS;
- Other Nebraska State agencies and stakeholders, such as Nebraska State Laboratories/Reference Labs and more;
- Neighboring HIEs such as the Iowa Statewide HIE, the Kansas Statewide HIE, the Wyoming Statewide HIE, etc.;
- Neighboring state agencies such as state Medicaid agencies, State Departments of Health, etc.; and
- Federal agencies including CMS, SSA, CDC, VA, and DoD.

The benefits of employing a NwHIN Gateway are:

- The ability to interact with the aforementioned trading partners (states, federal agencies, HIEs);
- The ability to leverage a standards-based platform (NwHIN Exchange with a NwHIN CONNECT compliant Gateway) for communication and interoperability;
- The ability to utilize NwHIN for both clinical and administrative transactions with multiple trading partners; and

- A decrease in dependence on other entities to provide connectivity and interoperability with health care partners.

Nebraska DHHS will continue to evaluate options regarding NwHIN connectivity and the impact of relying on NeHII for exchange over NwHIN.

6.5.6 Integrating the Healthcare Enterprise Statement and Standards Integration to Drive MITA Compliancy

As higher levels of MITA maturity require higher levels of interoperability between information technology systems, appropriate attention should be given to the standards adopted in support of interoperability. Integrating the Healthcare Enterprise (IHE) is an international collaborative formed by HIMSS and the Radiological Society of North America (RSNA).

IHE promotes the use of existing industry standards, including HL7 and DICOM standards. Core services established as part of NwHIN were developed, in part, based on IHE standards. The close connection between IHE, NwHIN, and pre-existing industry standards underscores the value of adopting these standards and protocols. As adoption of IHE standards grow, so does the value in terms of interoperability between disparate systems.

The DHHS Roadmap incorporates compliance with industry-accepted standards such as IHE and NwHIN. Adoption of such sets of standards allows Nebraska DHHS to build a highly interoperable, standards-based infrastructure in compliance with MITA.

6.5.7 Meaningful Use Provisions with Exchange Components

The table below enumerates each of the Meaningful Use provisions described in the Final Rule and provides relevant standards to the recording or reporting of each measure. The standards listed below represent standards at the time of this writing and may not represent current standards. For those measures related to Public Health reporting, guidelines should be followed as prescribed by the department of Public Health not to exceed the required standard for certified EHR technology.

Table 15: Meaningful Use Provisions

Criteria	NwHIN or Local	Relevant Standards	Comments
Core Provision			
CPOE	Local	TBD	Lower priority than other exchanges; phase 1 requirement is only for entering order into system, not to transmit them.
Adverse event clinical decision support (drug-drug/drug-allergy check).	Local	TBD	
E-prescribing.	NwHIN	NCPDP; HL7	
Record demographics.	Local		

Criteria	NwHIN or Local	Relevant Standards	Comments
Current diagnoses.	NwHIN	CCD;IMPLEMENTATION SPECIFICATION: HITSP C32 et.al.	Access to clinical summaries is part of NwHIN.
Maintain active medications/allergies.	Local		
Record and chart changes.	Local		
Record smoking status.	Local		
Implement one CDS rule.	Local		
Submit quality reports.	NwHIN	CMS Physician Quality Reporting Initiative (PQRI) 2009 Registry XML Specification	Based on Physician Quality Reporting Initiative (PQRI) work done to date; assume push of data for time being, no query/retrieve support required.
Provide patients a copy of their electronic health information.	NwHIN or Local	Structured: *CCD;IMPLEMENTATION SPECIFICATION: HITSP C32* et al. Unstructured: HITSP C62	Use NwHIN if patient uses PHR service Provider to maintain data; messaging-based standards may apply for some exchanges.
Summary of care for each transition of care and referral (discharge summaries).	NwHIN	CCD;IMPLEMENTATION SPECIFICATION: HITSP C32 et.al.	Already supported by NwHIN.
Capability to exchange key clinical information (coordination).	NwHIN	Structured: CCD;IMPLEMENTATION SPECIFICATION: HITSP C32 et al. Unstructured: HITSP C62	Already supported by NwHIN; messaging-based standards may apply for some exchanges.
Appropriate security and privacy.	NwHIN		Not technically an exchange, but the NwHIN must provide the appropriate trust fabric to support the MU provisions. Currently NwHIN Exchange uses a system-level trust model, and should be reviewed to ensure that MU requirements are accommodated.
Menu Provision			
Drug-formulary checks.	Local		
Record advance directives.	Local		
Retrieve lab results.	NwHIN	HITSP C36 (HL7 v2.5.1 message-based); HITSP C37 (CDA document exchange).	Need to determine how HL7 v2 messaging can be transported over NwHIN Web services.
Generate lists of conditions.	Local		NwHIN support for analytic queries down the road may be helpful.
Patient reminders.	Local		
Timely electronic access/ clinical summaries for each visit.	NwHIN or Local	Structured: CCD;IMPLEMENTATION SPECIFICATION: HITSP C32 et al. Unstructured: HITSP C62	Use NwHIN if patient uses PHR service Provider to maintain data; messaging-based standards may apply for some exchanges.

Criteria	NwHIN or Local	Relevant Standards	Comments
Patient education.	Local		
Medication reconciliation.	Local		Complete set of data for reconciliation may require exchange to receive medical history from other Providers.
Summary of care for each transition of care and referral (discharge summaries).	NwHIN	CCD;IMPLEMENTATION SPECIFICATION: HITSP C32 et.al.	Already supported by NwHIN.
Submit data to immunization registries.	NwHIN	HITSP C72 (HL7 bv.2.3.1)/C78	Upgrade available based on HL7 v2.5.1.
Submit reportable lab results to public health agencies.	NwHIN	CDC Implementation Guide (based on HL7 v.2.5.1)	
Provide electronic syndromic surveillance.	NwHIN	HL7 v.2.5.1	Already implemented in CDC pilot.

Appendix A: Acronyms

Acronym	Phrase
AIU	adoption, implementation, or upgrade
AHRQ	United States Department of Health and Human Services Agency for Healthcare Research and Quality
AoA	United States Administration on Aging
ARRA	American Recovery and Reinvestment Act of 2009
BMI	body mass index
CAH	critical access hospital
CCN	CMS Certification Number
CDC	Centers for Disease Control and Prevention
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CICS	Customer Information Control System
CMS	Centers for Medicare and Medicaid Services
CPOE	computerized physician order entry
DBH	State of Nebraska Division of Behavioral Health
DHHS	State of Nebraska Department of Health and Human Services
DoD	United States Department of Defense
DPH	State of Nebraska Division of Public Health
eBHIN	Nebraska Electronic Behavioral Health Information Network
EDI	electronic data interchange
EH	eligible hospital
EHR	electronic health record
EMR	electronic medical record
EP	eligible professional
FFP	federal financial participation
FHA	Federal Health Architecture
FHSC	First Health Services Corporation
FQHC	federally qualified health center

Acronym	Phrase
FY	fiscal year
HIE	health information exchange
HIMSS	Healthcare Information and Management Systems Society
HIPAA	Health Information Portability and Accountability Act
HIT	health information technology
HITECH	Health Information Technology for Economic and Clinical Health
HMO	health maintenance organization
HRSA	United States Department of Health and Human Services' Health Resources and Services Administration
IAPD	Implementation Advance Planning Document
IHE	Integrating the Healthcare Enterprise
IHS	Indian Health Service
MCO	managed care organization
MARS	Management & Administrative Reporting Subsystem
MBES/CBES	Medicaid and State CHIP Budget and Expenditure System
MIP	Medicaid EHR Incentive Program
MITA	Medicaid Information Technology Architecture
MITA SS-A	Medicaid Information Technology Architecture State Self-Assessment
MLTC	Nebraska DHHS Division of Medicaid & Long-Term Care
MMIS	Medicaid Management Information System
NAMIS II	Nebraska Aging Management Information System
NEDSS	Nebraska Electronic Disease Surveillance System
NeHII	Nebraska Health Information Initiative
NESIIS	Nebraska State Immunization Information System
N-FOCUS	Nebraska Family Online Client User System
NwHIN	Nationwide Health Information Network
NITC	Nebraska Information Technology Commission
NLR	CMS National Level Repository
NPI	National Provider Identification

Acronym	Phrase
NRHA	National Rural Health Association
OIG	Office of the Inspector General
ONC	Office of the National Coordinator for Health Information Technology
ORHP	HRSA Office of Rural Health Policy
PAS	State of Nebraska Personal Assistance Services program
PHINMS	Public Health Information Network Messaging System
PHR	Personal Health Record
POS	Point of Service system
PQRI	Physician Quality Reporting Initiative
REC	Regional Extension Center
RHC	rural health clinic
RHIN	Rural Nebraska Healthcare Network
RSNA	Radiological Society of North America
SENHIE	South East Nebraska Health Information Exchange
SLR	Nebraska State Level Repository
SMHP	State Medicaid Health Information Technology Plan
SSA	Social Security Administration
SSEDON	Syndromic Surveillance Event Detection of Nebraska
SURS	Surveillance and Utilization Review Subsystem
TCHS	Thayer County Health Services
TIN	Taxpayer Identification Number
UNMC	University of Nebraska Medical Center
VA	Veterans Administration
VA NWIHCS	Veterans Administration Nebraska-Western Iowa Health Care System
VistA	Veterans Health Information Systems and Technology Architecture
Wide River TEC	Wide River Technology Extension Center
WNHIE	Western Nebraska Health Information Exchange

Appendix B: Glossary

Term	Definition
Adoption, Implementation, or Upgrade (AIU)	These terms are used by CMS as part of the eligibility criteria for EHR incentives. These terms reference the provider's adoption, implementation or upgrade of a certified EHR system.
American Recovery and Reinvestment Act (ARRA)	An economic stimulus package enacted by the 111th Congress in February 2009, commonly referred to as the Stimulus or The Recovery Act.
Authentication	Authentication is a method or methods employed to prove that the person or entity accessing information is who they claim.
Authorization	Authorization is a system established to grant access to information. Authorization also establishes the level of access an individual or entity has to a data set and includes a management component—an individual or individuals must be designated to authorize access and manage access once access is approved.
Broadband	A medium that can carry multiple signals, or channels of information, at the same time without interference. Broadband Internet connections enable high-resolution videoconferencing and other applications that require rapid, synchronous exchange of data.
Children's Health Insurance Program (CHIP)	CHIP program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid.
Computerized Physician Order Entry (CPOE)	Computer-based systems that automate and standardize the clinical ordering process in order to eliminate illegible, incomplete, and confusing orders. CPOE systems typically require physicians to enter information into predefined fields by typing or making selections from on-screen menus. CPOE systems often incorporate, or integrate with, decision support systems.
CONNECT	CONNECT is an open source software solution that supports health information exchange – both locally and at the national level. CONNECT uses Nationwide Health Information Network standards and governance to make sure that health information exchanges are compatible with other exchanges being set up throughout the country. CONNECT is also a Nebraska application. See Section 3.7.1.
Critical Access Hospital (CAH)	A hospital that is certified to receive cost-based reimbursement from Medicare. The reimbursement that CAHs receive is intended to improve their financial performance and thereby reduce hospital closures.
Data warehouse	A large database that stores information like a data repository but goes a step further, allowing users to access data to perform research-oriented analysis.

Term	Definition
Decision Support System (DSS)	A computer-based information system that supports business or organizational decision-making activities intended to help decision makers compile useful information from a combination of raw data, documents, personal knowledge, or business models to identify and solve problems and make decisions.
Electronic Data Interchange (EDI)	Electronic data interchange is the structured transmission of data between organizations by electronic means. It is used to transfer electronic documents or business data from one computer system to another computer system, i.e. from one trading partner to another trading partner without human intervention.
Electronic Health Record (EHR)	An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.
Electronic Medical Record (EMR)	An electronic record of health-related information for an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization.
Eligible Hospital (EH)	A hospital that meets the criteria for payment of Medicaid EHR incentives.
Eligible Professional (EP)	A professional who meets the criteria for payment of Medicaid EHR incentives.
EnterpriseOne	Nebraska's accounting and payment system which is used to make all payments issued by the State, including MMIS claims payments. The system utilizes Oracle's JD Edwards application.
e-prescribing	Practice in which drug prescriptions are entered into an automated data entry system (handheld, PC, or other), rather than handwriting them on paper. The prescriptions can then be printed for the patient or sent to a pharmacy via the Internet or other electronic means.
Federal Health Architecture (FHA)	A collaborative body composed of several federal departments and agencies, including the Department of Health and Human Services, the Department of Homeland Security, the Department of Veterans Affairs, the Environmental Protection Agency, the United States Department of Agriculture, the Department of Defense, and the Department of Energy. FHA provides a framework for linking health business processes to technology solutions and standards, and for demonstrating how these solutions achieve improved health performance outcomes.
Federally Qualified Health Center (FQHC)	A health center that receives cost-based reimbursement for Medicare and Medicaid patients as a mechanism to increase primary care services to high risk populations in underserved areas.
Formulary	A list of medications (both generic and brand names) that are covered by a specific health insurance plan or pharmacy benefit manager, used to encourage utilization of more cost-effective drugs. Hospitals sometimes use formularies of their own, for the same reason.

Term	Definition
Health Information Exchange (HIE)	The electronic movement of health-related information among organizations according to nationally recognized standards.
Health Information Technology (HIT)	The application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision-making.
Health Information Technology for Economic and Clinical Health Act (HITECH)	On February 17, 2009, President Obama signed into law the Health Information Technology and Clinical Health Act (HITECH) as part of the American Recovery and Reinvestment Act. HITECH codifies and funds the Office of the National Coordinator for Health Information Technology and provides for the infusion of $19 billion over a four-year period, in grants and loans, for infrastructure and incentive payments under Medicare and Medicaid for providers who adopt and use health information technology. It also expands security and privacy provisions and penalties to HIPAA Business Associates of covered entities.
Health Insurance Portability and Accountability Act of 1996 (HIPAA)	A federal law intended to improve the portability of health insurance and simplify health care administration. HIPAA sets standards for electronic transmission of claims-related information and for ensuring the security and privacy of all individually identifiable health information.
Indian Health Service	A part of the U.S. Public Health Service within the US Department of Health and Human Services, the Indian Health Service is responsible for providing federal health services to American Indians and Alaska Natives.
Integrating the Healthcare Enterprise (IHE)	Integrating the Healthcare Enterprise (IHE) was formed by the Healthcare Information and Management Systems Society and the Radiological Society of North America. IHE is an initiative by health care professionals to improve the way health care information is shared between systems and organizations around the world for the purpose of improving the overall quality of health care to patients. The mission of IHE is to achieve interoperability of systems through the precise definition of health care tasks, the specification of standards-based communication between systems required to support those tasks, and the testing of systems to determine that they conform to the specifications.
Interoperability	HIMSS' definition of interoperability is "ability of health information systems to work together within and across organizational boundaries in order to advance the effective delivery of healthcare for individuals and communities."
Meaningful Use	As defined by CMS in 42 CFR Part 495.
Medicaid Information Technology Architecture (MITA)	A federal, business-driven initiative that affects the Medicaid enterprise in all states by improving Medicaid program administration, via the establishment of national guidelines for processes and technologies. MITA is a common business and technology vision for state Medicaid organizations that supports the unique needs of each state.
Medicaid Management Information System (MMIS)	The MMIS is one of the primary repositories of provider information. MMIS capabilities will be leveraged to fulfill a range of functions, including the provision of data necessary to enable payment administration.

Term	Definition
Medicaid and State CHIP Budget and Expenditure System (MBES/CBES)	This is the reporting system to CMS that documents actual expenditures that CMS will pay to States for the Medicaid program expenditures. The Form 64 is a statement of expenditures and reconciles the monetary advance made to the state on the basis of the Form 37. When using the MBES/CBES states can electronically submit their Form 64 and do not have to submit a hard copy.
National Level Repository (NLR)	The NLR is the federal database that stores Medicaid and Medicare EHR Incentive Program data. This database supports MEIPRAS.
Nationwide Health Information Network (NwHIN)	The federal government's program to implement a national interoperable system for sharing electronic medical records or EMRs (a.k.a. electronic health records or EHR). NwHIN describes the technologies, standards, laws, policies, programs and practices that enable health information to be shared among health decision makers, including consumers and patients, to promote improvements in health and healthcare. The development of a vision for the NwHIN began more than a decade ago with publication of an Institute of Medicine report, "The Computer-Based Patient Record".
Nebraska Information Technology Commission (NITC)	The NITC is a nine-member, governor-appointed commission. Its mission is The mission of the Nebraska Information Technology Commission is to make the State of Nebraska's information technology infrastructure more accessible and responsive to the needs of its citizens, regardless of location, while making investments in government, education, health care and other services more efficient and cost effective.
NwHIN Gateway	A NwHIN Gateway is a set of interfaces, adapters, and subsystems that facilitates connection to, and exchange with, the NwHIN network.
Office of the National Coordinator for Health Information Technology (ONC)	ONC provides leadership for the development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of health care and the ability of consumers to manage their care and safety.
Personal Health Record (PHR)	An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.
Portal	A website that offers a range of resources, such as email, chat boards, search engines, and content.
Provider	A provider is an individual or group of individuals who directly (primary care physicians, psychiatrists, nurses, surgeons, etc) or indirectly (laboratories, radiology clinics, etc) provide health care to patients. In the case of this SMHP and the EHR Incentive Program, Provider refers to both eligible professionals (EPs) and eligible hospitals (EHs).
Public health	Public health is the art and science of safeguarding and improving community health through organized community effort involving prevention of disease, control of communicable disease, application of sanitary measures, health education, and monitoring of environmental hazards.

Term	Definition
Regional Extension Center (REC)	An organization that has received funding under the Health Information Technology for Economic and Clinical Health Act to assist primary care health care providers with the selection and implementation of electronic health record technology.
Resource and Patient Management System (RPMS)	Resource and Patient Management System (RPMS) is a decentralized automated information system of over 60 integrated software applications. Many RPMS applications can function in a standalone environment if necessary or appropriate. The system is designed to operate on micro- and mini-computers located in Indian Health Service or tribal healthcare facilities. RPMS software modules fall into three major categories: 1) practice management applications that perform patient registration, scheduling, billing, referrals, and linkage functions; 2) clinical applications that support various healthcare programs within IHS; and 3) infrastructure applications.
Rural Health Clinic (RHC)	A clinic certified to receive special Medicare and Medicaid reimbursement, intended to increase primary care services for Medicaid and Medicare patients in rural communities.
Stakeholder	A stakeholder is any organization or individual that has a stake in the exchange of health information, including health care providers, health plans, health care clearinghouses, regulatory agencies, associations, consumers, and technology vendors.
State Level Repository (SLR)	The SLR is the database supporting the Medicaid EHR Incentive Program administration. The SLR will capture state-collected data elements as part of the intake. The SLR will contain basic data elements that have been transferred from the NLR (e.g., National Provider Identifier (NPI); CMS Certification Number (CCN) for an EH; EP type; affiliation, etc.). The SLR will capture other relevant information from the EP/EH (e.g., email address; EP affiliation with a managed care organization) to establish eligibility for the EHR incentive program, including patient volume and attestation information.
Telehealth	Is the remote care delivery or monitoring between a healthcare provider and patient. There are two types of telehealth: phone monitoring (scheduled encounters via the telephone) and telemonitoring (collection and transmission of clinical data through electronic information processing technologies.
Telemedicine	Is a rapidly developing application of clinical medicine where medical information is transferred through interactive audiovisual media for the purpose of consulting, and sometimes remote medical procedures or examinations.
Vendor	A vendor is an organization that provides services and supplies to other organizations. In the context of health information exchange, the term usually refers to technology vendors who provide hardware or software, such as electronic health records, e-prescribing technology, or security software.
Veterans Health Information System and Technology Architecture (VistA)	An enterprise-wide information system – a collection of about 100 integrated software modules – built around an Electronic Health Record, used throughout the United States Department of Veterans Affairs medical system, known as the Veterans Health Administration.

Appendix C: HIMSS Analytics EMR Adoption Model Stages

Stage	Description
0	• Some clinical automation may exist. • Laboratory and/or pharmacy and/or radiology not installed.
1	• All three major ancillaries (laboratory, pharmacy and radiology) installed.
2	• Major ancillary clinical systems feed data to clinical data repository (CDR) that provides physician access for retrieving and reviewing results. • CDR contains a controlled medical vocabulary (CMV) and the clinical decision support system and rules engine for rudimentary conflict checking. • Optional for extra points - Information from document imaging systems may be linked to the CDR.
3	• Clinical documentation installed (e.g. vital signs, flow sheets, nursing notes, care plan charting, and/or the electronic medication administration record (eMAR) system are scored with extra points and are implemented and integrated with the CDR for at least one service in the hospital. • First level of clinician decision support is implemented to conduct error checking with order entry (i.e. drug/drug, drug/food, drug/lab, conflict checking normally found in the pharmacy). • Some level of medical image access from picture archive and communication systems (PACS) is available for access by physicians via the organization's intranet or other secure networks.
4	• Computerized practitioner/physician order entry (CPOE) for use by any clinician added to nursing and CDR environment. • Second-level of clinical decision support related to evidence-based medicine protocols implemented. • If one patient service area has implemented CPOE and completed previous stages, this stage has been achieved.
5	• The closed loop medication administration environment is fully implemented in at least one patient care service area. The eMAR and bar coding or other auto-identification technology, such as radio frequency identification (RFID), are implemented and integrated with CPOE and pharmacy to maximize point-of-care patient safety processes for medication administration.
6	• Full physician documentation/charting (structured templates) are implemented for at least one patient are service area. • A full complement of radiology PACS systems is implemented (i.e. all images, both digital and film-based, are available to physicians via an intranet or other secure network.
7	• Clinical information can be readily shared via electronic transactions or exchange of electronic records with all entities within a regional health network (i.e., other hospitals, ambulatory clinics, sub-acute environments, employers, payers and patients).

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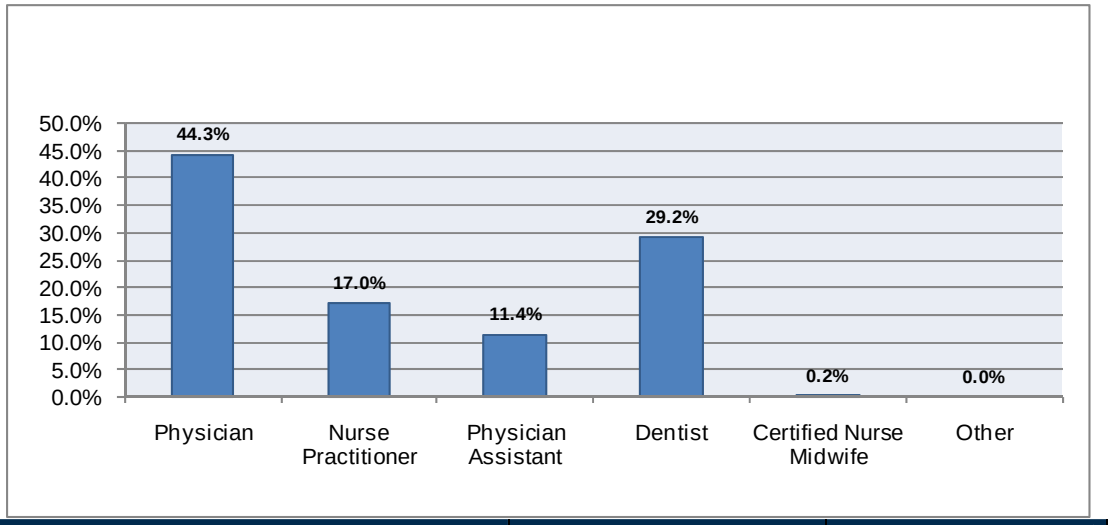
Appendix D: Eligible Professional Survey Results

This document provides eligible professional survey results. Please note that the responses reported below are not in survey questionnaire order. The order presented is designed to follow the analysis and findings of the report in the SMHP, Section 3.1.2 – Provider Surveys. Additionally, certain responses have been omitted because the information provided in the question was intended to provide stratification data and not other substantive data.

I. Survey Participant Description

What best describes your professional category? (q2)

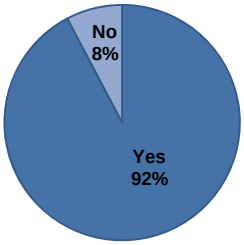
Professional Category



Answer Options	Response Percent	Response Count
Physician	44.3%	237
Nurse Practitioner	17.0%	91
Physician Assistant	11.4%	61
Dentist	29.2%	156
Certified Nurse Midwife	0.2%	1
Other	0.0%	0
answered question		535
skipped question		18

Please indicate if you are an enrolled Medicaid provider. (q7)

Medicaid Provider



Answer Options	Response Percent	Response Count
Yes	92.3%	441
No	7.7%	37
	answered question	478
	skipped question	75

Urban versus Rural

Answer Options	Urban	Urban %	Rural	Rural %	Response Percent	Response Count
Yes	273	90%	166	98%	92.4%	439
No	32	10%	4	2%	7.6%	36
answered question	305		170			475
skipped question						6

What best categorizes the facility type of your primary place of practice outside a hospital setting? (q5)

Answer Options	Response Percent	Response Count
Group or Partnership Medical Practice	34.1%	161
Solo Dental Practice	19.3%	91
Solo Medical Practice	10.6%	50
Group or Partnership Dental Practice	8.3%	39
Multi-Specialty Group	7.6%	36
Rural Health Clinic	7.2%	34
Other	5.5%	26
Federally Qualified Health Center	3.2%	15
Group or Partnership Psychiatry Practice	1.9%	9
Nursing Home or Long Term Care facility	0.8%	4
Community-Based Behavioral Health Organization	0.6%	3
Solo Psychiatry Practice	0.4%	2
Indian Health Clinic	0.4%	2
answered question		472
skipped question		81

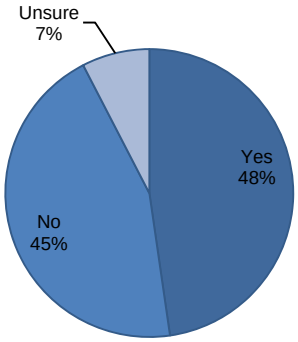
Please indicate your specialty type(s). (q3)

Answer Options	Response Percent	Response Count
General Family Practice	42.6%	209
Other	17.7%	87
General Pediatrics	9.6%	47
Surgical Subspecialties	6.3%	31
Internal Medicine Subspecialties	5.3%	26
Psychiatry	5.1%	25
Emergency Medicine	3.5%	17
General Internal Medicine	3.1%	15
Obstetrics/Gynecology	2.4%	12
General Surgery	2.4%	12
Ear, Nose and Throat (ENT)	2.0%	10
Neurology	2.0%	10
Ophthalmology	1.6%	8
Not Applicable	1.6%	8
Cardiology	1.4%	7
Dermatology	1.0%	5
answered question		491
skipped question		62

II. Electronic Health Record (EHR) Use

Does your primary place of practice currently utilize an EHR system? (q9)

Use EHR System



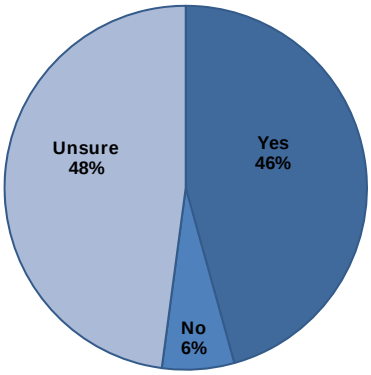
Answer Options	Response Percent	Response Count
Yes	47.7%	220
No	44.7%	206
Unsure	7.6%	35
answered question		461
skipped question		92

Urban versus Rural

Answer Options	Urban	Urban %	Rural	Rural %
Yes	150	51%	69	42%
No	120	41%	85	51%
Unsure	23	8%	12	7%
answered question	293		166	

Please indicate if the EHR system in place is certified. (q12)

EHR Certified

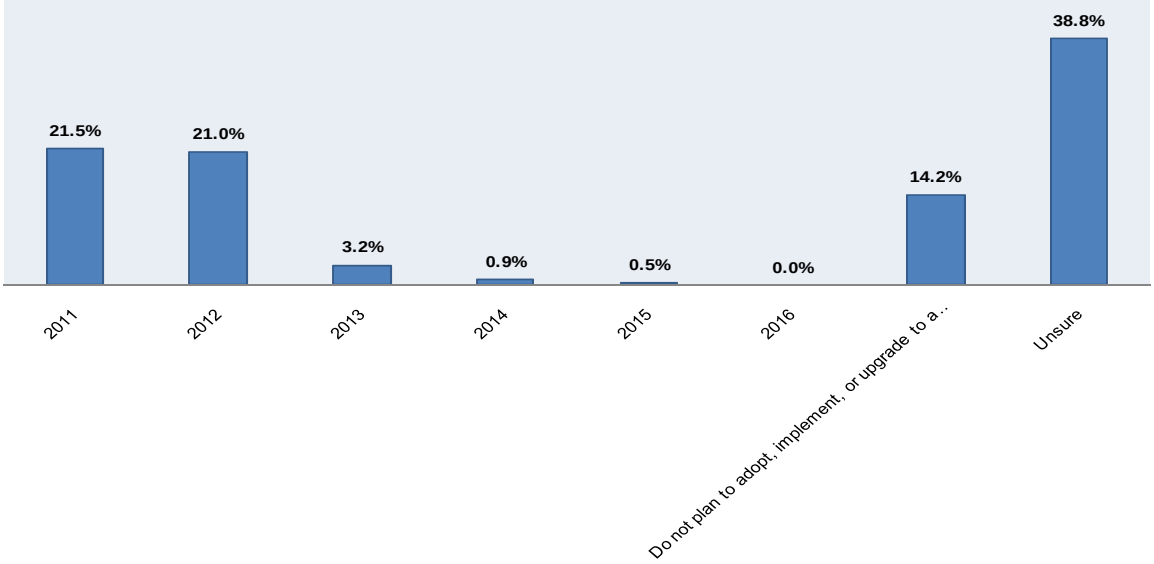


Answer Options	Response Percent	Response Count
Yes	45.7%	100
No	6.4%	14
Unsure	47.9%	105
	answered question	219
	skipped question	334

Urban versus Rural

Answer Options	Urban	Urban %	Rural	Rural %
Yes	69	46%	31	46%
No	7	5%	7	10%
Unsure	74	49%	30	44%
answered question	150	100%	68	100%

When do you plan to adopt, implement, or upgrade to a certified EHR system? (q13) Year of Adopt, Implement, or Upgrade or EHR



Answer Options	Response Percent	Response Count
2011	21.5%	47
2012	21.0%	46
2013	3.2%	7
2014	0.9%	2
2015	0.5%	1
2016	0.0%	0
Do not plan to adopt, implement, or upgrade to a certified EHR system	14.2%	31
Unsure	38.8%	85
answered question		219
skipped question		334

Urban versus Rural

Answer Options	Urban	Urban %	Rural	Rural %
2011	29	23%	17	19%
2012	17	*13%*	29	*32%*
2013	5	4%	2	2%
2014	2	2%	0	0%
2015	1	1%	0	0%
2016	0	0%	0	0%
Do not plan to adopt, implement, or upgrade to a certified EHR system	18	14%	13	14%
Unsure	55	*43%*	*30*	*33%*
answered question	127	100%	91	100%

Please indicate the barriers to your primary place of practice purchasing a certified EHR system. (Select all that apply) (q14)

Answer Options	Response Percent	Response Count
Cost associated with purchase	61.3%	68
Cost associated with implementation and training of staff	57.7%	64
Cost associated with maintenance and upkeep	55.0%	61
Time associated with staff training and education	45.9%	51
Satisfied with current paper system	35.1%	39
Lack of knowledge and understanding about EHR technology	31.5%	35
Staff lacks the expertise to use EHR technology	20.7%	23
Unsure which certified EHR system to purchase	18.9%	21
Lack of technical staff resources	18.0%	20
Unsure	17.1%	19
Insufficient staff resources	16.2%	18
Security/privacy concerns	15.3%	17
Other	9.0%	10
Limited broadband availability	6.3%	7
Satisfied with current EHR system	5.4%	6
Satisfied with current EMR system	1.8%	2
answered question		111
skipped question		442

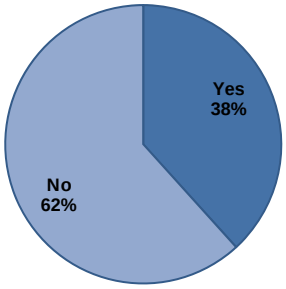
Urban versus Rural

Answer Options	Urban	Urban %	Rural	Rural %
Cost associated with purchase	39	58%	29	67%
Cost associated with implementation and training of staff	35	*52%*	29	*67%*
Cost associated with maintenance and upkeep	33	*49%*	28	*65%*
Time associated with staff training and education	32	48%	19	44%
Satisfied with current paper system	25	37%	14	33%
Satisfied with current EHR system	4	6%	2	5%
Satisfied with current EMR system	1	1%	1	2%
Unsure which certified EHR system to purchase	11	16%	10	23%
Lack of knowledge and understanding about EHR technology	17	*25%*	18	*42%*
Staff lacks the expertise to use EHR technology	11	*16%*	12	*28%*
Lack of technical staff resources	10	15%	10	23%
Limited broadband availability	2	3%	5	12%
Insufficient staff resources	12	18%	6	14%
Security/privacy concerns	11	16%	6	14%
Unsure	12	18%	7	16%
Other	9	13%	0	0%
Comments	12	18%	2	5%
answered question	67	100%	43	100%

III. Meaningful Use

Do you know the requirements for becoming a Meaningful User of EHR technology? (q29)

Know the Requriements Meaningful Use



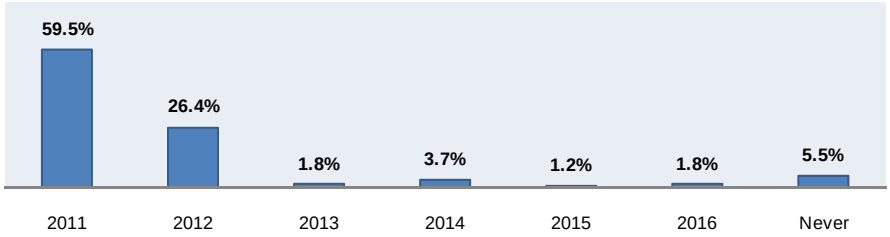
Answer Options	Response Percent	Response Count
Yes	38.3%	165
No	61.7%	266
answered question		431
skipped question		122

Urban versus Rural

Answer Options	Urban	Urban %	Rural	Rural %
Yes	107	39%	57	37%
No	166	61%	97	63%
answered question	273	100%	154	100%

What year do you plan to become a Meaningful User of EHR technology? (q30)

Year of Becoming a Meaningful EHR User



Answer Options	Response Percent	Response Count
2011	59.5%	97
2012	26.4%	43
2013	1.8%	3
2014	3.7%	6
2015	1.2%	2
2016	1.8%	3
Never	5.5%	9
answered question		163
skipped question		390

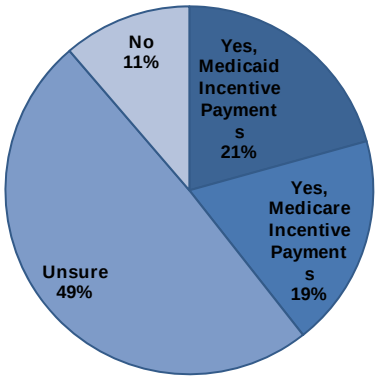
Urban VS Rural

Answer Options	Urban	Urban %	Rural	Rural %
2011	65	*62%*	32	*55%*
2012	22	*21%*	21	*36%*
2013	3	3%	0	0%
2014	4	4%	2	3%
2015	1	1%	1	2%
2016	2	2%	1	2%
Never	8	8%	1	2%
answered question	105	100%	58	100%

IV. MCD Incentive Program

Do you plan to apply for either the Medicare or Medicaid EHR incentive payments? (q15)

Plan to Apply for Medicaid or Medicare Incentive Payments

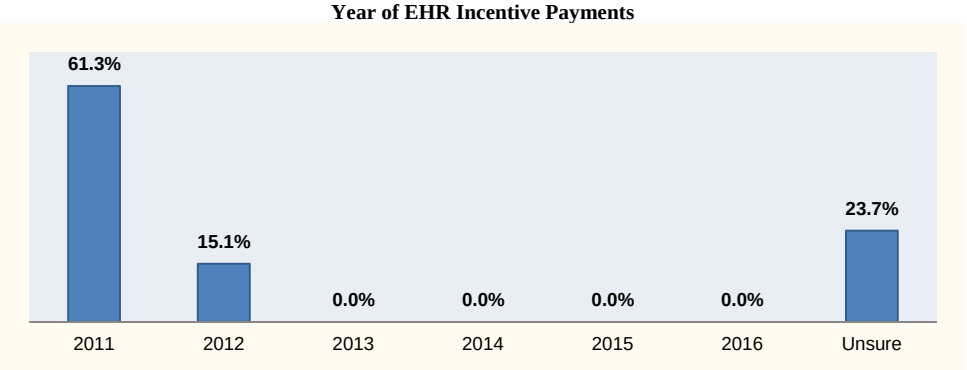


Answer Options	Response Percent	Response Count
Yes, Medicaid Incentive Payments	20.7%	93
Yes, Medicare Incentive Payments	18.7%	84
Unsure	49.3%	222
No	11.3%	51
answered question		450
skipped question		103

Urban versus Rural

Answer Options	Urban	Urban %	Rural	Rural %
Yes, Medicaid Incentive Payments	60	21%	33	20%
Yes, Medicare Incentive Payments	48	17%	35	22%
Unsure	138	48%	82	51%
No	39	14%	11	7%
answered question	285	100%	161	100%

What is the first year you plan to apply for Medicaid EHR incentive payments? (q16)

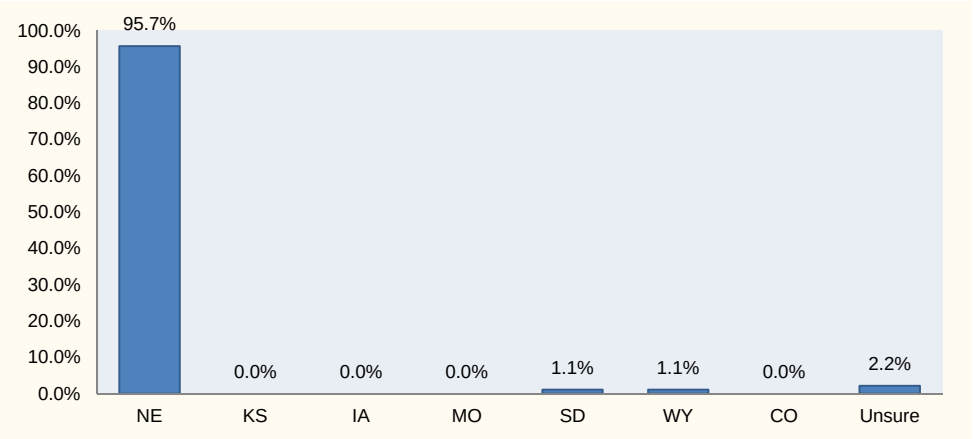


Answer Options	Response Percent	Response Count
2011	61.3%	57
2012	15.1%	14
2013	0.0%	0
2014	0.0%	0
2015	0.0%	0
2016	0.0%	0
Unsure	23.7%	22
answered question		93
skipped question		460

Urban versus Rural

Answer Options	Urban	Urban %	Rural	Rural %
2011	41	*67%*	16	*50%*
2012	8	13%	6	19%
Unsure	12	*20%*	10	*31%*
2013	0	0%	0	0%
2014	0	0%	0	0%
2015	0	0%	0	0%
2016	0	0%	0	0%
answered question	61	100%	32	100%

In which state do you plan to apply for Medicaid EHR incentive payments? (q17)

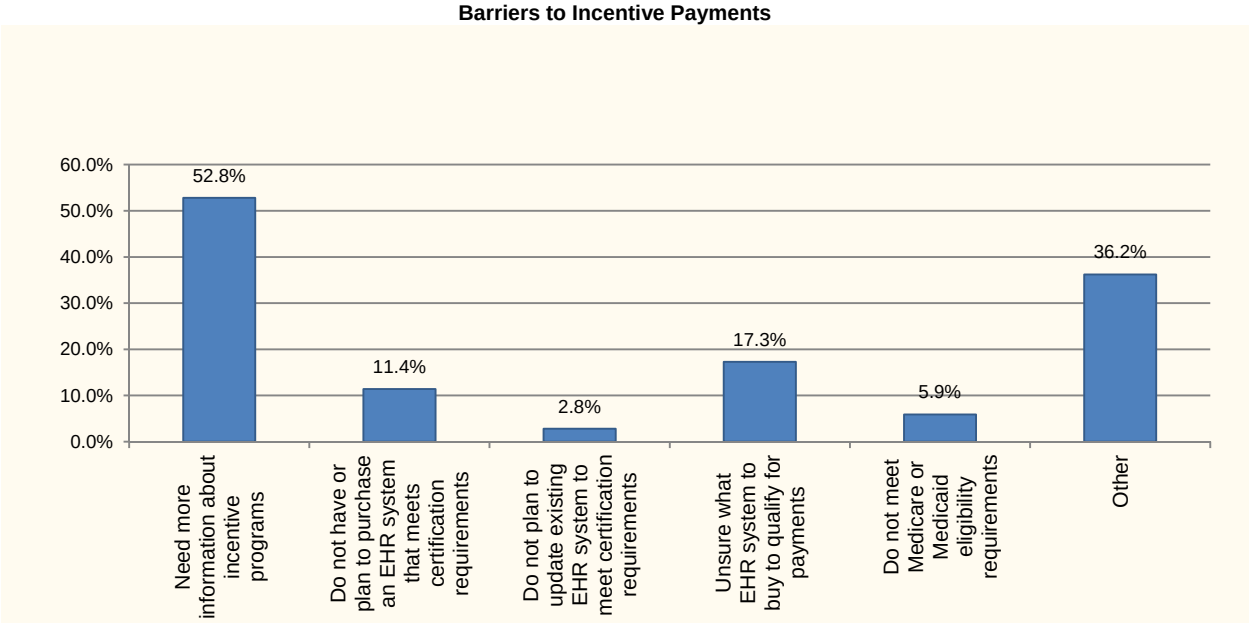


Answer Options	Response Percent	Response Count
NE	95.7%	89
KS	0.0%	0
IA	0.0%	0
MO	0.0%	0
SD	1.1%	1
WY	1.1%	1
CO	0.0%	0
Unsure	2.2%	2
answered question		93
skipped question		460

Urban versus Rural

Answer Options	Urban	Urban %	Rural	Rural %
NE	60	98%	29	91%
SD	0	0%	1	3%
WY	0	0%	1	3%
Unsure	1	2%	1	3%
KS	0	0%	0	0%
IA	0	0%	0	0%
MO	0	0%	0	0%
CO	0	0%	0	0%
answered question	61	100%	32	100%

What are the reasons for being unsure or not seeking Medicare or Medicaid EHR incentive payments? (Select all that apply) (q18)



Answer Options	Response Percent	Response Count
Need more information about incentive programs	52.8%	134
Do not have or plan to purchase an EHR system that meets certification requirements	11.4%	29
Do not plan to update existing EHR system to meet certification requirements	2.8%	7
Unsure what EHR system to buy to qualify for payments	17.3%	44
Do not meet Medicare or Medicaid eligibility requirements	5.9%	15
Other	36.2%	92
answered question		254
skipped question		299

Urban VS Rural

Answer Options	Urban	Urban %	Rural	Rural %
Need more information about incentive programs	76	46%	57	66%
Do not have or plan to purchase an EHR system that meets certification requirements	18	11%	11	13%
Do not plan to update existing EHR system to meet certification requirements	2	1%	5	6%
Unsure what EHR system to buy to qualify for payments	24	15%	20	23%
Do not meet Medicare or Medicaid eligibility requirements	12	7%	3	3%
Other	71	43%	19	22%
answered question	165	100%	86	100%

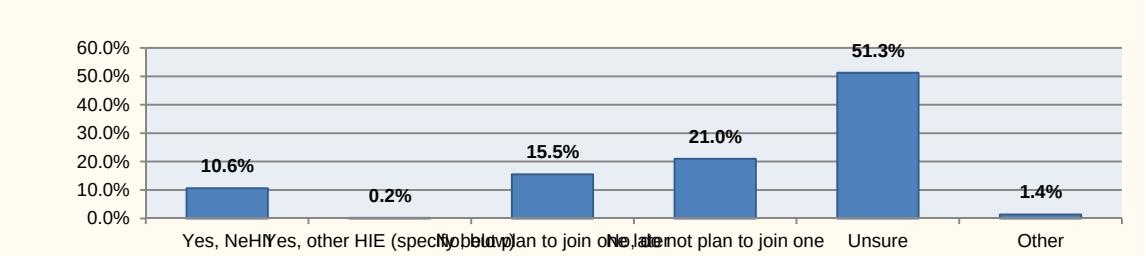
Please enter the best estimate of your individual patient volume. (q8)

Patient Mix	19% or less	20%	21%	22%	23%	24%	25%	26%	27%	28%	29%	30% or more	Response Count
Medicaid Count	231	42	0	2	2	3	47	1	4	1	1	110	444
Percentage	52%	9%	0%	0%	0%	1%	11%	0%	1%	0%	0%	25%	
Needy Patient Count	279	33	0	1	0	1	15	0	1	1	1	81	413
Percentage	68%	8%	0%	0%	0%	0%	4%	0%	0%	0%	0%	20%	
											answered question		451
											skipped question		102

V. HIE

Does your primary place of practice participate with the Nebraska Health Information Initiative (NeHII) or another regional Health Information Exchange (q26)

Join HIE



Answer Options	Response Percent	Response Count
Yes, NeHII	10.6%	46
Yes, other HIE (specify below)	0.2%	1
No, but plan to join one later	15.5%	67
No, do not plan to join one	21.0%	91
Unsure	51.3%	222
Other	1.4%	6
answered question		433
skipped question		120

Urban versus Rural

Answer Options	Urban	Urban %	Rural	Rural %
Yes, NeHII	37	13%	8	5%
Yes, other HIE (specify below)	0	0%	1	1%
No, but plan to join one later	42	15%	25	16%
No, do not plan to join one	53	19%	38	24%
Unsure	139	51%	83	53%
Other	4	1%	2	1%
Comments	6	2%	4	3%
answered question	275	100%	157	100%

Please indicate the barriers to your primary place of practice joining an available HIE. (Select all that apply) (q27)

Answer Options	Response Percent	Response Count
Lack of knowledge and understanding about HIE	45.3%	43
Cost associated with fees	41.1%	39
Cost associated with implementation and training of staff	38.9%	37
Satisfied with existing manual process to obtain patient data	34.7%	33
Security/privacy concerns	32.6%	31
Insufficient staff resources	31.6%	30
Current product does not support HIE	21.1%	20
Lack of technical staff resources	21.1%	20
Unsure	21.1%	20
Limited broadband availability	10.5%	10
Other	2.1%	2
answered question		95
skipped question		458

Urban Vs Rural

Answer Options	Urban	Urban %	Rural	Rural %
Current product does not support HIE	9	*16%*	11	*28%*
Cost associated with fees	24	44%	15	38%
Cost associated with implementation and training of staff	21	38%	16	41%
Lack of knowledge and understanding about HIE	26	47%	17	44%
Lack of technical staff resources	8	*15%*	12	*31%*
Insufficient staff resources	18	33%	12	31%
Security/privacy concerns	20	36%	11	28%
Satisfied with existing manual process to obtain patient data	26	*47%*	7	*18%*
Limited broadband availability	2	*4%*	8	*21%*
Unsure	9	16%	10	26%
Other	0	0%	2	5%
Comments	1	2%	3	8%
answered question	55	100%	39	100%

VI. Broadband Accessibility

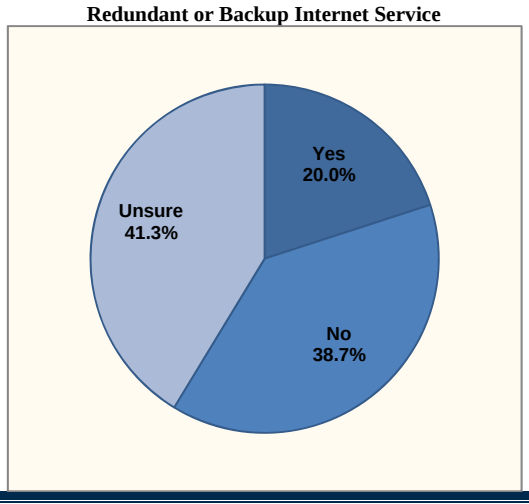
Please select the type(s) of internet service utilized at your primary place of practice. (Select all that apply) (q19)

Answer Options	Response Percent	Response Count
Cable	37.8%	165
Digital Subscriber Line	30.0%	131
Unsure	22.0%	96
T-1	12.1%	53
Other	3.0%	13
None	1.4%	6
Satellite	0.2%	1
Dial-up	0.2%	1
answered question		437
skipped question		116

Urban versus Rural

Answer Options	Urban	Urban %	Rural	Rural %
Cable	123	*44%*	42	*27%*
Digital Subscriber Line	60	*22%*	71	*46%*
T-1	32	12%	20	13%
Satellite	1	0%	0	0%
Dial-up	1	0%	0	0%
None	1	0%	5	3%
Unsure	68	24%	26	17%
Other	9	3%	3	2%
Comments	10	4%	5	3%
answered question	278	100%	155	100%

Does your primary place of practice have redundant or back-up internet services? (q22)

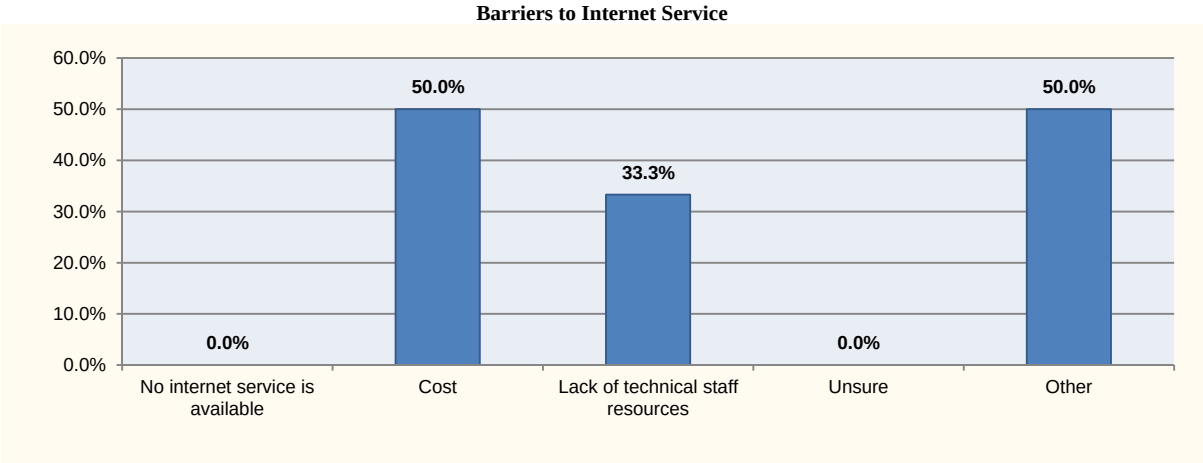


Answer Options	Response Percent	Response Count
Yes	20.0%	86
No	38.7%	167
Unsure	41.3%	178
answered question		431
skipped question		122

Urban versus Rural

Answer Options	Urban	Urban %	Rural	Rural %
Yes	64	23%	22	14%
No	98	36%	69	45%
Unsure	114	41%	62	41%
answered question	276	100%	153	100%

Please indicate why your primary place of practice does not have internet service. (Select all that apply) (q21)

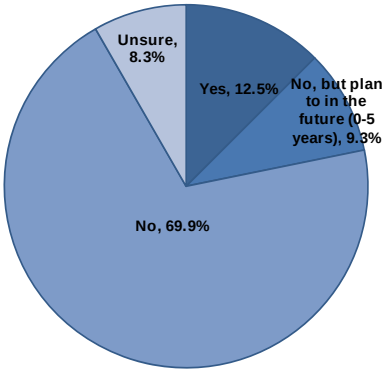


Answer Options	Response Percent	Response Count
No internet service is available	0.0%	0
Cost	50.0%	3
Lack of technical staff resources	33.3%	2
Unsure	0.0%	0
Other	50.0%	3
answered question		6
skipped question		547

VII. HIT Modules

Does your primary place of practice use Telemedicine to provide patient care? (q28)

Use of Telemedicine



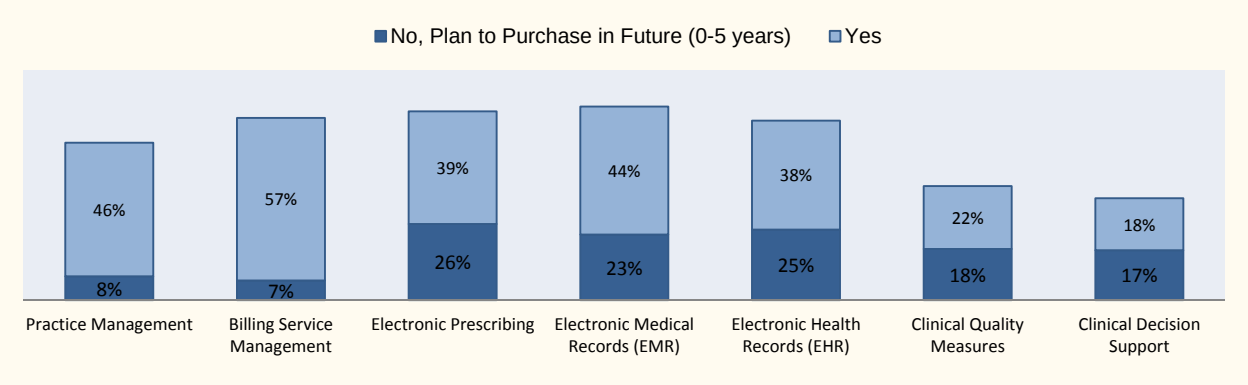
Answer Options	Response Percent	Response Count
Yes	12.5%	54
No, but plan to in the future (0-5 years)	9.3%	40
No	69.9%	302
Unsure	8.3%	36
answered question		432
skipped question		121

Urban versus Rural

Answer Options	Urban	Urban %	Rural	Rural %
Yes	30	11%	23	15%
No, but plan to in the future (0-5 years)	20	7%	20	13%
No	193	70%	108	70%
Unsure	32	12%	4	3%

Please indicate which of the following HIT modules are in use at your primary place of practice. (q31)

HIT Module - Yes and Plan to within Five Years



Answer Options	Yes	No, Plan to Purchase in Future (0-5 years)	No, Do Not Plan to Purchase	Unsure	Response Count
Practice Management	196	35	52	139	422
Billing Service Management	239	29	52	103	423
Electronic Prescribing	164	111	66	78	419
Electronic Medical Records	185	95	57	79	416
Electronic Health Records	159	103	51	107	420
Clinical Quality Measures	91	74	74	177	416
Clinical Decision Support	75	72	69	199	415
answered question					426
skipped question					127

Urban versus Rural

Practice Management

Answer Options	Urban		Rural	
Yes	126	47%	70	45%
No, Plan to Purchase in Future (0-5 years)	17	6%	18	12%
No, Do Not Plan to Purchase	30	11%	22	14%
Unsure	95	35%	42	27%

Billing Service Management

Answer Options	Urban		Rural	
Yes	152	57%	86	56%
No, Plan to Purchase in Future (0-5 years)	15	6%	14	9%
No, Do Not Plan to Purchase	33	12%	19	12%
Unsure	68	25%	34	22%

Electronic Prescribing

Answer Options	Urban		Rural	
Yes	115	*43%*	48	*31%*
No, Plan to Purchase in Future (0-5 years)	52	*20%*	59	*38%*
No, Do Not Plan to Purchase	43	16%	23	15%
Unsure	55	21%	22	14%

Electronic Medical Records

Answer Options	Urban		Rural	
Yes	124	47%	61	40%
No, Plan to Purchase in Future (0-5 years)	50	19%	44	29%
No, Do Not Plan to Purchase	36	14%	21	14%
Unsure	55	21%	23	15%

Electronic Health Records (EHR)

Answer Options	Urban		Rural	
Yes	103	39%	56	36%
No, Plan to Purchase in Future (0-5 years)	56	21%	47	31%
No, Do Not Plan to Purchase	32	12%	19	12%
Unsure	76	28%	29	19%

Clinical Quality Measures

Answer Options	Urban		Rural	
Yes	52	20%	39	25%
No, Plan to Purchase in Future (0-5 years)	42	16%	31	20%
No, Do Not Plan to Purchase	50	19%	24	16%
Unsure	118	45%	58	38%

Clinical Decision Support

Answer Options	Urban		Rural	
Yes	47	18%	28	18%
No, Plan to Purchase in Future (0-5 years)	41	16%	30	19%
No, Do Not Plan to Purchase	44	17%	25	16%
Unsure	130	50%	68	44%

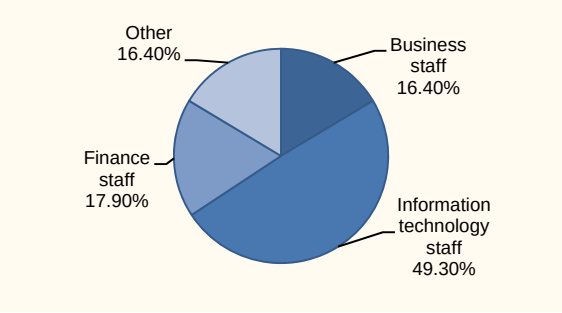
Appendix E: Eligible Hospital Survey Results

Please note that the responses reported below are not in survey questionnaire order. The order presented is designed to follow the analysis and findings of the report in the SMHP, Section 3.1.2 – Provider Surveys. Additionally, certain responses have been omitted because the information provided in the question was intended to provide stratification data and not other substantive data.

I. Survey Participant Description

What best describes your professional category? (q2)

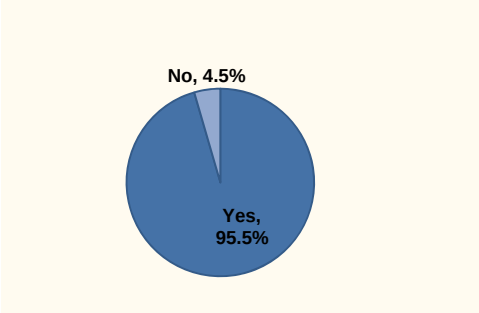
Professional Category



Answer Options	Response Percent	Response Count
Business staff	16.4%	11
Information technology staff	49.3%	33
Finance staff	17.9%	12
Other	16.4%	11
answered question		67
skipped question		2

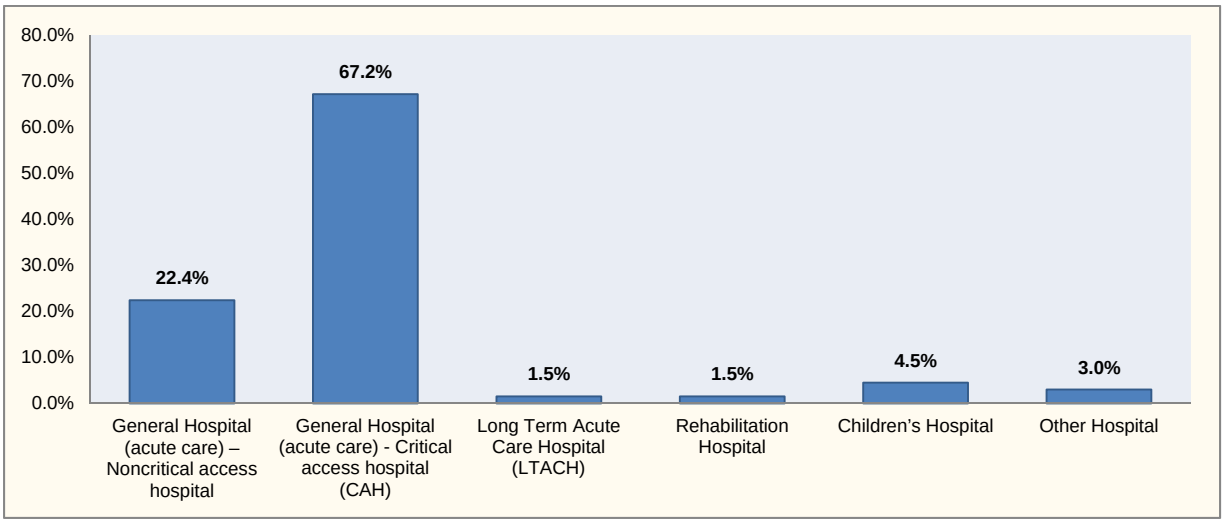
Please indicate if the hospital is an enrolled Medicaid provider. (q5)

Medicaid Provider



Answer Options	Response Percent	Response Count
Yes	95.5%	63
No	4.5%	3
answered question		66
skipped question		3

What best categorizes the hospital type? (Q3)



Answer Options	Response Percent	Response Count
General Hospital (acute care) - Critical access hospital	67.2%	45
General Hospital (acute care) – Noncritical access hospital	22.4%	15
Children's Hospital	4.5%	3
Other Hospital	3.0%	2
Long Term Acute Care Hospital	1.5%	1
Rehabilitation Hospital	1.5%	1
answered question		67
skipped question		2

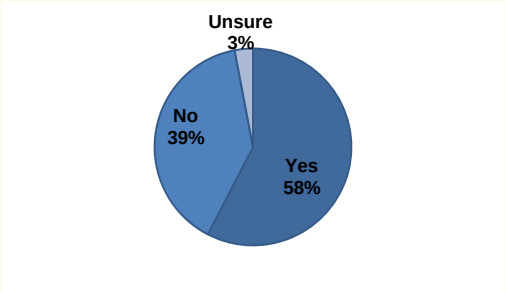
Urban versus Rural

Answer Options	Urban	Urban %	Rural	Rural %
General Hospital (acute care) – Noncritical access hospital	10	*59%*	5	*10%*
General Hospital (acute care) - Critical access hospital	1	*6%*	43	*88%*
Long Term Acute Care Hospital	1	6%	0	0%
Rehabilitation Hospital	1	6%	0	0%
Children's Hospital	3	18%	0	0%
Other Hospital	1	6%	1	2%
Comments	1	6%	1	2%
answered question	17	100%	49	100%
skipped question				

II. Electronic Health Record (EHR) Use

Does the hospital currently utilize an EHR system? (q7)

Current Utilization of EHR System



Answer Options	Response Percent	Response Count
Yes	57.6%	38
No	39.4%	26
Unsure	3.0%	2
answered question		66
skipped question		3

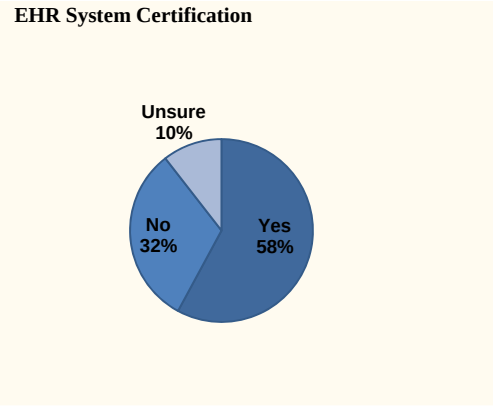
Stratification by Hospital Type

Answer Options	General Hospital (acute care) – Noncritical access hospital	General Hospital (acute care) – Noncritical access hospital Percentage	General Hospital (acute care) - Critical access hospital (CAH)	General Hospital (acute care) - Critical access hospital (CAH) Percentage
Yes	13	*87%*	21	*47%*
No	2	*13%*	22	*49%*
Unsure	0	*0%*	2	*4%*
answered question	15	100%	45	100%
skipped question	0	0%	0	0%

Urban versus Rural

Answer Options	Urban	Urban %	Rural	Rural %
Yes	14	*88%*	23	*47%*
No	2	*13%*	24	*49%*
Unsure	0	*0%*	2	*4%*
answered question	16	*100%*	49	*100%*

Please indicate if the EHR system in place is certified. (q10)



Answer Options	Response Percent	Response Count
Yes	57.9%	22
No	31.6%	12
Unsure	10.5%	4
answered question		38
skipped question		31

Hospital Type Stratification

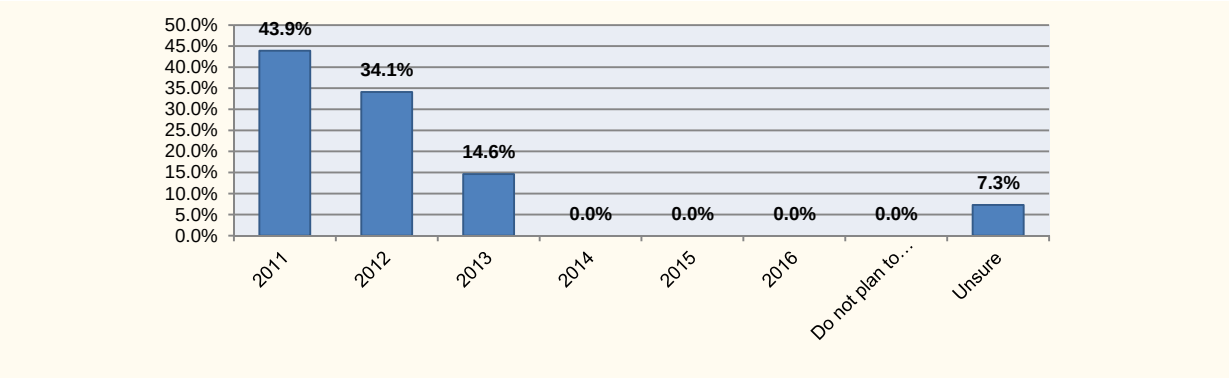
Answer Options	General Hospital (acute care) – Noncritical access hospital	General Hospital (acute care) – Noncritical access hospital percentage	General Hospital (acute care) - Critical access hospital (CAH)	General Hospital (acute care) - Critical access hospital (CAH) Percentage
Yes	5	*38%*	15	*71%*
No	8	*62%*	3	*14%*
Unsure	0	*0%*	3	*14%*
answered question	13	100%	21	100%
skipped question	0	0%	0	0%

Stratification by Urban Vs Rural

Answer Options	Urban	Urban %	Rural	Rural %
Yes	5	*36%*	16	*70%*
No	7	*50%*	5	*22%*
Unsure	2	*14%*	2	*9%*
answered question	14	100%	23	100%

When do you plan to adopt, implement, or upgrade to a certified EHR system? (q11)

Year of Adopt, Implement, or Upgrade a certified EHR system



Answer Options	Response Percent	Response Count
2011	43.9%	18
2012	34.1%	14
2013	14.6%	6
2014	0.0%	0
2015	0.0%	0
2016	0.0%	0
Do not plan to adopt, implement, or upgrade to a certified EHR system	0.0%	0
Unsure	7.3%	3
answered question		41
skipped question		28

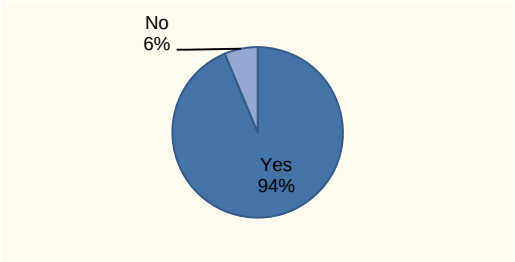
Please indicate the barriers to purchasing an EHR system. (Select all that apply) (q12)

Answer Options	Response Percent	Response Count
Unsure which certified EHR system to purchase	100.0%	3
Cost associated with purchase	66.7%	2
Lack of knowledge and understanding about EHR technology	66.7%	2
Cost associated with maintenance and upkeep	33.3%	1
Lack of technical staff resources	33.3%	1
Cost associated with implementation and training of staff	0.0%	0
Time associated with staff training and education	0.0%	0
Satisfied with current paper system	0.0%	0
Satisfied with current EHR system	0.0%	0
Satisfied with current EMR system	0.0%	0
Staff lacks the expertise to use EHR technology	0.0%	0
Limited broadband availability	0.0%	0
Insufficient staff resources	0.0%	0
Security/privacy concerns	0.0%	0
Unsure	0.0%	0
Other	0.0%	0
answered question		3
skipped question		66

III. Meaningful Use

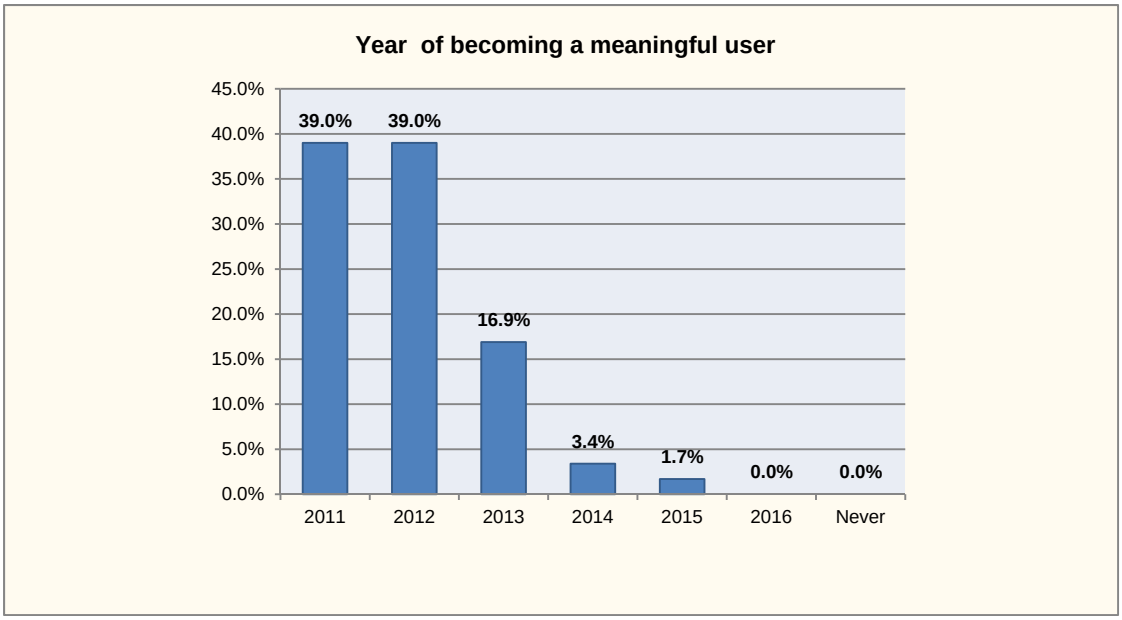
Do you know the requirements for becoming a Meaningful User of EHR technology? (q27)

Knowledge of Meaningful Use of EHR Technology



Answer Options	Response Percent	Response Count
Yes	93.7%	59
No	6.3%	4
answered question		63

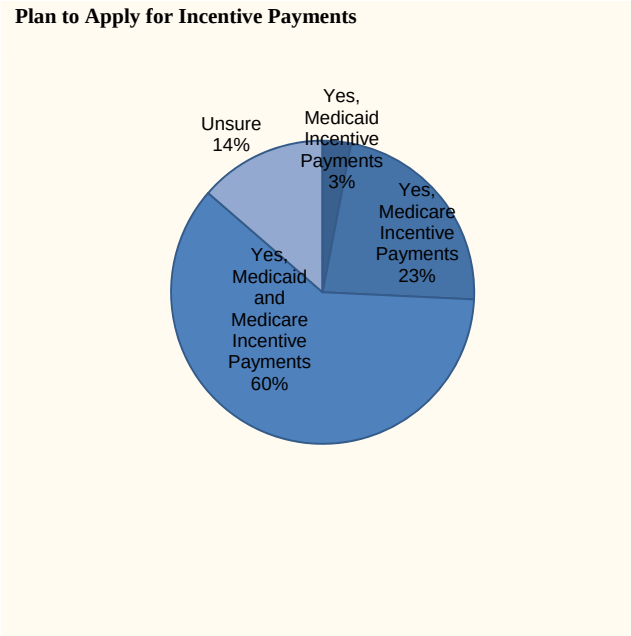
What year does the hospital plan to become a Meaningful User of EHR technology? (q28)



Answer Options	Response Percent	Response Count
2011	39.0%	23
2012	39.0%	23
2013	16.9%	10
2014	3.4%	2
2015	1.7%	1
2016	0.0%	0
Never	0.0%	0
answered question		59
skipped question		10

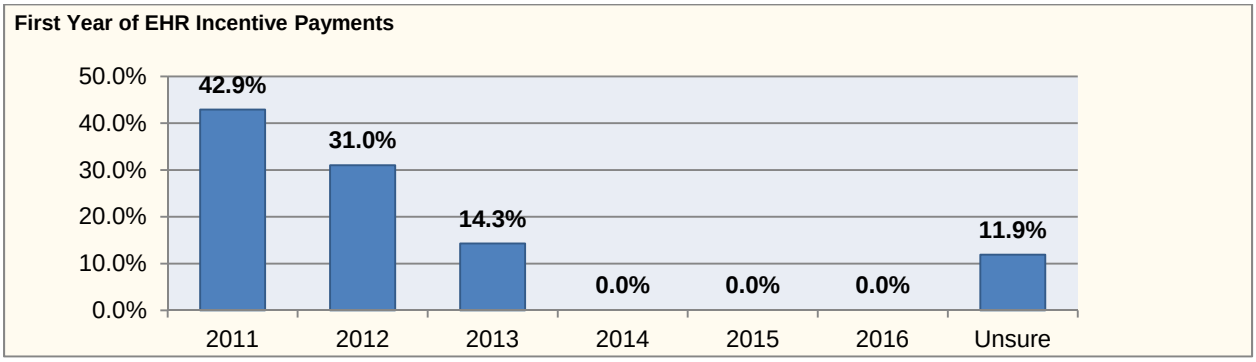
IV. Medicaid Incentive Program

Does the hospital plan to apply for EHR incentive payments? (q13)



Answer Options	Response Percent	Response Count
Yes, Medicaid Incentive Payments	3.0%	2
Yes, Medicare Incentive Payments	22.7%	15
Yes, Medicaid and Medicare Incentive Payments	60.6%	40
Unsure	13.6%	9
No	0.0%	0
answered question		66
skipped question		3

What is the first year the hospital plans to apply for Medicaid EHR incentive payments? (q14)

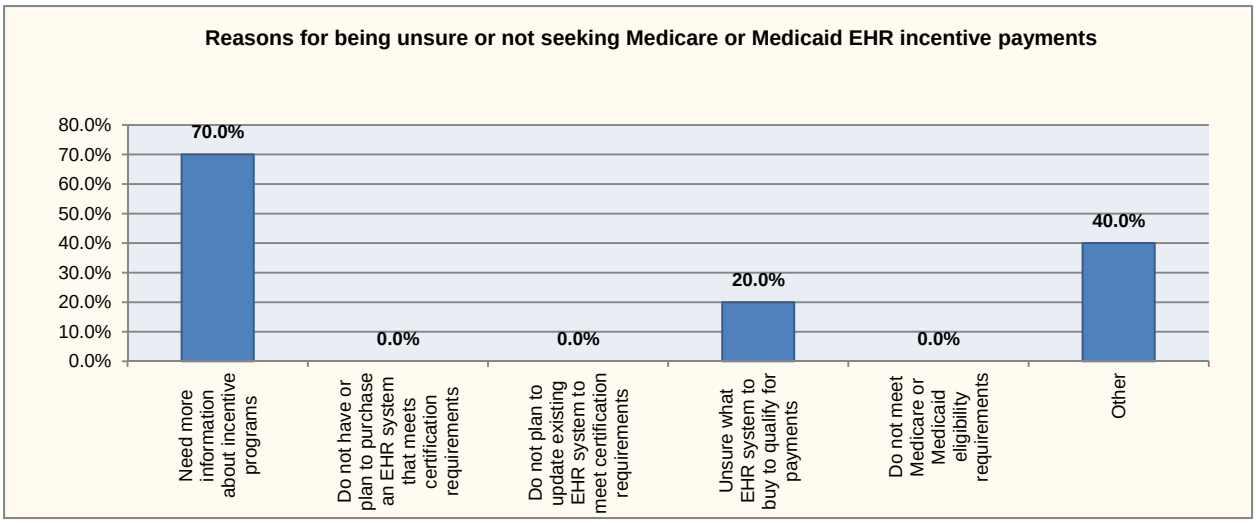


Answer Options	Response Percent	Response Count
2011	42.9%	18
2012	31.0%	13
2013	14.3%	6
2014	0.0%	0
2015	0.0%	0
2016	0.0%	0
Unsure	11.9%	5
answered question		42
skipped question		27

In which state does the hospital plan to apply for Medicaid EHR incentive payments? (q15)

Answer Options	Response Percent	Response Count
NE	100.0%	42
KS	0.0%	0
IA	0.0%	0
MO	0.0%	0
SD	0.0%	0
WY	0.0%	0
CO	0.0%	0
Unsure	0.0%	0
answered question		42
skipped question		27

What are the reasons for being unsure or not seeking Medicare or Medicaid EHR incentive payments? (Select all that apply) (q16)



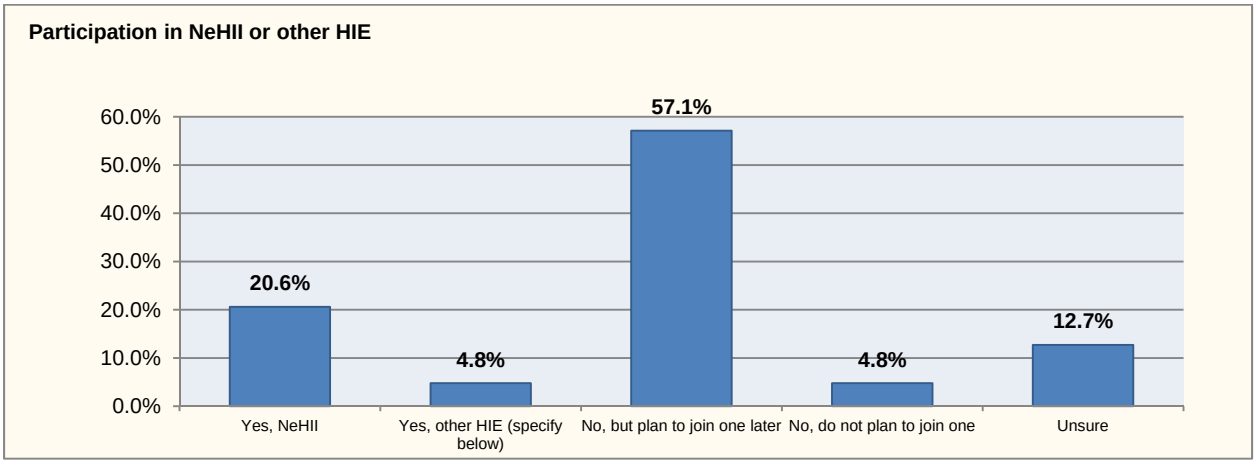
Answer Options	Response Percent	Response Count
Need more information about incentive programs	70.0%	7
Do not have or plan to purchase an EHR system that meets certification requirements	0.0%	0
Do not plan to update existing EHR system to meet certification requirements	0.0%	0
Unsure what EHR system to buy to qualify for payments	20.0%	2
Do not meet Medicare or Medicaid eligibility requirements	0.0%	0
Other	40.0%	4
answered question		10
skipped question		59

Please describe the hospital's payer mix by percentage. (q6)

Answer Options	0%	1%	2%	3%	4%	5%	6%	7%	8%	9%	10 or more %	Response Count
Medicaid #	1	0	0	1	3	10	5	4	5	1	**32**	62
Medicaid %	2%	0%	0%	2%	5%	16%	8%	6%	8%	2%	**52%**	
Medicare #	1	0	0	0	0	1	1	0	1	1	**56**	61
Medicare %	2%	0%	0%	0%	0%	2%	2%	0%	2%	2%	**92%**	
answered question												62
skipped question												7

V. Health Information Exchange (HIE)

Does the hospital participate with the Nebraska Health Information Initiative (NeHII) or another regional Health Information Exchange (HIE)? (q24)



Answer Options	Response Percent	Response Count
No, but plan to join one later	57.1%	36
Yes, NeHII	20.6%	13
Unsure	12.7%	8
Yes, other HIE (specify below)	4.8%	3
No, do not plan to join one	4.8%	3
answered question		63
skipped question		6

Please indicate the hospital's barriers to joining an available HIE. (Select all that apply) (q25)

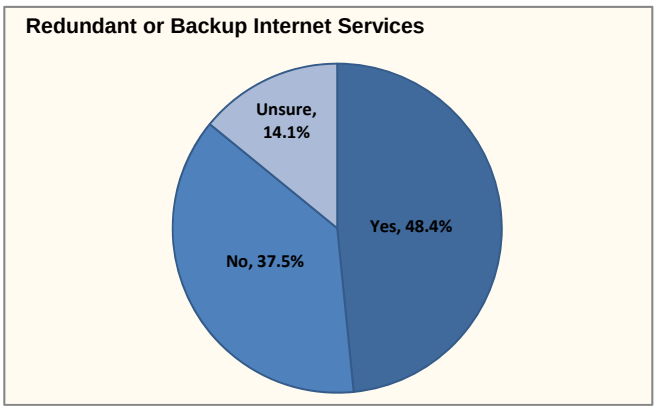
Answer Options	Response Percent	Response Count
Cost associated with fees	100.0%	3
Cost associated with implementation and training of staff	66.7%	2
Security/privacy concerns	66.7%	2
Current product does not support HIE	33.3%	1
Lack of knowledge and understanding about HIE	33.3%	1
Lack of technical staff resources	33.3%	1
Insufficient staff resources	33.3%	1
Limited broadband availability	33.3%	1
Satisfied with existing manual process to obtain patient data	0.0%	0
Unsure	0.0%	0
Other	0.0%	0
answered question		3
skipped question		66

VI. Broadband Accessibility

Please select the type(s) of internet service utilized by the hospital. (Select all that apply) (q17)

Answer Options	Response Percent	Response Count
T-1	50.8%	33
Digital Subscriber Line	46.2%	30
Cable	30.8%	20
Other	13.8%	9
Dial-up	1.5%	1
Unsure	1.5%	1
Satellite	0.0%	0
None	0.0%	0
answered question		65
skipped question		4

Does the hospital have redundant or back-up internet services? (q20)



Answer Options	Response Percent	Response Count
Yes	48.4%	31
No	37.5%	24
Unsure	14.1%	9
answered question		64
Skipped questions		5

Hospital Type Stratification

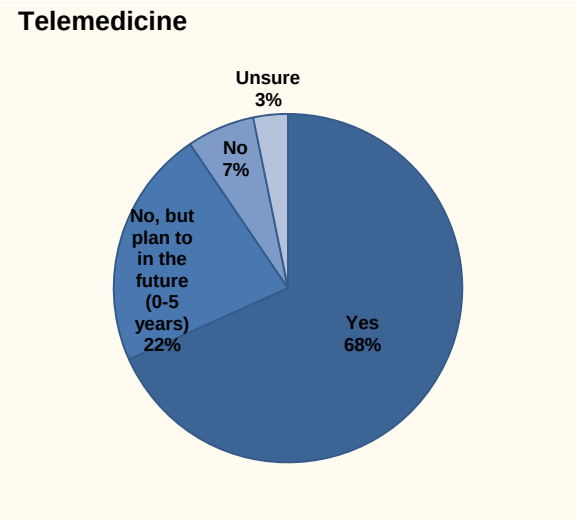
Answer Options	General Hospital (acute care) – Noncritical access hospital	General Hospital (acute care) – Noncritical access hospital Percentage	General Hospital (acute care) - Critical access hospital (CAH)	General Hospital (acute care) - Critical access hospital (CAH) Percentage
Yes	11	*79%*	16	*36%*
No	2	*14%*	21	*48%*
Unsure	1	*7%*	7	*16%*
answered question	14	100%	44	100%
skipped question	0	0%	0	0%

Please indicate why the hospital does not have internet service. (Select all that apply) (q19)

Answer Options	Response Percent	Response Count
No internet service is available	0.0%	0
Cost	0.0%	0
Lack of technical resources	0.0%	0
Unsure	0.0%	0
Other	0.0%	0
Comments	0.0%	0
answered question		0
skipped question		69

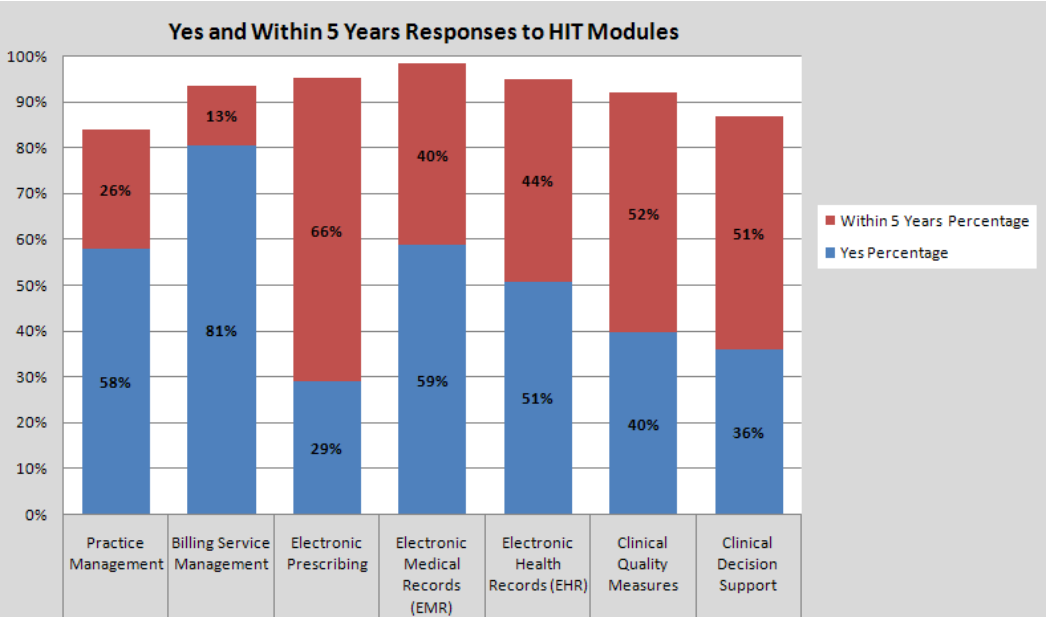
VII. Health Information Technology (HIT)

Does the hospital use Telemedicine to provide patient care? (q26)



Answer Options	Response Percent	Response Count
Yes	68.3%	43
No, but plan to in the future (0-5 years)	22.2%	14
No	6.3%	4
Unsure	3.2%	2
answered question		63
skipped question		6

Please indicate which of the following HIT modules are in use at the hospital. (q29)



Answer Options	Yes	Yes Percentage	No, Plan to Purchase in Future (0-5 years)	Within 5 Years Percentage	Response Count
Practice Management	36	58%	16	26%	62
Billing Service Management	50	81%	8	13%	62
Electronic Prescribing	18	29%	41	66%	62
Electronic Medical Records	37	59%	25	40%	63
Electronic Health Records	31	51%	27	44%	61
Clinical Quality Measures	25	40%	33	52%	63
Clinical Decision Support	22	36%	31	51%	61
answered question					**63**
skipped question					**6**

Urban versus Rural Practice Management

Answer Options	Urban	Urban %	Rural	Rural %
Yes	13	*87%*	23	*50%*
No, Plan to Purchase in Future (0-5 years)	2	*13%*	14	*30%*
No, Do Not Plan to Purchase	0	0%	5	*11%*
Unsure	0	0%	4	*9%*

Billing Service Management

Answer Options	Urban	Urban %	Rural	Rural %
Yes	13	87%	36	78%
No, Plan to Purchase in Future (0-5 years)	2	13%	6	13%
No, Do Not Plan to Purchase	0	0%	1	2%
Unsure	1	7%	2	4%

Electronic Prescribing

Answer Options	Urban	Urban %	Rural	Rural %
Yes	5	33%	13	28%
No, Plan to Purchase in Future (0-5 years)	10	67%	30	65%
No, Do Not Plan to Purchase	0	0%	0	0%
Unsure	0	0%	3	7%

Electronic Medical Records

Answer Options	Urban	Urban %	Rural	Rural %
Yes	14	*93%*	22	*48%*
No, Plan to Purchase in Future (0-5 years)	2	*13%*	23	*50%*
No, Do Not Plan to Purchase	0	0%	0	0%
Unsure	0	0%	1	2%

Electronic Health Records

Answer Options	Urban	Urban %	Rural	Rural %
Yes	12	*80%*	*18*	*39%*
No, Plan to Purchase in Future (0-5 years)	2	*13%*	25	*54%*
No, Do Not Plan to Purchase	0	0%	0	0%
Unsure	1	7%	2	4%

Clinical Quality Measures

Answer Options	Urban	Urban %	Rural	Rural %
Yes	11	*73%*	13	*28%*
No, Plan to Purchase in Future (0-5 years)	4	*27%*	29	*63%*
No, Do Not Plan to Purchase	0	0%	0	0%
Unsure	1	7%	4	9%

Clinical Decision Support

Answer Options	Urban	Urban %	Rural	Rural %
Yes	10	*67%*	11	*24%*
No, Plan to Purchase in Future (0-5 years)	4	*27%*	27	*59%*
No, Do Not Plan to Purchase	0	0%	0	0%
Unsure	1	7%	7	15%

Appendix F: NEHII's Board of Directors

NeHII Officers

- **President:** Harris Frankel, MD, Goldner, Cooper, Cotton, Sundell, Frankel, Franco Neurologists, Omaha, NE
- **Vice President:** Ken Lawonn, Alegent Health System, Omaha, NE
- **Secretary:** George Sullivan, Mary Lanning Memorial Hospital, Hastings, NE
- **Treasurer:** Steve Martin, Blue Cross and Blue Shield of Nebraska

NeHII Elected Directors

- Delane Wycoff, MD - Pathology Services PC, North Platte, NE
- Michael Westcott, MD - Alegent Health System, Omaha, NE
- Lisa Bewley - Regional West Medical Center, Scottsbluff, NE
- Roger Hertz - Methodist Health System, Omaha, NE
- Bill Dinsmoor - The Nebraska Medical Center, Omaha, NE
- Ken Foster – BryanLGH Health System, Lincoln, NE
- Gary Perkins – Children's Hospital & Medical Center, Omaha, NE
- Vivianne Chaumont, Director of Medicaid and Long-Term Care, Lincoln, NE
- George Sullivan – Mary Lanning Memorial Hospital, Hastings, NE

NeHII Appointed Directors

- Lt. Gov. Rick Sheehy
- Kevin Conway - Professional Organizations, Nebraska Hospital Association, Lincoln, NE
- Deb Bass - Executive Director, Bass & Associates Inc., Omaha, NE
- Sandy Johnson, Consumer Representative

NeHII Implementation Status

Facility	Start Imp Date	Point Person	Notes
Antelope Memorial Hospital Neligh	2012-09	Merry Sprout	**3/14** - Sent Readiness Assessment and VPN documents **3/28** - Called and left voice mail **4/11** - Called and left voice mail **5/14** - Received an email from Merry Sprout and they will be ready to focus on NeHII in the beginning of June. I will contact Kevin Trease the week of June 4. **7/1** - waiting for Kevin to get an interface engine - suggested MIrth. Installing new software and should be ready for NeHII implementation in September **8/24** - Contacted Kevin Trease and they are ready to implement. I sent the latest HL7 specs, Readiness Assessment and VPN connectiivty documentation. **9/6** - answering questions via email and waiting for paperwork from Kevin Trease
Avera Creighton Hospital Creighton	2012-09	Mark Schulte	Will send Readiness Assessment and VPN document in late June **6/13** - Sent documentation to Kathy Quinlavin **7/16** - Sent email requesting status and offering assistance. The individual missed my original email and will be completing the paperwork. **8/23** - Received email form Mark Schulte that both organizations (Avera Creighton and Avera St. Anthony's is ready to move forward. Scheduling kick off meeting for September. **9/10** - Kick off meeting set for September 26
Avera St. Anthony's Hospital O'Neill	2012-09	Ron Cork	Will send Readiness Assessment and VPN document in late June **6/13** - Sent documentation to Kathy Quinlavin **7/16** - Sent email requesting status and offering assistance. The individual missed my original email and will be completing the paperwork. **8/23** - Received email form Mark Schulte that both organizations (Avera Creighton and Avera St. Anthony's is ready to move forward. Scheduling kick off meeting for September. **9/10** - Kick off meeting set for September 25.
Beatrice Community Hospital	2012-11	Sebastian Sullivan	**7/27** - Sent Readiness Assessment and VPN documentation, sample project plan and kick off meeting agenda. **8/ 13** - Talked to Sebastian Sullivan and they will be ready to begin implementation in November **9/4** - Received confirmation email that they will being implementation on 10/29
Boys Town Research Hospital Omaha	2012-11	Ann Ducey	Will send Readiness Assessment and VPN document in late June **6/19** - Plans to implement in 4th quarter. Will send paperwork in late August. **8/24** - confirmed with Ann Ducey that they will move forward in October. Sending Readiness Assessment and

			VPN connectivity form
BryanLGH Lincoln	2012-05 - 2012-12	Teri Baer	**3/27** - Conference call to review completed Readiness Assessment and VPN documentation. Unable to commit to implementation date. Will implement in stages. **5/14** - The VPN form was incomplete. Have requested additional information from Karen Kisinski twice. Meeting scheduled for May 25. **6/6** - Deb and Chris are meeting with George Carr **9/10** - Sent RFP to Ed Duryee
Cass County Health System Atlantic, IA	2012-08	Steve Stark	**5/22** - Sent Readiness Assessment and VPN documentation **6/26** - Follow up concerning documents **8/11** - Received VPN Connectivity form **8/16** - Sent Readiness Assessment form **8/20** - Joni sent follow up email with sample kick off meeting agenda **8/28** - Received Readiness Assessment and VPN **9/13** - suggested dates for next week for Kick Off meeting
Chase County Community Hospital Imperial	2012-12	Jennifer Harris	**2/21** - Received Readiness Assessment **3/28** - Received VPN document **4/6** - Due to the cost from Healthland, NeHII implementation must be postponed until next fiscal year. **7/16** - left voice mail for Jennifer Harris **8/9** - Talked to Jennifer and set up a meeting **8/20** - Conference call with Jennifer Harris and Dustin (IT person at Chase County). They are ready to go if they do not have to pay duplicate interface fees. Blake Heidecker should get back to Deb on 8/24. **9/6** - Talked to Jennifer Harris and they are ready to move forward-paperwork complete.
Columbus Community Hospital Columbus	2012-05	Cheryl Tira	Readiness Assessment and VPN documents complete and sent to Axolotl **5/15** - NeHII team going to Columbus for kick-off meeting **5/18** - Sample ADT information has been sent and mapped. Lab information sent on Friday and will be mapped by 5/22. **6/4** - Sent sample radiology reports **8/20** - They will go live in September **9/13** - Will go live in September (ADT is currently live)
Cherry County Hospital Valentine	2013-05	Brent Peterson	Will send Readiness Assessment and VPN document in May to Brent Peterson **5/29** - Sent VPN connection and Readiness Assessment form to Mr. Peterson **7/28** - Talked to Brent Petersen and they have not implemented their EMR yet.

Community Hospital McCook	2012-09	Lori Beeby	**3/6** - Sent email asking about implementation on April as previously indicated **4/4** - Phone call with Lori. She indicated that she wanted to send the CCD document first and wouldn't be ready until the June/July time frame. **7/13** - The interface analyst has been out for surgery and will be out again in August. I am sending Lori documentation for the CCD document. I have changed the date to September as she said her interface analyst would be available then. Also sent questionnaire to send the CCD document **9/4** - Resent documentation requesting completion to allocate resources **9/13** - called Lori Beeby and she is out of the office. Will call again next week.
Community Medical Center Falls City	2013-10	Brian Evans	Due to implementation of NextGen, this facility will not move forward until second quarter 2013 **7/11** - Received email from Brian Evans that implementation will begin in October, 2013
Community Memorial Hospital Syracuse	2013-04	Matt Steinblock	Numerous phone calls and email. They want to implement now but doesn't want to pay double for extra interfaces. Healthlnad only allows for 4 interfaces and charges $1750 for each additional interface. If they interface with NeHII now, they will have to pay an additional $7,000 when they upgrade in addition to the $12,000.
Garden County Health Services Oshkosh	TBD	Dee Dee Waltman	**8/6** - Left voice mail for Dee Dee **8/23** - Left voice mail for Dee Dee **9/13** - Left voice mail for Dee Dee
Lexington Regional Health Center Lexington	TBD	Robb Hanna	**11/17** - Sent paperwork and generic project plan **2/17** - Sent email asking for status **3/8** - Received email and resent the Readiness Assessment and VPN document **8/21** - Left numerous voice mails and sent some emails the latest being 8/21.
Montgomery County Memorial Hospital Red Oak, IA	2012-08	Ron Kloewer	**5/22** - Sent Readiness Assessment and VPN documentation **6/26** - Follow up concerning documents **8/17** - Sent sample project plan to Tammy Philby, the PM at MCMH for NeHII **9/7** - Joni sent email asking if we could help complete the forms
Myrtue Medical Center Harlan, IA	2013-02	David Sirek	**7/20** - Received Participation Agreement **8/18** - They plan to begin implementation in the first quarter of 2013.

Perkins County Health Services Grant	2012-12	Jennifer Baumgartner	**3/6** - Sent Readiness Assessment and VPN document **3/22** - Due to the cost from Healthland, NeHII implementation must be postponed until next fiscal year. **7/16** - After talking to Jennifer Baumgartner, I will be contacting Blake Heidecker as Perkins will be upgrading early in 2013 to ensure there will not be double charges. **8/23** - Blake Heidecker should be getting back to Deb on August 24 to determine if their will be double charges or not. **9/6** - left voice mail about news from Healthland **9/14** - talked to Jennifer Baumgartner. She is completing the paperwork.
Plainview Area Health System Plainview	Unknown	Rick Gamel	**5/1** - Contacted Rick Gamel about implementation. He indicated that everything is handled to Omaha. I have talked to Susan Lorkovic at Alegent. **5/17** - After reviewing everything with Susan Lorkovic, I will be contacting Rich the week of May 21. Plainview can implement on NeHII if they have the staff and funds to do so. **5/22** - Contacted Rick Gamel and explained that they could move forward with NeHII if they have the staff and funding. He will check with his supervisor and get back to me.
Providence Medical Center Wayne	2012-10	Weston Lundgren	**4/13** - Anxious to get started with NeHII. Sending Readiness Assessment and VPN documentation and will contact mid-May. **5/17** - Contacted Weston Lundgren, resent appropriate documents and have a conference call scheduled for May 31. **5/31** - Call will need to be re-scheduled **6/4** - Sent emails with availble times for Friday, June 8 **6/8** - They have decided not to begin implementation until October, 2012. I will be contacting them in September. **8/29** - Resent necessary paperwork as well as the LOINC coding spreadsheet to Weston Lundgren.
Sidney Regional Health System Sidney	2012-07	Jennifer Brockhaus	**12/27** - Received Readiness Assessment and VPN document **2/28-2/29** - Kick off meeting in Sidney **3/27** - Signoff on specs from CPSI **4/12** - Received notification from CPSI that implementation can begin on 6/26 **7/12** - Began weekly implementations meetings **8/20** - ADT, lab and radiology results look good. Waiting for transcription reports. Tentatively plan to go live the third week of September. **9/11** - Will go live with ADT on 9/24 and clinical results on 10/2
TriValley Health Center Cambridge	2013-06	Scott Stransberg	**4/10** - Have left numerous phone calls (monthly since October) with no returns. Left last voice mail on May 21. **6/4** - Will be implementing their EMR in November 2012. Implementation postponed until after November. **6/30** - Their implementation will not begin until at least second quarter, 2013

York General Hospital York	2012-09	John Temple	**3/2** - Signed NeHII Participation Agreement **4/6** - Sent Readiness Assessment and VPN documentation **5/11** - Sent signed CPSI document and completed Readiness Assessment document **5/17** - Left voice mail for John Temple **7/10** - Implementation will begin on September 11, 2012. Currently working with John to schedule the kick-off meeting. **8/22** - Scheduled the kick off meeting for Wednesday, September 12. **9/11** - implementation in progress

NeHII Hospital Listing

	Active Participant	Implementation In Process	Signed Participation Agreement
Alegent – Bergan	x		
Alegent – Immanuel	x		
Alegent – Lakeside	x		
Alegent – Midlands	x		
Alegent – Schuyler	x		
Antelope Memorial Hospital			x
Avera Creighton Hospital		x	
Avera St. Anthony's Hospital		x	
Beatrice Community Hospital			x
Bellevue Medical Center	x		
Boys Town Research Hospital			x
BryanLGH			x
Cass County Health System		x	
Chase County Community Hospital			x
Cherry County Hospital			x
Children's Hospital and Medical Center	x		
Columbus Community Hospital		x	
Community Hospital			x
Community Medical Center			x
Community Memorial Hospital			x
Creighton University	x		
Garden County Health Services			x
Great Plains Regional Medical Center	x		
Lexington Regional Health Center			x
Mary Lanning Memorial Hospital	x		
Methodist	x		
Methodist – Women's	x		
Montgomery County Memorial Hospital			x
Myrtue Medical Center			x
Nebraska Spine Hospital	x		
Perkins County Health Services			x
Plainview Area Health System			x
Providence Medical Center			x
Regional West Medical Center	x		
Sidney Regional Medical Center		x	
The Nebraska Medical Center	x		
TriValley Health Center			x

York General Hospital		x	

Appendix G: Public Health Work Group Recommendations

PHR Work Group

Draft Conclusions and Recommendations

Revised March 25, 2009

Charge

- Gain a greater understanding of the different types of PHRs available, and make recommendations on engaging consumers and providers in the use of PHRS to manage health care.
- Help understand the interface between PHRs and EMRs and make recommendations on how to encourage providers of health information to populate PHRs with health information.
- Make recommendations on engaging employers and payers in the adoption of PHRs.
- Identify and disseminate best practices.

Invited Members

- Henry Zach, HDC 4Point Dynamics
- Marsha Morien, UNMC
- Ellen Jacobs, College of St. Mary
- Anne Skinner, UNMC
- Dan Griess, Box Butte General Hospital
- Clint Williams, Blue Cross Blue Shield of Nebraska
- Lisa Fisher, Blue Cross Blue Shield of Nebraska (alternate)
- Dr. James Canedy, Simply Well
- Michelle Hood, Nebraska Department of Health and Human Services, Immunization Registry
- TBA, Nebraska Department of Health And Human Services, Medicaid
- Kevin Fuji, Creighton University
- Roger Wilson, State of Nebraska, Human Resources
- David Lawton, Nebraska Department of Health and Human Services
- Karen Paschal, Creighton University

Conclusions

- Significant progress is being made in PHR interoperability standards and in the development of privacy and security protections.

- PHRs which are interoperable with other types of EMRs offer more value and convenience to consumers by reducing the need to personally enter data and by improving the timeliness, availability and accuracy of data.

- PHRs with financial management functions may offer further value to consumers by providing cost and benefit information to support decision making.

- PHRs which are interoperable may offer more value to health care providers. PHRs populated by data from providers may be viewed as being more reliable by health care providers.

- PHR adoption will require consumer education and incentives. Consumers may be more receptive to PHR adoption in conjunction with certain events such as the birth of a child, enrollment in college, the diagnosis of a chronic disease, or the need to manage care of a parent.

- Health care providers may also require education in incorporating PHRs into patient care and assistance in making adjustments in the practice workflow.
- PHRs as part of a broader health management program can help consumers reduce their health risks, better manage their health, and reduce their health care expenditures.
- PHRs as part of a broader health management program can help employers reduce their health care related costs.

Recommendations

- The State of Nebraska should explore making immunization data from the state's new immunization registry available to consumers through PHRs.
- Efforts should be made to encourage Nebraska's providers and health information exchanges to make patient data available to patients through PHRs in the future.
- The utilization of PHRs in conjunction with a broader health management program for State employees should be periodically evaluated as a potential way to reduce health care costs. Continued developments in PHRs may reduce implementation costs and increase the ROI.
- The utilization of PHRs in conjunction with a broader health management program for Medicaid recipients should be periodically evaluated as a potential way to reduce health care costs. Continued developments in PHRs may reduce implementation costs and increase the ROI.
- The eHealth Council should look for opportunities to partner with other organizations in educational efforts targeting consumers and providers on the use of PHRs.
- Continued research on the benefits of PHRs and the ROI for PHRs should be done.

Appendix H: Responses to CMS Questions

CMS Overview

State Medicaid HIT Plan (SMHP) Overview	
PURPOSE: The SMHP provides State Medicaid Agencies (SMAs) and CMS with a common understanding of the activities the SMA will be engaged in over the next 5 years relative to implementing Section 4201 Medicaid provisions of the American Recovery and Reinvestment Act (ARRA). THIS IS A DRAFT, OPTIONAL TEMPLATE.	***SCOPE:*** Section 4201 of the ARRA provides 90% FFP HIT Administrative match for three activities to be done under the direction of the SMA: 1. *Administer the incentive payments* to eligible professionals and hospitals; 2. *Conduct adequate oversight of the program*, including tracking meaningful use by providers; and 3. *Pursue initiatives to encourage the adoption of certified EHR technology* to promote health care quality and the exchange of health care information. We are particularly interested in how the States plan to go about making the provider incentive payments (100% FFP), how they will monitor them, and how the SMAs' plans will dovetail with other State-wide HIE planning initiatives and Regional Extension Centers supported by the Office of the National Coordinator for HIT (ONC) and other programs. Please be sure to indicate in the SMHP what activities the SMA expects will be included in a HITECH Implementation-APD or a MMIS APD so that CMS can crosswalk the SMHPs to their corresponding funding request documents. If a State has already begun work on their SMHP, they should consider how it lines up with the content in this draft template before submitting it to CMS for review.
TIME FRAME: The SMHP time horizon is five years, although States may discuss their plans beyond that, if appropriate. We understand States have a better understanding of their current, near-term needs and objectives, and that plans will change over time. For this reason, we will expect to receive annual updates, as well as as-needed updates, to keep CMS informed of the SMHP as it evolves, and States' ability to meet their targets over the next five years. We expect that States will want to revise their SMHPs over time, particularly for initiatives to encourage the adoption of certified EHR technology.	
REQUIRED VS. OPTIONAL CONTENT: We recognize that not every element of the SMHP is of equal weight and priority-level in order to implement the EHR Incentive Program at the barebones minimum. We have flagged the questions which a State may choose to defer for a later iteration. For example, some States may not be ready to take on activities in 2011 to promote EHR adoption and HIE among Medicaid providers but are fully planning to be able to make EHR incentive payments to the right providers, under the correct circumstances in the first year of the program.	

Narrative Responses to Section A

SECTION A: The State's "As-Is" HIT Landscape	
The State's "As-Is" HIT Landscape: This information should be a result of the environmental scan and assessment conducted with the CMS HIT P-APD funding; or was available to the SMA through other means (e.g. was part of the ONC HIE cooperative agreement planning and assessment activities or other HIT/E assessments.)	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.)? RESPONSE: Several surveys and assessments of EHR usage among Nebraska providers and hospitals were administered by different concerned entities over the past five years, and their findings are described in section 3.1.1. DHHS conducted its own survey in early 2011, summarized in section 3.1.2 and detailed in Appendices D and E. DHHS survey results demonstrated current EHR adoption at 48% of providers responding to the survey (with approximately 46% of those having a certified system in place). The survey data on eligible hospitals does break out results by type of hospital. 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? RESPONSE: The environmental scan demonstrated that reasonable access to broadband services currently exists across Nebraska, described in sections 3.1.2.4 and 3.1.2.2. Nebraska is actively expanding its access to broadband services and has received several significant BTOP and BIP grants to improve access particularly in rural areas of Nebraska. Nebraska has received several key broadband grants designed to expand the availability of broadband through enhancement of the 'middle mile" access to broadband infrastructure and sustainable public access to broadband. Section 3.4.1. 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. RESPONSE: Yes, there are three initiatives in Nebraska that received funding from HRSA to support HIT/EHR. These initiatives are explained in detail in the SMHP section 3.9. 4. Does the State have Veterans Administration or Indian Health Service clinical facilities that are operating EHRs? Please describe. RESPONSE: Yes, as described in section 3.1.3.3 there are VA facilities in Nebraska and Nebraska veterans also receive health care across state borders. The VA facilities use the VA VISTA system. IHS and tribal-based facilities and their EHR usage are described in section 3.1.3.1. 5. What stakeholders are engaged in any existing HIT/E activities and how would the extent of their involvement be characterized? RESPONSE: The Nebraska statewide HIE is NeHII. NeHII is a mature HIE operating in Nebraska with participants from Nebraska, Missouri, and Iowa. Section 3.2.1.1 provides further detail.

	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? RESPONSE: DHHS has collaborative relationships with a number of entities working on HIT/E in Nebraska. The Medicaid Director is a member of the NITC eHealth Council and serves on the governing board for NeHII. DHHS participates regularly in workgroups with Wide River REC, NeHII, eBHIN and the eHealth Council. Section 3.2.1. 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? RESPONSE: NeHII is the state's designated integrator, a well-developed HIE serving Nebraska and some regional partners. NeHII's governance structure and Nebraska Medicaid's involvement is detailed in section 3.2.1. 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. RESPONSE: The MMIS is not currently interoperable with HIE networks outside of claims payment (section 3.4.2). DHHS has coordinated its SMHP with MITA transition plans, as described in section 4. DHHS is currently completing a MITA SS-A, which will inform future MMIS planning and coordination. 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? RESPONSE: Current efforts to foster EHR adoption and facilitate HIE are being undertaken by numerous entities in Nebraska and are described throughout section 3. Nebraska Medicaid's role is detailed there. Primary collaborators include the NITC and its eHealth Council, NeHII, Wide River REC, eBHIN, and Nebraska Medicaid. Wide River REC activities are described in section 3, and DHHS continues to work with the REC to reach Medicaid eligible providers with information and education. The Communication Plan found in Appendix I outlines planned outreach channels for the EHR Incentive Program, with strategy described specifically in sections 3.1 and 3.2. 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. RESPONSE: Lt. Governor Rick Sheehy is the State HIT Coordinator. Nebraska Medicaid continues regular involvement and collaboration with the state HIT Coordinator, the NITC and HIE partners. Section 3.2 provides detail. 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? RESPONSE: The primary SMA activity likely to impact the EHR incentive program is the modernization of the MMIS. As described in section 3.3, the MITA SS-A in which DHHS is currently engaged will inform MMIS activities over the next five years.

	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. RESPONSE: DHHS undertook a detailed review of Medicaid regulations as they relate to privacy and security and uncovered no obstacles to EHR Incentive Program implementation. No recent legislative or regulatory changes appear likely to impact EHR Incentive Program implementation. This work is described in the first paragraph of section 4, with additional detail in Appendix J. 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. RESPONSE: NeHII HIE includes stakeholders in Iowa and Missouri and conversations with other regional partners are ongoing. Section 3.6 describes Medicaid beneficiary activity across state borders. Additionally, Nebraska veterans cross State borders to access VA health care services as detailed in section 3.1.3.3. 14. What is the current interoperability status of the State Immunization registry and Public Health Surveillance reporting database(s)? RESPONSE: There is no current interoperability between Medicaid and the immunization and health surveillance databases. Public Health, as the entity managing those databases, is currently working on health information exchange interfaces with the statewide HIE, and Medicaid is engaged with the HIE in the same dialogue (sections 3.4.4 and 4.8). 15. If the State was awarded an HIT-related grant, such as a Transformation Grant or a CHIPRA HIT grant please include a brief description. RESPONSE: N/A

Narrative Responses to Section B

SECTION B: The State's "To-BE" Landscape	
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. RESPONSE: Nebraska DHHS has a goal of furthering the adoption of certified EHR systems and technologies for providers in the state of Nebraska, while pursuing further stages of MITA adoption and compliancy. DHHS is working with NeHII, the HIE for the State of Nebraska, and will continue to coordinate and collaborate with NeHII as well as the REC to drive adoption of EHR systems and technologies by Nebraska providers. Section 4 provides an overview of Nebraska Medicaid's HIT vision for the years ahead, while section 6 details state benchmarks, goals and milestones regarding EHR adoption. 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 Services Bus? Master Patient Index? Record Locater Service? RESPONSE: SMA, as detailed in section 3.3, is currently undergoing a MITA SS-A activity which will help shape future vision and development of MMIS and IT system architecture. Specific to HIE, Nebraska DHHS is working in collaboration with NeHII and will participate in leveraging NeHII and the NITC's efforts towards inter-operative HIE. See sections 4.2 and 4.3. 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.)? RESPONSE: DHHS is planning a manual EHR Incentive Program implementation which will initially channel most provider interaction with SMA IT through telephone, email, and internet inquiry processes. Over time, system development to allow reporting of MU data and developing partnerships with the statewide HIE will facilitate provider interaction with SMA IT systems. Sections 4.1, 4.7, 6.4 and 6.5. 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 RESPONSE: NeHII is a well-developed HIE effort, and many partnerships with providers, health systems, and regional exchanges are already signed and in place. Nebraska Medicaid is formulating its own longer-term HIT/E goals and objectives with the existence of this mature HIE resource in mind and with reference to the State Medicaid Director letter of May 18, 2011. In terms of the EHR Incentive Program, the state will continue to collaborate with NeHII, Wide River REC, and other partners to further the adoption of certified EHR technologies and systems and the eventual meeting of meaningful use criteria by eligible providers. Sections 4.6.2 and 4.7.

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

   RESPONSE: DHHS is currently working in full collaboration with the REC and NeHII, and will continue to collaborate to drive the adoption of certified EHR technologies and systems via communication and education mechanisms in 2011 and beyond. The Communication Plan contained in Appendix I contains further detail.

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?

   RESPONSE: Nebraska has FQHCs and will continue to collaborate with the FQHCs, as well as with NeHII and the REC, to ensure and encourage the adoption of certified EHR systems and technologies in 2011 and beyond. See sections 3.9 and 4.9.

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

   RESPONSE: DHHS will continue to collaborate with NeHII and the REC to ensure that educational and outreach services are provided to facilitate the adoption of certified EHR technologies and systems and the meeting of meaningful use criteria. Through this partnership DHHS hopes to leverage joint efforts in order to reach as many providers, in as many venues, as possible. The Communication Plan in Appendix I contains additional detail.

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

   RESPONSE: Deferred.

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.?

   RESPONSE: N/A

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.

    RESPONSE: A legislative regulatory review was performed to assess the current status of Nebraska Medicaid regulations, documents, and internal policies, as well as other state statutes that may impact health information exchange in comparison with federal privacy and security regulations. This assessment was an important undertaking as Nebraska DHHS promotes electronic health record adoption and plans the SMHP because these efforts require measures that ensure the privacy and security of patient health information. Appendix J, section 4.1 provides additional detail.

Please include other issues that the SMA believes need to be addressed, institutions that will need to be present and interoperability arrangements that will need to exist in the next five years to achieve its goals.

	Deferred for later submissions of SMHP and IAPD. * This question may be deferred if the timing of the submission of the SMHP does not accord with when the long-term vision for the Medicaid IT system is decided. It would be helpful though to note if plans are known to include any of the listed functionalities/business processes. ** May be deferred.

Narrative Responses to Section C

SECTION C: Activities Necessary to Administer and Oversee the EHR Incentive Payment Program	
The State's Implementation Plan: Provide a description of the processes the SMA will employ to ensure that eligible professional and eligible hospital have met Federal and State statutory and regulatory requirements for the EHR Incentive Payments.	1. How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers? RESPONSE: DHHS will collect license/qualification from providers as part of the Provider Registration process, and this information plus sanction status will be checked as part of the pre-payment verification process. Sections 5.2.3.1 and 5.8.4. 2. How will the SMA verify whether EPs are hospital-based or not? RESPONSE: DHHS will supply CMS' definition of "Hospital-based" and will ask the physician to verify status. DHHS will use Medicaid claims to verify the percentage of services this provider rendered in a hospital setting (place of service codes 21 for inpatient hospital and 23 for emergency room). Sections 5.2.3.1 and 5.8.4. 3. How will the SMA verify the overall content of provider attestations? RESPONSE: Section 5.3 outlines and graphically depicts DHHS activities to verify provider attestation prior to payment. The CMS ONC-certification code submitted will be verified, as well as the number of meaningful use and clinical quality measures supplied. Calculations will be validated. Additionally, sections 5.8.3 and 5.8.4 detail the audit plan (data sources, methodology, pre-payment versus post-payment activities, etc.). 4. How will the SMA communicate to its providers regarding their eligibility, payments, etc? RESPONSE: Appendix I contains a Communication Plan which outlines outreach plans by which DHHS will inform providers about the EHR Incentive program, eligibility, registration process, etc.. The manual process DHHS proposes to utilize to implement the EHR Incentive Program will initially be presented to providers via outreach efforts, a web page and an email q&a box. Provider inquiries about registration processes, eligibility, payment status, etc. will be handled via existing communication channels (section 5.7). 5. What methodology will the SMA use to calculate patient volume? RESPONSE: DHHS will allow EPs to calculate patient volume using either CMS methodology outlined in 42 CFR Part 495. The SMHP describes this in section 5.2.3.1. 6. What data sources will the SMA use to verify patient volume for EPs and acute care hospitals? RESPONSE: DHHS will use the MMIS claims data to verify patient volume. Section 5.8.4 describes this. 7. How will the SMA verify that EPs at FQHC/RHCs meet the practices predominately requirement? RESPONSE: Nebraska recognizes that CMS has added clarification for this requirement, considering it a low risk audit item and difficult data to collect. CMS has directed that this

	is only likely to be audited if other concerns surface for that provider. Documentation from the provider's practice database, and Medicaid claims information as appropriate, would be the only available tools for verification. Sections 5.2.3.1 and 5.8.4 provide further detail. 8. How will the SMA verify adopt, implement or upgrade of certified electronic health record technology by providers? RESPONSE: DHHS will collect the required adopt, implement or upgrade attestation criteria, including a copy of a purchase order or invoice from the ONC-certified EHR system vendor. Prior to payment DHHS will verify this information along with the CMS ONC-certification code submitted by the provider. See section 5.3.5. 9. How will the SMA verify meaningful use of certified electronic health record technology for providers' second participation years? RESPONSE: DHHS plan to use data directly from the provider's EHR systems or from data available through the HIE/HIT data repositories. See section 5.3.6. 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. RESPONSE: DHHS does not propose any changes to the federal MU definition. Section 5.3.6. 11. How will the SMA verify providers' use of certified electronic health record technology? RESPONSE: DHHS plans to accept attestations regarding the use of certified technology that includes entry of the CMS ONC-certified EHR system code. Prior to payment DHHS will verify the CMS ONC-certification code submitted by the provider against CMS data sources. Section 5.8.4. 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? RESPONSE: SMA will collect this via the attestation process. In the short term this may be through the provider completing and submitting a paper form; in the long term the state may move to an on-line process for collecting attestations and clinical quality measures. Section 5.3.6. 13. * How will this data collection and analysis process align with the collection of other clinical quality measures data, such as CHIPRA? RESPONSE: DHHS has not assessed how this data collection and analysis aligns with collection of other clinical quality measures data. This information will be provided in subsequent versions of the SMHP. 14. What IT, fiscal and communication systems will be used to implement the EHR Incentive Program? RESPONSE: Existing fiscal and communication systems will be used with the possible addition of EHR-specific human resources. In particular, DHHS will leverage the existing

MMIS, License Management, and Vital Statistics systems as part of the eligibility determination process. From a fiscal systems standpoint DHHS will utilize the existing State Accounts Payable system to track and issue payments. Communications will take place via a number of existing systems including websites, e-mail, and telephone. See section 5.5 and Appendix I.

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

    RESPONSE: Changes to existing systems are not expected. Possible exception would be creation of an automated interface with EnterpriseOne, see section 5.5.

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

    RESPONSE: Fourth Quarter calendar year 2011 (if needed, not anticipated). See section 6.1, Table 14.

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

    RESPONSE: Third Quarter calendar year 2011. Section 6.1, Table 14.

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)?

    RESPONSE: Nightly batch process utilizing a mainframe to mainframe file transfer. Section 5.2.

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

    RESPONSE: Nebraska has established a Web page devoted to the EHR Incentive Program that provides information for staff and external stakeholders. This web site will be the key hub for Medicaid providers to obtain EHR Incentive Program information.

    The web page is available to all EPs and EHs, with a location and visibility within the DHHS website aligned with the level of strategic importance DHHS places on the program. Links to the EHR web page are available from the Nebraska Medicaid home page, any pages related to technology, and the most highly subscribed-to provider information page.

    The EHR web page demonstrates partnership efforts with the Regional Extension Center (REC), health information exchange (HIE), and other strategic HIE partners by placement of reciprocal links.

    As a method for outreach and education through electronic subscribership alerts, the EHR website is utilized to notify provider subscribers of newly-released provider bulletins, time-sensitive events, national calls, and webinars. The EHR web site is also a conduit for dialogue with Medicaid providers as it contains the link to the EHR mailbox URL where providers can email the EHR state staff with questions and receive timely responses. The EHR website has and will continue to be updated with relevant timelines, documents and materials, including final versions of the SMHP and IAPD. The website is described along with additional communication tools and strategies in section 2.1.2 of Appendix I.

20. Does the SMA anticipate modifications to the MMIS and if so, when does the SMA

anticipate submitting an MMIS I-APD?

RESPONSE: For the purposes of the Medicaid Incentive Program, the MMIS will be utilized as a data source in support of the operations of the program, as opposed to being the operational system for the program. Given this role, DHHS plans to use MMIS data as it is, and does not anticipate the need to modify the system. Section 5 contains the overview of MIP processes and their interaction points with the MMIS, and section 6.5.1 discusses MMIS alignment with MITA missions and goals.

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

    RESPONSE: DHHS anticipates that Providers will be able to access the Medicaid Inquiry Line to address Provider questions regarding the incentive program. Additionally, the Communication Plan will take advantage of the existing Provider communication infrastructure and will incorporate existing bulletins and notification strategies to communicate the timeline and rollout of incentive payments. The Communication Plan in Appendix I details additional outreach activities specific to the EHR Incentive Program.

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?

    RESPONSE: As described in section 5.8.2, DHHS will utilize an informal appeal process specific to the EHR Incentive Program, which will allow dialogue between providers and EHR staff as a final determination on eligibility is being determined. Formal appeals will follow the Medicaid appeal process as outlined in 465 NAC 2.

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?

    RESPONSE: All incentive payments and Administrative costs will be tracked using existing financial processes and controls. The State will code all incentive payments with accounting codes which are unique to only the MIP program, which will allow the system to isolate and report on those payments separate from all other accounting transactions. All activity associated with the administration of the program will be tracked in the State's time accounting system using job codes uniquely associated to the MIP program. This will allow the State to isolate and report on Administrative costs separate from all other costs. Section 5.5 and 5.8.1.

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

    RESPONSE: SMA plans to process payments weekly as needed. Section 5.8.1.

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?

    RESPONSE: Incentive payments will be paid directly to the provider (or their employer or facility to which they have assigned payment) from the State's Accounts Payable system (EnterpriseOne) which will utilize existing accounting controls. The amount of the incentive payment will come directly from the MIP payment calculation process via a formal payment request. The payment amount is entered into EnterpriseOne exactly as

	indicated on the payment request without any deductions or rebates, and as a final step the payment is reviewed manual before it's released for issuance. Section 5.5 and 5.8.1. 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? RESPONSE: DHHS does not plan to designate an entity promoting the adoption of certified EHR technology. Therefore, no response is required. Section 5.2.3.1. 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? RESPONSE: Nebraska will pay providers through the Fee-for Service (FFS) program. Managed care entities will not be used to disburse incentive payments eliminating the need to calculate an impact to capitation rates. Section 5.4.1.3. 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? RESPONSE: Calculation processes are described in section 5.4.1.1. 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.? RESPONSE: Initially, DHHS plans to implement the EHR Incentive Program with existing staff, augmented as needed by new state staff under the direct supervision of DHHS. Other described contractor relationships are not applicable to Nebraska. Oversight structure is described in section 5.8.1. 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 RESPONSE: DHHS has made the following assumptions: **CMS NLR development and provider support:** Since DHHS implementation of the Medicaid EHR Incentive Program will take place after CMS has developed NLR and provider support initiatives, not many assumptions are necessary. DHHS assumes that CMS will continue to meet forecasted timelines for execution of functionality of the Medicare & Medicaid EHR Incentive Program Registration and Attestation System and continued support of published program details and clarification. **Status/availability of certified EHR technology:** There are currently over six hundred

	certified EHR products on the Certified Health IT Product List (CHPL). Therefore, assumptions need not be made related to availability of certified product. If any concerns may be had, they relate to issues of provider access to certified EHR technology due to cost. DHHS expects that the incentives available through the EHR Incentive program will address these access issues. **REC:** MLTC believes that Wide River REC will play an instrumental role in the adoption of Electronic Health Records through communication and direct technical assistance to providers, particularly as it relates to FQHCs and RHCs. MLTC developed the EHR Incentive program operations with the expectation that Wide River REC will meet its adoption goals and has a plan for ongoing sustainability. MLTC has worked and will continue to work with Wide River to facilitate their achievement and continued existence. **HIE cooperative agreements:** Assumptions are made in the form of HIE sustainability and capability. Since the primary HIE in the State (NeHII), has been operational since 2009, DHHS needs to coordinate information exchange efforts with NeHII. DHHS is currently developing business and use cases from which these interactions will stem. **State-specific readiness factors:** DHHS MLTC development efforts for the EHR Incentive program follow many of the other divisional and statewide efforts. Therefore, DHHS will follow and support development timelines for these efforts. Section 6.3. *May be deferred

Narrative Responses to Section D

SECTION D: The State's Audit Strategy	

The State's Audit Strategy: Provide a description of the audit, controls and oversight strategy for the State's EHR Incentive Payment Program.	What will be 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):
	
	• 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.
	
	RESPONSE: DHHS does not plan to use contractors at this time and plans to do the following pre-payment audit activities:
	
	• All Medicaid only hospitals. Medicaid only hospitals are those that are not dually eligible (Medicare and Medicaid eligible);
	• For dually certified hospitals, Medicaid will verify the Medicaid percentage and review the results of the Medicare audits;
	• Compare Provider's Medicaid patient volume supplied during attestation to the previous year's Medicaid patient volume. If the attested patient volume is outside a determined percent variance of the previous year's Medicaid patient volume, the Provider will be queued for audit. *AIU* attestation patient volume is based on 90 days, so the previous year's patient volume will have to be adjusted accordingly; and
	• DHHS will use a statistically significant random sampling methodology to identify a sufficient number of payments to review.
	
	DHHS plans to do the following post-payment:
	
	• Post-payment audits will be conducted randomly as well as targeted. The information required for audits may go beyond the data stored in the SLR. Other auditable data sources may include:
	  • Provider enrollment files maintained by DHHS;
	  • Provider EHR system data associated with Meaningful Use criteria;
	  • State licensing and accreditation boards;
	  • Provider Medicare cost reports;
	  • Provider, encounter, and claims data and reimbursement information stored in the MMIS; or
	  • Provider financial statements, accounting records, and patient information.
	
	Manual pre-payment audits may also include these same data sources. Sections 5.8 and 5.8.4.
	
	• 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?
	
	RESPONSE: SMA plans to follow its current standard operating procedures for tracking

	overpayments and status of overpayments. Sections 5.8.3 and 5.9. • Describe the actions the SMA will take when fraud and abuse is detected. RESPONSE: DHHS will follow its current standard operating procedure and refer all fraud and abuse to the MFCU. Details in section 5.8.3. • 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. RESPONSE: DHHS plans to consider all existing data sources to verify Meaningful Use. Per section 6, relationships and roles for Nebraska HIE are still being defined and are expected to develop over the first years of the EHR Incentive Payment program. • 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) RESPONSE: Yes, DHHS plans to use random and targeted sampling methods as appropriate. Sections 5.8.3 and 5.8.4. • **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)? RESPONSE: DHHS plans to incorporate existing program integrity and program audit standard operating procedures. Any existing data sources will be leveraged when appropriate. Sections 5.8.3 and 5.8.4. • Where are program integrity operations located within the State Medicaid Agency, and how will responsibility for EHR incentive payment oversight be allocated? RESPONSE: Program Integrity is located with the DHHS MLTC as part of the Operations Section. EHR Incentive Payment program oversight will come from the same section of the Division, in cooperation between the Operations Unit and the Medicaid IT Initiatives Unit. Section 5.8.1. * The sampling methodology part of this question may be deferred until the State has formulated a methodology based upon the size of their EHR incentive payment recipient universe. ** May be deferred

Narrative Responses to Section E

SECTION E: The State's HIT Roadmap	
The State's HIT Roadmap: Annual Measurable Targets Tied to Goals	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. RESPONSE: The narrative and graphical pathways are shown at the beginning of section 6. The graphic and narrative tables detail the prominent activities by year and quarter, highlighting significant milestones along the way. See Section 6.1. and Table 14. 2. What are the SMA's expectations re provider EHR technology adoption over time? Annual benchmarks by provider type? RESPONSE: Eligible Professional and Eligible Hospital EHR adoption over time is described in section 6.2 and Table 15. Annual benchmarks are given and broken out by provider type. 3. Describe the annual benchmarks for each of the SMA's goals that will serve as clearly measurable indicators of progress along this scenario. RESPONSE: The EP and EH EHR adoption benchmark goals over time are highlighted in section 6.1. 4. Discuss annual benchmarks for audit and oversight activities. RESPONSE: DHHS plans to implement an Audit Plan that includes pre-payment verifications, pre-payment audits and post-payment audits. The benchmarks for the Verification and Audit Strategy will be established after the detailed audit protocols are completed and at the conclusion of the first 90 days of the program. During the first 90 days, DHHS will be evaluating the level of participation and creating an inventory of the types of EPs who apply for the incentives, as well as the number of hospitals. The initial list of registrations will be evaluated and considered as DHHS initiates the pre-payment verifications, audits and post-payment audits. DHHS will also seek information from other States regarding their evaluation of the initial implementation and will evaluate and set the benchmarks for the first year of participation after this 90 day period has concluded. Sections 5.8.3 and 5.8.4 and Table 14. CMS is looking for a strategic plan and the tactical steps that SMAs will be taking or will take successfully implement the EHR Incentive Program and its related HIT/E goals and objectives. We are specifically interested in those activities SMAs will be taking to make the incentive payments to its providers, and the steps they will use to monitor provider eligibility including meaningful use. We also are interested in the steps SMAs plan to take to support provider adoption of certified EHR technologies. We would like to see the SMA's plan for how to leverage existing infrastructure and/or build new infrastructure to foster HIE between Medicaid's trading partners within the State, with other States in the area where Medicaid clients also receive care, and with any Federal providers and/or partners. * Where the State is deferring some of its longer-term planning and benchmark development for HIT/E in order to focus on the immediate implementation needs around the EHR Incentive Program, please clearly note which areas are still under development in the SMA's HIT Roadmap and will be deferred.

Appendix I: Communication Plan

State Medicaid Health Information Technology Plan

Communication Plan

September 28, 2012

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1 OVERVIEW

The Medicaid Incentive Payment (MIP) program will provide incentive payments to eligible professionals (EPs) and eligible hospitals (EHs) for efforts to adopt, implement, or upgrade certified Electronic Health Record (EHR) technology for meaningful use. This communication plan will be included in the State Medicaid Health Information Technology Plan (SMHP) and is intended to provide strategic direction for facilitation of effective communication between Nebraska Medicaid and EPs and EHs. The objective of this plan is to promote the adoption of EHR technology by informing EPs and EHs about the incentive payments and how to apply for them, particularly in the areas around the requirements to qualify for incentive payments, potential amount of incentive payments, and meaningful use requirements. This plan will be the basis for the Nebraska Department of Health and Human Services' (DHHS) creation of a DHHS Communication Operational Plan and project plan. This plan provides the methods for communication, the communication strategies, and a high level timing strategy based on the Nebraska plan for payment of incentives.

2 METHODS OF COMMUNICATION

2.1 Web Page

Nebraska provides a Web page devoted to the EHR incentive program that includes the following details:

1. Eligibility criteria;
2. Enrollment forms and instructions
3. Potential payout amounts;
4. Payment timelines;
5. Calculations examples;
6. How to apply;
7. Resources for more information;
8. Links to other pertinent Nebraska and CMS Web pages
9. Link to REC; and
10. Frequently asked questions.

The Web page is available to all EPs and EHs. Content for the Web Page will be updated frequently and subscribers to the web page will receive an e-mail update.

2.2 E-mail

Alerts will be sent out as needed to EPs and EHs who subscribe to receive e-mails from a Web page subscriber list on the Web page. There were 225 subscribers in 12/2010. This increased to 875 by 2/2012 (three months before launch) and to 1,103 in 8/2012 (three months after launch).

2.3 Survey

Separate surveys tailored to EPs and EHs respectively have been distributed by e-mail and will be available on the Web page. Surveys will also be distributed though professional organizations. These surveys will collect information and allow the participant to subscribe for further alerts from other distribution channels. Survey effectiveness as a communication tool will be evaluated.

2.4 Medicaid Provider Bulletins

Bulletins are available electronically for all EPs and EHs. All issued bulletins remain available for EPs and EHs to reference any time. Since EPs and EHs are already required to check these bulletins online, this is anticipated to be highly effective communication tool. A provider bulletin was released in 3/2012 which announced the Medicaid Incentive Program launch date.

2.5 Provider Handbooks

Handbooks are provider-type specific, and therefore affected provider handbooks will be updated as necessary. This is also a highly effective method of communication because providers are required to stay current with items covered in their respective handbooks. These handbooks are found online.

2.6 Social Networks

DHHS may use social networks, such as Twitter and Facebook, to generate messages that will inform the followers of updates to the Nebraska EHR Web page. Followers can then choose to go to the Web page themselves. DHHS will follow all established Nebraska State Standards and Guidelines for social media usage as established at:

http://www.nitc.ne.gov/standards/4-205.html

2.7 Postal Mail

Hard copies of extremely important notifications will be mailed to all providers who are eligible for incentive payments. This delivery method will be used sparingly because of the cost.

2.8 Medicaid Inquiry Line

Providers access the Medicaid inquiry line for provider support; so providers will contact the line with incentive payment questions. Incentive questions will be directed to Nebraska Medicaid EHR Program staff.

2.9 Workshops / Traveling Road Shows

Nebraska developed several slides show presentations which are posted on the website. These slide show presentations have also been given at various events, including the following:

- Wide River REC workshop,
- FQHC/RHC webinar session,
- Nebraska HIMSS Chapter Meeting,
- CIMRO Quality forum,
- Healthcare Financial Management Association (HFMA) presentation
- Webinars sponsored by REC
- CMS IHS training in Iowa

- We will be attending an RHC meeting in September to promote the Medicaid EHR Incentives and answer questions.

2.10 Professional Association Meetings

Nebraska Medicaid will develop and provide relevant EHR literature to associations and work with associations on the best ways to deliver materials to providers. The associations are responsible for delivering information to its members. This is effective as an alternative method to electronic communication with the providers, and allows for the associations to provide feedback. When the strategically important partnerships are made with the professional associations, Medicaid and the professional associations will plan for Web pages to have reciprocal links to each other. Regular meetings are held with a representative from the Nebraska Hospital Association. A handout is being distributed at the fall meeting with the Nebraska Medical Association.

2.11 Public Information Officer

DHHS will identify a public information officer (PIO) who will issue press releases and strategically placed media to support the program. All communication efforts will be reviewed by the PIO. A press release was issued on our launch date. The Wide River REC also issued a press release when the first EHR payment was made.

3 STRATEGY

3.1 Primary Communication Strategy

The primary communication strategy of Nebraska Medicaid will be to direct providers to the Web page The EHR webpage is updated to give instructions and enrollment tips as well as links to important CMS sites. This web page allows users to subscribe to receive automated notices when the website is updated. There were 225 subscribers to this site in 12/2010. This increased to 875 in 2/2011 (three months prior to launch) and has increased to 1103 in 8/2011 (3 months after launch).

The Survey is also intended to provide a way for the providers to subscribe for e-mail alerts, increasing the number of providers who receive alerts to check the Web page. Alerts of Web page updates will be sent by e-mails and possibly social network.

DHHS has strategic communication alliances with professional associations and will develop methods of delivering communications to providers though the professional association channels.

The Medicaid inquiry line will answer questions, but also serves as a way to direct the provider to the Web page for the most up-to-date information. DHHS will measure and adjust activities based on response to the program and communication feedback from all mechanisms.

3.2 Other Communication Strategies

Other methods for reaching out to providers who may not utilize electronic communication exclusively are workshops, professional association meetings, and.e-mail. Workshops will allow providers to come and interact with Nebraska Medicaid to discuss the incentive payments. Distributing information through associations will allow for provider feedback through the association. Additionally, the association will also have a means of reaching its members that is not dependent on the Medicaid e-mail alert system. Outreach activities have included e-mails submitted to the CAHs in Nebraska as well as those providers who registered with the NLR and selected Nebraska Medicaid, but hadn't yet submitted their enrollment for Nebraska's Medicaid Incentive Program. .

4 TIMING

DHHS will be informing providers of the availability of incentive payments using the methods defined in Section 2. The following table describes the communication delivery method and the timing of the communication. This table also provides information regarding the role of DHHS staff.

Table 1: Communication Timing

Delivery Method	Start Date	Frequency	Completion of Materials	NE DHHS Role
Web page	12/2010	As needed	Currently implemented on Web page. Subscriber feature has been added. Survey is complete and has been released.	Preparation and distribution of materials for Web page messages – Medicaid IT Initiatives Unit (MITI).
E-mail	ASAP E-mails will begin with Web page changes and with milestone dates. For example: "Providers can sign up for incentive payments in XX months."	E-mails are planned for release at a frequency to be determined to keep current with providers. E-mails will also be sent as needed based on upcoming events.	Build an e-mail distribution list by having the Web page accept subscriptions. DHHS will plan the ability to store and access the e-mail addresses of the subscriptions. DHHS will provide a group mailbox function to send e-mails to the subscribers whenever an update is made to the Web page.	Add Web page functionality to accept subscribers and store e-mail addresses – MITI. Set up and monitor a group EHR mailbox – MITI.
Survey	February 2011 – March	Coordinate with Statewide Strategic and Operational Plan survey updates.	Survey has been distributed using multiple mechanisms:	Participate in survey evaluation and conclusions.
Medicaid Provider Bulletins	Three months prior to "go live" date.	As needed.	A Medicaid Provider Bulletin was issued in 3/2012 to announce our launch date. This would have reached any providers who may not have subscribed to our EHR website.	Individual program specialists and program managers are responsible for their content – MLTC.

Delivery Method	Start Date	Frequency	Completion of Materials	NE DHHS Role
Social Networks	After Web page is implemented.	Regularly scheduled updates weekly, biweekly, or monthly. Also as needed for milestone events.	Set up Social Network accounts using a group e-mail address.	Set up and maintenance of Social Network accounts – MLTC and Public Information Office.
Medicaid Inquiry Line		Continuous	An incentive payment expert is available to handle calls.	Answers to basic incentive payment questions
Workshops	Two months prior to "go live" date	As needed.		DHHS will set up workshops with providers – MITA.
Professional Association Meetings	Two to three months prior to "go live" date	As needed.	Use workshop materials.	Contact Professional associations and distribute materials as necessary – MITI.

Appendix J: Privacy and Security Regulatory Assessment

State Medicaid Health Information Technology Plan

Privacy and Security Regulatory Assessment

April 12, 2011

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1 Executive Summary

Public Consulting Group (PCG) conducted a comprehensive review of the Nebraska Medicaid regulations (Titles 471, 480 and 482), the Nebraska Medicaid Program State Plan (State Plan), and Nebraska Department of Health and Human Services (DHHS) Health Insurance Portability and Accountability Act (HIPAA) privacy and security policies and internal memoranda. At the completion of the review, PCG completed a gap analysis to determine whether Nebraska Medicaid regulations, Medicaid documents, or internal policies and procedures were in conflict with federal privacy and security rules contained in HIPAA and the Health Information Technology for Economic and Clinical Health Act (HITECH) or whether required elements were missing.

This review concluded that none of the Nebraska Medicaid regulations were in conflict with HIPAA or HITECH. However, PCG documents a number of gaps in DHHS internal HIPAA privacy and security policies and procedures. The gaps indicate that either the policy does not address, or does not adequately address, a requirement under federal law, or the policy is not updated to reflect changes from HITECH. Because Nebraska is moving forward with health information technology and the planning for payment of incentives to its providers that adopt electronic health record systems and become meaningful users of this electronic technology, PCG recommends that DHHS update or draft additional internal policies and procedures to meet all of the requirements under HIPAA and HITECH.

2 Introduction

The Nebraska Department of Health and Human Services is currently conducting a review of its Medicaid regulatory framework. This Privacy and Security Review document presents the results of the review relating to Nebraska health information privacy and security. This information will be included as part of the Medicaid Regulatory Report and will also be incorporated into the State Medicaid Health Information Technology Plan (SMHP). This document also provides information regarding gaps between the current privacy and security regulations and recommended updates to comply with HIPAA and HITECH.

2.1 Statement of the Issues

HIPAA and HITECH establish the Privacy and Security Rules governing the access, use and/or disclosure of "protected health information" by "covered entities" and their "business associates." Covered entities and business associates are required to meet certain security requirements associated with creating, maintaining, and transmitting electronic protected health information. HIPAA contains, and HITECH strengthens, civil and criminal enforcement procedures for violations of its requirements. The Nebraska Medicaid agency, its contractors, and its providers are "covered entities" or "business associates" that may access, use, and/or disclose "protected health information," and "electronic protected health information," including any electronic protected health information as may be maintained in the Medicaid Management Information System (MMIS). Nebraska DHHS must comply with HIPAA and HITECH. This report provides regulatory compliance information.

2.2 Objectives of the Review

The first objective of this review was to determine if the Nebraska Medicaid regulations, the State Plan, and Nebraska DHHS Policies and Procedures are consistent with the electronic transaction standards and the privacy and security provisions under HIPAA and the privacy and security provisions under HITECH. The second objective of this review was to determine whether Nebraska materials provide sufficient, useful, well organized guidance to "covered entities," including operations personnel employed by covered entities, regarding disclosure and use of "protected health information."

2.3 Scope of the Review

The scope of this review included all of the statutes and documents listed below in Section 3. The review is limited to an evaluation of compliance and consistency with the electronic transaction standards and the privacy and security provisions under HIPAA and the privacy and security provisions under HITECH. This review did not include any evaluation of actual practices concerning the disclosure and use of protected health information by operations personnel employed by covered entities in Nebraska, nor did it include any evaluation of information system security within the MMIS or other systems that contain protected health information.

2.4 Review Methodology

The analysis of the materials documented in Section 3 includes a comparison of written State statutes, regulations, and policies and procedures with federal privacy and security regulations.

3 Regulatory Inventory with Links

3.1 Federal Regulations

1. Heath Information Technology for Economic and Clinical Health Act—Title XIII, Sections 13001-13424, February 17, 2009. http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/hitechact.pdf
2. HIPAA Privacy Rule—45 C.F.R. Parts 160 and 164, *Standards for Privacy of Individually Identifiable Information; Final Rule,* December 28, 2000. http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/prdecember2000all8parts.pdf
3. Modifications to the HIPAA Privacy Rule—45 C.F.R. Parts 160 and 164, *Standards for Privacy of Individually Identifiable Information; Final Rule,* August 14, 2002. http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/privrulepd.pdf
4. HIPAA Security Rule—45 C.F.R. Parts 160, 162, and 164, *Health Insurance Reform: Security Standards; Final Rule*, February 20, 2003. http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/securityrulepdf.pdf
5. HIPAA Enforcement Rule—45 C.F.R. Parts 160 and 164, *HIPAA Administrative Simplification: Enforcement; Final Rule*, February 16, 2006. http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/finalenforcementrule06.pdf
6. Modifications to HIPAA Enforcement Rule—45 C.F.R. Parts 160 and 164, *HIPAA Administrative Simplification: Enforcement; Interim Final Rule*, October 30, 2009. http://www.hhs.gov/ocr/privacy/hipaa/administrative/enforcementrule/enfifr.pdf
7. Breach Notification Rule—45 C.F.R. Parts 160 and 164, *Breach Notification for Unsecured Protected Health Information; Interim Final Rule,* August 24, 2009. http://edocket.access.gpo.gov/2009/pdf/E9-20169.pdf
8. Modifications to HIPAA Privacy, Security and Enforcement Rules—45 CFR Parts 160 and 164, *Modifications to the HIPAA Privacy, Security, and Enforcement Rules Under the Health Information Technology for Economic and Clinical Health Act; Proposed Rule*, July 14, 2010. http://frwebgate3.access.gpo.gov/cgi-bin/PDFgate.cgi?WAISdocID=XObLxD/7/2/0&WAISaction=retrieve
9. HIPAA Electronic Transaction and Code Sets—45 C.F.R. Parts 160 and 162, *Health Insurance Reform: Standards for Electronic Transactions; Announcement of Designated Standard Maintenance Organizations;* Final Rule and Notice, August 17, 2000. http://www.cms.gov/TransactionCodeSetsStands/Downloads/txfinal.pdf
10. HIPAA Electronic Transaction and Code Sets—45 C.F.R. Parts 160 and 162, *Health Insurance Reform: Modifications to Electronic Transaction Standards and Code Sets*, undated. *http://www.cms.gov/TransactionCodeSetsStands/Downloads/ModificationstoElectronicDataTransactionStandardsandCodeSets.pdf*

3.2 Federal Guidance

1. Guidance found on the Office of Civil Rights: http://www.hhs.gov/ocr/
2. Guidance found at the Office of the National Coordinator:

http://healthit.hhs.gov/portal/server.pt?open=512&objID=1147&parentname=CommunityPage&parentid=10&mode=2&in_hi_userid=11113&cached=true

3.3 State Regulations

1. Nebraska Medical Assistance Program Services, Title 471
   http://www.hhs.state.ne.us/reg/t471.htm
2. Home and Community-Based Waiver Services and Optional Targeted Case Management Services, Title 480
   http://www.hhs.state.ne.us/reg/t480.htm
3. Nebraska Medicaid Managed Care, Title 482
   http://www.hhs.state.ne.us/reg/t482.htm

3.4 Nebraska State Plan

1. Nebraska Medicaid Program State Plan
   http://www.hhs.state.ne.us/med/XIXstateplan/index.htm
2. Planning Advance Planning Document for Medicaid Health Information Project (sent electronically, no link provided)

3.5 State Policies and Procedures (sent electronically, no link provided)

HIPAA Privacy Policies

1. Training Policy, HHSS Policy Number: HIPAA PP-5201-3
2. Documentation Policy, HHSS Policy Number: HIPAA PP-41114J-2
3. Complaints Policy, HHSS Policy Number: HIPAA PP-41114d-3
4. Document Retention Policy, HHSS Policy Number: HIPAA PP-41114L-2
5. Mitigation Policy, HHSS Policy Number: HIPAA PP-41114f-3
6. Policy and Procedures Policy, HHS Policy Number: HIPAA PP-41114i-2
7. Refrain from Intimidating or Retaliatory Acts Policy, HHSS Policy Number:

HIPAA PP-41114g-2

1. *Safeguards Policy*, HHSS Policy Number: HIPAA PP-41114c-3
2. *Sanctions Policy*, HHSS Policy Number: HIPAA PP-41114e-2
3. *Right to Request Privacy Protection Policy*, HHSS Policy Number: HIPAA PP-41110-2
4. *Transition Provisions Policy*, HHSS Policy Number: HIPAA PP-41114k-4
5. *Waiver of Rights Policy*, HHSS Policy Number: HIPAA PP-41114h-2
6. *De-Identification of Protected Health Information Policy*, HHSS Policy Number: HIPAA PP-41122-1
7. *Right to Access a Deceased Individual's Protected Health Information Policy*, HHSS Policy Number: HIPAA PP-41120-1
8. *Right to Access Protected Health Information Policy*, HHSS Policy Number: HIPAA PP-41111-2
9. *Right to Agree or Object Policy*, HHSS Policy Number: HIPAA PP-4116L-2
10. *Right to Amend Protected Health Information Policy*, HHSS Policy Number: HIPAA PP-41112-2

11. *Right to an Accounting of Disclosures Policy*, HHSS Policy Number: HIPAA PP-41113-3
12. *Right to Designate a Personal Representative Policy*, HHSS Policy Number: HIPAA PP-41121-1
13. *Treatment, Payment and Operations Authorization Policy*, HHSS Policy Number: HIPAA PP-41115-2
14. *Minimum Necessary Standard Policy*, HHSS Policy Number: HIPAA PP-4111-2
15. *Designated Record Set Policy*, HHSS Policy Number: HIPAA PP-4113-3
16. *Preemption of State Law Policy*, HHSS Policy Number: HIPAA PP-4112-3
17. *Notice of Privacy Practices Policy*, HHSS Policy Number: HIPAA PP-41109-2
18. *Unemancipated Minors Policy*, HHSS Policy Number: HIPAA PP-41114L-2
19. *Business Associate Agreement Policy*, HHSS Policy Number: HIPAA PP-0602-4
20. *Emergency Disclosure Policy*, HHSS Policy Number: HIPAA PP-7251-3
21. *Organizational Policy*, HHSS Policy Number: HIPAA PP-41113-2
22. *Protected Health Information Uses and Disclosures Policy*, HHSS Policy Number: HIPAA PP-41118-2
23. *Protected Health Information Policy*, HHSS Policy Number: HIPAA PP-41118-2

DHHS Master Interagency/Business Associate Agreement, Revision 02-17-2010

HHSS Security Policies

1. *Software Acceptable Use Policy*, Policy Number: HHSS-2004-004
2. *Software Acceptable Use—Employee Home Use Standard*, Policy Number: HHSS-2004-004-B
3. *Software Acceptable General Use Standard*, Policy Number: HHSS-2004-004-A
4. *Information Technology (IT) Security Policy*, Policy Number: HHSS-2004-002
5. *Information Technology (IT) Resources Acceptable Use Policy*, Policy Number: HHSS-2004-003
6. *Information Technology (IT) Risk Assessment Standard*, Policy Number: HHSS-2004-002-B
7. *Information Technology (IT) Security Audit Standard*, Policy Number: HHSS-2004-002-A
8. *Information Technology (IT) Access Control Standard*, Policy Number: HHSS-2004-002-C
9. *Information Technology (IT) Resources Acceptable Use Standard*, Policy Number: HHSS-2004-003-A
10. *Information Technology (IT) Incident Reporting Standard*, Policy Number: HHSS-2004-002

DHHS Security Policies

1. *Computer Property Management*
2. *Employee Identification Policy*
3. *Identification and Access Policy and Procedures for the Nebraska State Office Building in Lincoln,* March 19, 2002

HHSS Privacy Memoranda

1. *Use and Disclosure of PHI for Marketing Purposes*, September 25, 2003
2. *Verification of Requests for Protected Health Information*, May 6, 2003

3. *HIPAA Violation Process*, October 29, 2003

HHSS Security Memoranda

1. *HIPAA Compliant Technical Safeguards—Access Controls*, December 6, 2004
2. *HIPAA Compliant Administrative Safeguard—Contingency Plan*, October 4, 2004
3. *HIPAA Compliant Physical Safeguards—Device and Media Controls,* February 8, 2005
4. *HIPAA Compliant Physical Safeguards— Facility Access Controls*, January 19, 2005
5. *HIPAA Compliant Technical Safeguards—Integrity and Person or Entity Authentication*, December 16, 2004
6. *HIPAA Compliant Technical Safeguards—Transmission Security*, December 16, 2004

4 Gap Analysis and Narrative Overview

4.1 Regulatory Gap Analysis – Chapters 471, 480 and 482; State Medicaid Plan

Nebraska Medicaid regulations do not conflict with or have gaps relative to the HIPAA electronic transaction standards or the Privacy and Security Regulations under HIPAA and HITECH. However, please note, Nebraska Medicaid regulations Titles 471, 480 and 482 contain few provisions that would implicate these regulations. Relevant Nebraska regulatory provisions are summarized and discussed below.

4.1.1 Electronic Transaction Standards

Nebraska Medicaid regulations comply with HIPAA electronic transaction standards. HIPAA mandates transaction standards for the electronic transfer of health care information for specific purposes (e.g. eligibility inquiry and response, claims processing etc.). If an entity engages in one or more of the identified transactions, the entity must comply with the standard for that transaction. The HIPAA required transaction standards are as follows:

1. Patient Eligibility Inquiry and Response (transaction regarding patient's eligibility for coverage): ASC X12N 270-271(all others) and NCDPD (pharmacy transactions).
2. Prior Authorization and Referral (inquiry and response regarding prior authorization or referral for health care services): ASC X12N 278 (all others) and NCDPD (pharmacy transactions).
3. Claims or Encounters (reimbursement for health care services performed): ASC X12N 837 (Professional, Institutional, and Dental) and NCPDP (retail pharmacy transactions).
4. Claims Status Inquiry and Response (transaction regarding processing status of submitted claim or encounter): ASC X12N 276-277 (all others) and NCDPD (pharmacy transactions).
5. Remittance Advice (explanation of claim processing and/or payment sent to provider): ASC X12N 835.

HIPAA does not require that a Trading Partner Agreement be entered into between providers and payers, including Medicaid. However, if entered into, the Trading Partner Agreement may not alter in any way the requirements for a standard transaction.

Nebraska Regulations, Title 471, Chapter 3 establishes requirements for payment of Medicaid Services. Section 3003 requires providers to submit claims for the payment of medical services using the appropriate HIPAA mandated standard for electronic transactions. Title 471, Chapter 2, Section 2-001.09 requires an approved Trading Partner Agreement between the State and "any entity that exchanges standard electronic transactions." Title 471, Chapter 3, Section 3002.01(6) indicates that a Trading Partner Agreement may be required as a condition of receiving payment. Throughout the numerous Chapters of Title 471, there are frequent references to the appropriate HIPAA mandated standard for electronic transactions.

4.1.2 Privacy and Security of Protected Health Information

There is very little reference to health information or medical records, or any requirements governing the privacy and security of either, in Nebraska Medicaid regulations Titles 471, 480 and 482 or the State Plan. Nebraska regulations, Title 471, Nebraska Medical Assistance Program Services, makes only general reference to maintaining the privacy and security of health or medical records. If made part of a provision, the language is broad, such "meet the requirements of state and federal laws" or "providers must ensure the confidentiality of patient records." Specific references to the privacy and security of health information or medical records under Nebraska regulations, Title 471 are listed below.

> 471, Section 1-006.10C
>
> "Each telehealth site shall have established written quality of care protocols and patient confidentiality guidelines to ensure telehealth services meet the requirements of state and federal laws."
>
> 471, Section 1-006.10F
>
> "The practitioner shall keep a complete medical record on all telehealth services provided to clients, following all applicable statutes and regulations for medical record keeping and confidentiality."
>
> 471, Section 10-013.01
>
> "The hospital must have a procedure for ensuring the confidentiality of patient records. Information form or copies of records may be released only to authorized individuals, and the hospital must ensure that unauthorized individuals cannot gain access to or alter patient records."
>
> Title 471, Section 20-001.19
>
> "Each provider shall maintain accurate, complete, and timely records and shall always adhere to procedures that ensure the confidentiality of clinical data."
>
> Title 471, Section 32-001.05
>
> "Each provider shall maintain accurate, complete and timely records and shall always adhere to procedures that ensure the confidentiality of clinical data."
>
> Title 471, Section 35-014.04
>
> "Records must be kept in a locked file when not in use. For purposes of confidentiality, disclosure of rehabilitation information is subject to all the provisions of applicable State and Federal laws."

Nebraska regulations Title 480, *Home and Community-Based Waiver Services and Optional Targeted Case Management Services*, has two provisions that have slightly stricter requirements than HIPAA

regarding the confidentiality of health information: 1) Chapter 10, Section 10-004; and 2) Chapter 10, Section 10-006. These provisions are lengthy and do not lend themselves to being easily reproduced in this report. Neither of these provisions is in conflict with federal law as HIPAA permits states to have stricter requirements governing the privacy and security of health information. Under HIPAA, if more stringent, a state's provisions must be followed.

Nebraska regulations Title 482, *Nebraska Medicaid Managed Care*, addresses privacy and security broadly by requiring the health plan and MH/SA Providers to generally comply with all requirements of HIPAA (see Chapter 4, Section 4-003.01 and Chapter 5, Section 5-002.05A respectively). Two other sections under Title 482 address privacy issues. Title 482, Chapter 3, Section 3-004 state Enrollment Brokers (EBs) must "maintain the confidentiality of client-specific information." The EB must not publish or otherwise release client information without the prior written approval of the Department." Chapter 7, Section 7-001 guarantees patients the right to "talk with his/her doctor and health plan and know his/her medical information will be kept confidential." Neither of these provisions is in conflict with HIPAA or HITECH.

The State Plan, Section 4.3 states that "under State statute which imposes legal sanctions, safeguards are provided that restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan." This provision is stricter than HIPAA or HITECH requirements because it limits the purposes under which this information can be used. However, as stated above, HIPAA permits states to have stricter requirements governing the privacy and security of health information.

4.2 Regulatory Gap Analysis – State Privacy and Security Policies.

PCG recommends amendments based on final (and as applicable), proposed changes to the HIPAA Privacy and Security Rules. These recommended changes are described under Section 5, Recommendations, below. Additionally, PCG has determined that DHHS will need to create additional policies to be in full compliance with the HIPAA Privacy and Security Rule, as well as HITECH.

5 Recommendations

5.1 Nebraska Medicaid Regulations—Electronic Transactions.

As noted above, Nebraska Medicaid regulations are in compliance with HIPAA and HITECH. However, in order to be more consistent with federal regulations, PCG recommends DHHS consider the following changes to State statutes:

1. Modify the definition of "standard transaction" under Title 471, Chapter 3, Section 3-001 from "means an electronic transaction that complies with the applicable standard adopted under federal law" to "means an electronic transaction that complies with the applicable standard adopted under 45 CFR Part 162 Subparts I-R."
2. Modify the definition of "Trading Partner Agreement" under Title 471 Chapter 2, Section 2-002.02 and Chapter 3, Section 3-001 by adding the following second sentence: "A Trading Partner Agreement may not, in any way, modify transaction standards as defined under 45 CFR Part 162 Subparts I-R."

5.2 Nebraska Internal Privacy and Security Policies

5.2.1 Nebraska Privacy Policies and Procedures

PCG recommends that DHHS consider updates to all HIPAA Privacy policies because as currently written they: 1) are difficult to understand; 2) are "piece-mealed"; 3) do not include a pre-emption analysis; and 4) in general, do not provide practical, usable guidance for operations personnel. The DHHS internal privacy policies appear to have been written to address an individual HIPAA provision by cite (e.g. 45 C.F.R. 164.502) rather than grouped together in a logical way based on internal operations (examples are given below under specific recommendations). Moreover, the policies appear to be "copying and pasting" of exact language out of the text of the HIPAA Privacy Regulations, which are technical and legal, and therefore, may be hard for operations personnel to understand. Additionally, none of the policies incorporate or describe the impact of a pre-emption analysis, which is required by HIPAA. The policies make reference to the requirement that a pre-emption analysis be performed. However, none of the policies indicate what Nebraska law might say in relationship to a HIPAA Privacy Rule requirement, or what impact that law might have. For example, does Nebraska have separate release of information laws that may be stricter than HIPAA? If so, then the *Treatment, Operations Authorization* policy should be changed to reflect both HIPAA and State law. Similarly, several of HIPAA provisions reference "applicable law" or "state law." The DHHS privacy policies make the appropriate reference to "applicable law" if stated under the HIPAA Privacy Rule, but do not describe or otherwise incorporate what may actually be "applicable law" under Nebraska law. For example, see policies *Right to Designate Personal Representative*, *Unemancipated Minors*, and *Right to Access Protected Health Information*. In order to be effective, relevant State law implications need to be incorporated into the policies. DHHS provided several privacy and security "Compliance Memorandum," which do a better job of taking difficult requirements and applying them to business operations. However, PCG recommends that DHHS consider updating and amending the HIPAA privacy policies.

PCG recommends the following, specific changes to DHHS HIPAA Privacy Policies:

1. Training

   a. Since the compliance date has passed, and in order to slightly broaden the scope (to include the Security Rule), PCG recommends updating the Training policy statement to say: "It is the policy of the Health and Human Services System to deliver training to the workforce on DHHS HIPAA policies and procedures within a reasonable time after their effective state date."

   b. Update Section 3*, DHHS HIPAA Training Program Compliance Deadline*, by either: 1) deleting it (since the effective date has come and past); or 2) rewriting it to say: "All members of the DHHS workforce as of April 14, 2003 have received, at minimum, the DHHS HIPAA Level-I 'HIPAA Privacy and Security Awareness' training."

2. Mitigation

   This policy should cross reference to a Breach Notification Policy or memorandum since the issues of mitigating "harmful effect" and the breach notification requirements are similar.

3. Right to Request Privacy Protection Policy

   Amend this policy to comply with Section 13405(a) of HITECH, which requires a covered entity to comply with a requested restriction if: "(1) except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full." Based on these new requirements, PCG recommends the following changes to this policy:

   a. Change the wording on page 2, *The Standard, (i)(B)(ii),* to "a covered entity is not required to agree to a restriction, except when disclosure is to health plan for payment or health care operations purposes and the protected health information being restricted pertains solely to an item or services for which the health care provider has been paid in full."

   b. Add an implementation specification or procedure to accommodate the change in rules.

4. De-Identification of Protected Health Information

   PCG recommends changing this policy to add language regarding limited data sets as defined under HITECH Section 13405(b), which states, "subject to subparagraph (B), a covered entity shall be treated as being in compliance with section 164.502(b)(1) of title 45, Code of Federal Regulations, with respect to the use, disclosure, or request of protected health information described in such section, only if the covered entity limits such protected health information, to the extent practicable, to the limited data set (as defined in section 164.514(e)(2) of such title) or,

if needed by such entity, to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request, respectively."

5. Right to Access Protected Health Information

   Add provision that addresses the following requirements from HITECH (Section 13405(e)) which permits access to PHI maintained in an electronic format. Specifically, Section 13405(e) of HITECH states, "in applying section 164.524 of title 45, Code of Federal Regulations, in the case that a covered entity uses or maintains an electronic health record with respect to protected health information of an individual—(1) the individual shall have a right to obtain from such covered entity a copy of such information in an electronic format and, if the individual chooses, to direct the covered entity to transmit such copy directly to an entity or person designated by the individual, provided that such choice is clear, conspicuous, and specific, and (2) notwithstanding paragraph (c)(4) of such section, any fee that the covered entity may impose for providing such individual with a copy of such information (or summary or explanation of such information) if such copy (or summary or explanation) is in an electronic form shall not be greater than the entity's labor cost in responding to the request for the copy (or summary or explanation)." These new requirements are also reflected, albeit slightly differently, in the July 14, 2010, *Modifications to the HIPAA Privacy, Security, and Enforcement Rules Under the Health Information Technology for Economic and Clinical Health Act: Proposed Rule* ("Modifications to the HIPAA Privacy and Security Rule"). Nebraska should monitor the publication of the Final Rule to ensure this policy incorporates any final changes. As proposed, these changes would require entities to provide patients with access to PHI "in the form and format requested by the individual, if is readily producible in such form and format; or if not, in a readable hard copy form or such other form and format as agreed to by the covered entity and the individual." PHI held *electronically* must be provided in an electronic form and format, if requested if readily producible. If not readily producible, the PHI must be made available "in a readable electronic form and format as agreed to by the covered entity and the individual." Additionally, under these proposed rules, access to PHI must be made available in "a timely manner."

6. Right to an Accounting of Disclosures

   This policy will need to be amended to account for changes under HITECH Section 13405(c), which as of January 1, 2014, will require entities to provide an accounting of disclosures for those disclosures made for treatment, payment and health care operations' purposes if the PHI is used or maintained in an electronic health record. This section also contains some additional, specific, related requirements that Nebraska may want to add to this policy. Since the effective date of these changes is not until, January 1, 2014, DHHS may wish to delay their update to this policy.

7. Right to Designate a Personal Representative

   This policy references "unemancipated minors" on Page 3. Does Nebraska law recognize unemancipated minors? If so, PCG recommends changing this policy to define what an unemancipated minor is and what their rights are under this policy.

8. Minimum Necessary Standard

   DHHS should consider amending this policy to address the following changes made under Section 13405(B) of HITECH, which states: "subject to subparagraph (B), a covered entity shall be treated as being in compliance with section 164.502(b)(1) of title 45, Code of Federal Regulations, with respect to the use, disclosure, or request of protected health information described in such section, only if the covered entity limits such protected health information, to the extent practicable, to the limited data set (as defined in section 164.514(e)(2) of such title) or, if needed by such entity, to the minimum necessary to accomplish the intended purpose of such use, disclosure, or request, respectively." Please note, under Section 13405(b)(3), the expectations to the minimum necessary requirements under 45 CFR 164.502(b)(1) still apply.

9. Treatment, Payment, and Operations Authorization Policy and Protected Health Information Policies

   These two policies could be combined with the "Protected Health Policy" to more broadly define and describe the circumstances under which written patient authorization is required based both on HIPAA and relevant State law requirements, as well as articulating the treatment payment, and health care operations exception to patient authorization. Separately, these policies are confusing and provide limiting information. For example, the *Treatment, Payment and Operations* policy only includes two circumstances under which patient authorization is required. Moreover, it does not specifically state that authorization is not required for treatment, payment and health care operations purposes.

10. Designated Record Set

    This policy could be terminated. If terminated, relevant language pertaining to the definition of a "designated record set" could be added to either the (1) "Right to Access Protected Health Information" or (2) Right to Amend Protected Health Information" policies as applicable.

11. Preemption of State Law

    This policy does not need to exist. Rather, DHHS should include their preemption analysis within each policy, as applicable. If DHHS prefers to keep this policy, any preemption analysis performed should be linked or appended to it.

12. Unemancipated Minors Governance

    This policy should state if Nebraska recognizes emancipated minors, and if so, how being emancipated affects this policy.

13. Business Associate

    HITECH contains a number of provisions that affect business associates (see Sections 13401, 13402, 13404, 13405(b)(2), 13405(c)(3)(B), 13405(d), 13406(a) and 13408), including the definition of who may be a business associate (See Section 13408). However, these changes apply to a business associate, not a covered entity. It is not clear from the documents provided whether Nebraska DHHS would ever be a business associate. If so, this policy would need to be modified to address the additional requirements for business associates under HITECH.

Please note that the Proposed Modifications to the HIPAA Privacy and Security Rule contain proposed provisions affecting: 1) required uses and disclosures related to business associates; 2) disclosures to business associates; and 3) business associate contracts under 45 CFR 164.502(a)(5), CFR 164.502(e)(1) and CFR 164.504 (e)(1)-(5) respectively. This policy will need to be amended to reflect these changes should they finalized.

DHHS has provided its Master Interagency/Business Association Agreement, Revision date 2/17/2010 ('Agreement"). This Agreement contains provisions that address changes under HITECH.

14. HIPAA Privacy Rule Emergency Disclosure of PHI and the Individual Right to Agree or Object Policies

    These two policies should be combined. A patient's right to agree or object to uses and disclosures under 45 CFR 164.510 is fairly limited. The final DHHS policy addressing this provision should provide clear guidance of the circumstance under which CFR 164.510 applies in the DHHS setting.

15. Organizational Requirements Policy

    This policy defines DHHS as a "covered entity." PCG recommends that this policy also describe the impact of being a covered entity (e.g. that it must comply with all HIPAA Privacy and Security requirements).

    This policy also references business associate contracts under the "Standards" section. As described above, business associate contracts have been affected by provisions in HITECH and Proposed Modifications to the HIPAA Privacy and Security Rules. This standard should be deleted (since it would be covered in the business associate policy) or modified as described above.

16. Protected Health Information

    In addition to changes suggested under "9" above, this policy should be amended to address any changes that are finalized under the Proposed Modifications to the HIPAA Privacy and Security Rule. The Proposed Modifications to the HIPAA Privacy and Security Rule adds "or business associate" to: (1) 164.502(a), first sentence after "covered entity;" and (2) 164.502(b)(1) in the middle of the sentence after covered entity. If these changes are made permanent, DHHS will need to modify their policy to include the new standard.

    Additionally, the Proposed Modifications to the HIPAA Privacy and Security Rule makes proposed to changes to 45 CFR 164.502(e)(1)(ii), which appears to remove the exceptions to obtaining satisfactory assurances and replace with other language. If these changes are made permanent, sentence 2 of item number 5 under the "Administration" Section would need to be deleted.

    Finally, the Proposed Modifications to the HIPAA Privacy and Security Rules adds "for a period of 50 years following the death of the individual" to the requirements that a covered entity must apply HIPAA standards to deceased individuals under 45 CFR 164.502(f).

17. Notice of Privacy Practices

    The Proposed Modifications to HIPAA Privacy and Security Rules create additional requirements including statements that must be added to a covered entity's Notice of Privacy Practice. If finalized, this policy, as well as DHHS's Notice of Privacy Practices, will need to be amended.

18. Use and Disclosure of PHI for Marketing Purposes Memorandum

    This memorandum should be updated to includes changes to marketing provisions under Section 13406 (a) of HITECH. In general, these changes specify that communications about a product or service is not considered a "health care operation" unless certain conditions are met.

PCG recommends DHHS draft the following additional HIPAA Privacy Rule policies:

1. A policy to address the requirements under Section 13405(d), "Prohibition on Sale of Electronic Health Records or Protected Health Information" of HITECH. In general, these provisions prohibit a covered entity or business associate from directly or indirectly receiving remuneration in exchange for any protected health information unless an authorization is obtained or if one of the exceptions listed are met.

2. To the extent applicable for DHHS operations, a policy to address protected health information used and/or disclosed for fundraising purposes. The HIPAA Privacy Rule originally addresses these requirements at 45 CFR 164.514(f). HITECH amends these provisions at Section 13406(b). The Proposed Modifications to the HIPAA Privacy and Security Rules also addresses these at proposed changes 45 CFR 164.514(f).

3. An authorization policy describing the requirements for written authorization under the HIPAA Privacy Rule, as well as proposed modifications, at 45 CFR 164.508. Alternatively, DHHS may include these requirements under either the *Protected Health Information* policy or that policy combined with the *Treatment, Payment and Health Care Operations* policy.

5.2.2 Nebraska Security Policies and Procedures

In general, the DHHS security policies are easier to understand and provide more practical guidance about expectations related to security. However, in order to more fully address the requirements under the HIPAA Security Rule, PCG recommends the following changes to these policies:

1. Information Technology (IT) Security Policy

   This policy appears to be the broad, security oversight policy. However, it is missing a number of elements that would need to be added to fully address the requirements of the HIPAA Security Rule that are not otherwise addressed in other policies. PCG recommends making the following additions to this policy:

   a. Include a statement that DHHS will assign and maintain one or more individuals who are responsible for functioning as Security Officer as required by 45 CFR

164.308(a)(2)). In addition to this policy, DHHS should ensure that a Security Officer job description exists and that it "tracks" who has held this role since the effective date of the Security Rule.

b. Section 5.0, "Enforcement" should be edited to remove "Acceptable Use Policy" from the first sentence and amended to more broadly ensure compliance with 45 CFR 164.308(a)(1)(ii)(C).

c. Add a section about security policies and procedures including the need to create, maintain, update and document policies and procedures. (See 45 CFR 164.316(a)-(b)).

d. Add a section about security awareness and training procedures for employees. (See 45 CFR 164.308(a)(5)(ii)(A)-(C). Please note, this training is provided (DHHS staff gave PCG a copy of the HIPAA Privacy and Security Training Guide provided to employees.

e. Add a section to include workforce security measures as required under 45 CFR 164.308(a)(3)(ii)(A).

2. <u>Information Technology (IT) Risk Assessment Standard</u>

This policy addresses many of the requirements related to risk analysis and risk management. However, PCG recommends the following to strengthening this policy:

a. Clarify what processes or procedures constitute "initial" and "on-going" risk assessment measures.

b. More thoroughly define the security measures DHHS will take to reduce risks and vulnerabilities as described in 45 CFR 164.308(a)(1)(ii)(B).

3. <u>Information Technology (IT) Security Audit Standard</u>

This policy primarily addresses audit process related to access to electronic protected health information. This policy would be stronger if it also contained processes for auditing the integrity and transmission of electronic protected health information. (See 45 CFR 164.312(c)(2) and 164.312(e)(2)(i)).

4. <u>Information Technology (IT) Access Control Standard</u>

a. Under Section 2.0, "Scope," at the end of the last sentence, include the following: "including systems that store and/or transmit electronic protected health information."

b. Under Section 3.1, "Unique User Identification Guidelines," rewrite the first sentence to say: "Unique User Identification (LOG-on ID) is used to identify an individual, provide services, and levels of access to DHHS networks, applications, and systems, including those containing electronic protected health

information. In the second sentence, give an example of an DHHS system that contains electronic protected health information.

c. This policy should provide better broad-based guidance on how access is determined, tracked and modified based on role, movement in the department, and termination. (See 45 CFR 164.308(a)(3)(ii)(A)-(C), 45 CFR 164.312(a)(2)(i)).

d. Include a section describing any automatic time outs for inactivity of systems containing electronic protected health information. (See 45 CFR 164.312(a)(2)(iii)).

e. Include a section describing measures to address workstation security issues as required under 45 CFR 164.310(b)-(c).

Although not covered in policies, the following security requirements are addressed in HHSS Compliance Memoranda. HHSS should consider making these actual DHHS policies rather than Compliance Memoranda.

1. Encryption and Data Transmission—addressed in the *HIPAA Compliant Technical Safeguards—Access Controls* Compliance Memorandum and the *HIPAA Compliant Technical Safeguards—Transmission Security* Compliance Memorandum.
2. Contingency Plan—addressed in the *HIPAA Compliant Administrative Safeguard—Contingency Plan* Compliance Memorandum.
3. Data Management— addressed in the *HIPAA Compliant Administrative Safeguard—Contingency Plan* Compliance Memorandum and the *HIPAA Complaint Technical Safeguards—Integrity and Person or Entity Authentication* Compliance Memorandum.
4. Reuse, Destruction and Disposal—addressed in the *HIPAA Compliant Physical Safeguards—Device and Media Controls* Compliance Memorandum.
5. Facility Access Controls—addressed in the *HIPAA Complaint Physical Safeguards Facility Access Controls* Compliance Memorandum.

Data Management issues are also addressed under the DHHS Administrative Policy, *Computer Property Management.* Facility Access Controls are also addressed under the DHHS *Employee Identification Policy* and *the Identification and Access Policy and Procedures for the Nebraska State Office Building in Lincoln.*

PCG recommends DHHS have a Breach Notification policy. Breach notification requirements are established under Section 13402 of HITECH (also found at 45 CFR Subpart D (164.400-164.313). Although "breach" is similar to a "security incident" and processes may overlap somewhat with the *Information Technology (IT) Incident Reporting Standard*, they are different and should be addressed under separate policies. However, per DHHS, IT policies do not have the authority for this. Rather, a Breach Notification policy would fall under the administrators and not IS&T or the HIPAA office.

6 Conclusion

The Privacy and Security Medicaid Regulatory Review and Report was performed to assess the current status of Nebraska Medicaid specific regulations, documents, and internal policies and procedures in comparison with federal privacy and security regulations. This analysis was an important undertaking as Nebraska DHHS promotes electronic health record adoption and plans the SMHP because these efforts require measures that ensure the privacy and security of patient health information. As stated above, Nebraska internal policies and procedures contain a number of potential gaps in relationship to HIPAA and HITECH requirements. This report provides detailed, suggested changes that if implemented, will reduce any potential gaps and help demonstrate DHHS' commitment to implementing measures that protect the privacy and security of patient health information.

Appendix K: Statewide Health Information Exchange Strategic and Operational Plan Environmental Scan

Links to the most recent versions of the strategic and operational eHealth Plans are below:

http://www.nitc.nebraska.gov/eHc/plan/NebStrategiceHealthPlanV51Feb32011.pdf

http://www.nitc.nebraska.gov/eHc/plan/OperationalplanV3.1Feb2011withAppendix.pdf

Appendix L: EH Payment Calculation Instructions

MLTC will calculate payments for all eligible hospitals using information submitted by the hospital upon application. It is a requirement that auditable data sources be used to calculate EHR hospital incentive amounts. MLTC has elected to use Medicaid and Medicare cost reports as well as other internal data to validate the hospital-reported information. MLTC will make payments to eligible hospitals over a three-year time period: 50 percent in the first year, 40 percent in the second year and 10 percent in the third year.

Hospitals will be required to submit information from the relevant cost report(s) for the purpose of determining payment calculations. Calculations will be made by DHHS staff and presented to Eligible Hospitals for review prior to final eligibility determination.

It is important to note, for the purposes of this calculation that discharges and inpatient bed-days are limited to those from the acute care portion of a hospital. This would exclude services rendered in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital.

As set forth in the Federal rule, the formula for calculating Medicaid hospital EHR incentive payments is based on the product of two factors:

Overall Amount x Medicaid Share

Overall Amount

The overall EHR amount is based upon the sum over a theoretical four years of payment where the amount for each year is the product of three factors: 1. An Initial Amount, 2. The Medicare Share, and 3. A Transition Factor applicable to each of a theoretical four years.

1. Initial Amount

The sum of a $2 million base amount and the product of a per discharge amount (of $200) and the number of discharges (for discharges between 1,150 and 23,000 discharges).

MLTC will calculate the average growth rate for a hospital based on discharges reported in Medicare/Medicaid Cost Reports over the most recent 3 years prior to the year on which payment is based. Nursery bed days/discharges and swing-bed days are not to be included in the reported number.

Per Federal regulations, if a hospital's average annual rate of growth is negative over the 3 year period, it will be applied as such.

2. The Medicare Share

Set at one (1) for each year

3. The transition factor which phases down the incentive payments over the four-year period is shown below:

Year	Transition Factor
Year 1	1
Year 2	0.75
Year 3	0.50
Year 4	0.25

Medicaid Share

The numerator of the Medicaid Share is the sum of: 1) estimated number of Medicaid acute inpatient-bed-days*; and, 2) the estimated number of Medicaid managed care acute inpatient-bed-days.

The denominator of the Medicaid Share is the product of: 1) estimated total number of acute inpatient-bed-days for the eligible hospital during that period; and, 2) the estimated total amount of the eligible hospital's charges during that period, not including any charges that are attributable to charity care divided by the estimated total amount of the hospital's charges during that period.

* It is important to note that Medicaid acute inpatient-bed-days may not include those patients for which Medicare paid a share (dually eligible recipients).

A more detailed breakdown can be seen below:

{Sum over 4 year of [(Base Amount ($2 million) + Discharge Related Amount Applicable for Each Year) * Medicare Share (1) * Transition Factor Applicable for Each Year]}

Multiplied By

{(Medicaid acute inpatient-bed-days + Medicaid managed care acute inpatient-bed-days) divided by [(total acute inpatient-bed days) times (estimated total charges minus charity care charges) divided by (estimated total charges)]}

The following tables outline the body of data that need be reported and the payment calculation process that will take place based on information provided by a hospital.

Total Discharges - Fiscal Year 1*	Worksheet S-3, Part I, Column 15, Line 12
Total Discharges - Fiscal Year 2	Worksheet S-3, Part I, Column 15, Line 12
Total Discharges - Fiscal Year 3	Worksheet S-3, Part I, Column 15, Line 12
Total Discharges - Fiscal Year 4	Worksheet S-3, Part I, Column 15, Line 12
Total Medicaid Days	Worksheet S-3, Part I, Column 5, Lines 1, 6-10 (and validated against MMIS data)
Medicaid HMO Days	Worksheet S-3, Part I, Column 5, Line 2
Total Hospital Days	Worksheet S-3, Part I, Column 6, Lines 1, 2, 6-10
Total Charity Charges	Worksheet S-10, Line 30
Total Hospital Charges	Worksheet C, Part I, Column 8, Line 101

* For the first payment year, data on hospital discharges from the hospital fiscal year that ends during the federal fiscal year prior to the hospital fiscal year that serves as the first payment year will be used as the basis for determining the discharge-related amount for hospitals that begin participation prior to FFY 2013. Beginning with FFY 2013, discharge data from the most recent continuous 12 month period for which data are available prior to payment year will be used in the calculation.

The following stepped instruction demonstrates an example of a hospital payment calculation:

Step 1: Enter the end date of the last full facility fiscal year.

Hospital Fiscal Year Close
6/30/2010

Step 2: Fill in the overall facility discharges to cover each of these time periods.

Fiscal year	Total Discharges
6/30/2010 (Hypothetical baseline year)	4720
6/30/2009	4650
6/30/2008	4695
6/30/2007	5000

Step 3: Determine the Average Growth Rate.

Fiscal Year	Discharges	Growth Rate
6/30/2010 (Hypothetical baseline year)	4720	1.51%
6/30/2009	4650	- 0.96%
6/30/2008	4695	- 6.10%
6/30/2007	5000	
Average Growth Rate		- 1.85%

Step 4: Apply growth rate to the base number of discharges.

Hypothetical Year	Reported Discharges	Growth Rate	Calculated Discharges
Base Year	4720	- 1.85%	4720
Year 2		- 1.85%	4633
Year 3		- 1.85%	4547
Year 4		- 1.85%	4463

Step 5: Determine eligible discharges. Only discharges between 1,149 and 23,000 are to be used in the equation.

Hypothetical Year	Calculated Discharges	Eligible Discharges
Base Year	4720	3571
Year 2	4633	3484
Year 3	4547	3398
Year 4	4463	3314

Step 6: Multiply the eligible discharges by $200

Hypothetical Year	Eligible Discharges	Eligible Discharge Payment
Base Year	3571	$ 714,200.00
Year 2	3484	$ 696,800.00
Year 3	3398	$ 679,600.00
Year 4	3314	$ 662,800.00

Step 7: Add the base year amount per payment year: $2,000,000

Hypothetical Year	Eligible Discharge Payment	Discharge Payment + Base Amount
Base Year	$ 714,200.00	$ 2,714,200.00
Year 2	$ 696,800.00	$ 2,696,800.00
Year 3	$ 679,600.00	$ 2,679,600.00
Year 4	$ 662,800.00	$ 2,662,800.00

Step 8: Use Eligible Discharge Payment and Medicaid Transition Factor to create Overall EHR Amount

Hypothetical Year	Discharge Payment + Base Amount	Transition Factor	Overall Amount
Base Year	$ 2,714,200.00	1	$ 2,714,200.00
Year 2	$ 2,696,800.00	.75	$ 2,022,600.00
Year 3	$ 2,679,600.00	.5	$ 1,339,800.00
Year 4	$ 2,662,800.00	.25	$ 665,700.00
Total Payment			$ 6,742,300.00

Step 9: Report the number of Inpatient Medicaid Bed Days, Total Inpatient Bed Days, Total Charges (for all discharges), and Total Charity Care (for all discharges)

Medicaid IP Bed Days	Total IP Bed Days	Total Charges	Charity Care
2905	23220	$ 212,600,100.00	$ 12,759,310.00

Step 10: Calculate the Medicaid Bed Day Ratio

Medicaid IP Bed Days	Total IP Bed Days	Medicaid Bed Day Ratio
2905	23220	12.51%

Step 11: Calculate the Non-Charity Care Share Ratio

Total Charges – Charity Care	Total Charges	Non-Charity Care Share Ratio
$199,840,790.00	$ 212,600,100.00	94.00%

Step 12: Calculate the Medicaid Share. Used to weight Medicaid's impact on total bed days. It is considered a better metric than discharges since Medicaid patients generally have a higher illness burden.

Medicaid Bed Day Ratio	Medicaid Bed Day Ratio	Medicaid Share
12.51%	94.00%	13.31%

Step 13: Multiply the Overall EHR Amount by the Medicaid Share. Determines Total Payment

Overall Amount	Medicaid Share	Medicaid Aggregate Payment
$ 6,742,300.00	13.31%	$ 897,400.13

Step 14: Apply payment distribution methodology

Payment Year	Percentage	Medicaid Aggregate Payment
Year 1	50%	$ 448,700.07
Year 2	40%	$ 358,960.05
Year 3	10%	$ 89,740.01

Appendix M: Process Timing

Eligible Professionals

Eligibility Check	Process /Source	Happy Path		Extended Prepayment Audit		PA		Problem Registration	
		Check	Time (min)	Check	Time (min)	Check	Time (min)	Check	Time (min)
NLR data matches SLR data.	B-6 compared to SLR Registration Provider Name, NPI, Medicaid ID, TIN, Payee NPI, Payee Name, Payee Address, Provider Type, Provider Specialty, ONC Cert. #	x	3	x	3	x	3	x	3
SLR matches MMIS.	SLR compared to MMIS NPI, TIN, TIN Type, CCN, Provider Type, Provider Specialty, name, legal name, address, phone, contact e-mail	x	3	x	3	x	3	x	3
EP assignment payee relationship is valid.	MMIS	x	1	x	1	x	1	x	1
Must be one of the permissible professional types.	NPPES, MMIS	x	1	x	1	x	1	x	1
Must be licensed to practice in the State.	NE Licensure System, Licensure Documentation	x	1	x	1	x	1	x	1
Cannot be excluded, sanctioned, or otherwise deemed ineligible to receive payments from the State (e.g. already received incentive payment).	State excluded list, OIG List, Medicaid and CHIP Information Sharing System (Program Integrity /Provider Enrollment)	x	3	x	3	x	3	x	3

Eligibility Check	Process /Source	Happy Path		Extended Prepayment Audit		PA		Problem Registration	
		Check	Time (min)	Check	Time (min)	Check	Time (min)	Check	Time (min)
EP must not appear on Death Registry.	SSDMF	x	1	x	1	x	1	x	1
Flags present								x	7200
EP must practice in a PA-led FQHC or RHC if he/she is a Physician Assistant (PA)	CMS-29, MLTC-62, HRSA Data Warehouse Report Tool					x	15	x	15
EPs must have more than 50% or his/her patient encounters occur at a FQHC or RHC in a six-month period during the prior calendar year to practice predominantly in an FQHC or RHC.	MMIS/Encounter data using prebuilt query	x	3			x	3	x	3
EP must not be hospital based (more than 10% of his/her Medicaid claims must be outside POS 21 or 23)	MMIS/Encounter data using prebuilt query	x	1	x	1			x	1
EP must have valid group/individual reporting.	MMIS, Practices Using Group Reporting Report	x	1	x	1	x	1	x	1
EP must have an appropriate patient volume 30% Medicaid patient volume.	MMIS/Encounter data using prebuilt query	x	5	x	5	x	5	x	5
Flag present								x	7200
Must have certified EHR system.	Check ONC Certification Number against CHPL	x	1	x	1	x	1	x	1

Eligibility Check	Process /Source	Happy Path		Extended Prepayment Audit		PA		Problem Registration	
		Check	Time (min)	Check	Time (min)	Check	Time (min)	Check	Time (min)
Must adopt, implement, or upgrade (AIU) certified EHR technology capable of meeting meaningful use.	Review documentation to confirm against attestation election and required document table.	x	1	x	1	x	1	x	1
Resolve Issues								x	7200
Review Proximity to Volume Threshold.	CHIP by County Table	x	1	x	1			x	1
Random Prepayment Audit Selection	Audit Selection Tool	X	1	x	1			x	1
Review Volume against Prior Year	MMIS/Encounter data using prebuilt query	X	1	x	1			x	1
Secondary check of Eligibility	SLR					x	1	x	1
Secondary check of AIU	SLR					x	1	x	1
Secondary check of Patient Volume	MMIS/Encounter data using prebuilt query					x	15	x	15
Flags present								x	7200
Check payment holds	MMIS	x	1	x	1	x	1	x	1
Confirm EnterpriseOne Address Entry	EnterpriseOne	x	1	x	1	x	1	x	1
Prepare Payment Approval Request	Internal DOC	X	1	x	1	x	1	x	1
Send/Receive D-16	NLR Interface							x	960
Secondary Check Sanctions	State Excluded List, OIG List, Medicaid & CHIP Information Sharing System (Integrity/Provider Enrollment)	x	3	x	3	x	3	x	3
Secondary Check Death Registry	SSDMF	x	1	x	1	x	1	x	1
Prepare Payment Request for EnterpriseOne	EnterpriseOne	X	1	x	1	x	1	x	1

Eligibility Check	Process /Source	Happy Path		Extended Prepayment Audit		PA		Problem Registration	
		Check	Time (min)	Check	Time (min)	Check	Time (min)	Check	Time (min)
EnterpriseOne payment request	EnterpriseOne	x	1	x	1	x	1	x	1
Submit and receive EnterpriseOne payment record	EnterpriseOne							x	960
D18									
	Total Minutes		37		34		65		30789
	Days		0		0		0		64
	Hours		0		0		1		1
	Minutes		37		34		5		9

Eligible Hospitals

Eligibility Check	Process /Source	Happy Path (Acute)		Childrens		Problem Registration	
		Check	Time (min)	Check	Time (min)	Check	Time (min)
NLR data matches SLR data.	B-6 compare to SLR Registration Provider Name, NPI, Medicaid ID, TIN Provider Type, ONC Cert. #	x	3	x	3	x	3
SLR matches MMIS.	SLR compared to MMIS NPI, TIN, TIN Type, CCN, Provider Type, name, legal name, address, phone, contact e-mail	x	3	x	3	x	3
Must be one of the permissible professional types.	NPPES, MMIS	x	1	x	1	x	1
Must be licensed to practice in the State.	NE Licensure System, Licensure Documentation	x	1	x	1	x	1
Cannot be excluded, sanctioned, or otherwise deemed ineligible to receive payments from the State (e.g. already received incentive payment).	State excluded list, OIG List, Medicaid and CHIP information sharing system (program integrity/provider enrollment)	x	3	x	3	x	3

Eligibility Check	Process /Source	Happy Path (Acute)		Childrens		Problem Registration	
		Check	Time (min)	Check	Time (min)	Check	Time (min)
Flags present						x	7200
EH must have valid CCN in appropriate range.	MMIS	x	1	x	1	x	1
Must have valid Length of Stay	Cost Reports	x	5			x	5
EP must have an appropriate patient volume 10% Medicaid patient volume.	MMIS/Encounter data using prebuilt query	x	5			x	5
Flag present						x	7200
Verify reported data against filed cost report.	Medicare Cost Report	x	5	x	5	x	5
Calculate Payment Amount	EH Payment Calculator	x	5	x	5	x	5
Confirm Payment Amount						x	960
Resolve Issues						x	7200
Must have certified EHR system.	Check ONC Certification Number against CHPL	x	1	x	1	x	1
Must adopt, implement, or upgrade (AIU) certified EHR technology capable of meeting meaningful use.	Review documentation to confirm against attestation election and required document table.	x	1	x	1	x	1
Secondary check of Eligibility	SLR	x	1	x	1	x	1
Secondary check of AIU	SLR	x	1	x	1	x	1
Secondary check of Patient Volume	MMIS/Encounter data using prebuilt query	x	15			x	15
Flags present						x	7200
Check payment holds	MMIS	x	1	x	1	x	1
Confirm EnterpriseOne Address Entry	EnterpriseOne	x	1	x	1	x	1
Prepare Hospital Payment Approval Request	Internal DOC					x	960
Send/Receive D-16	NLR Interface					x	960

Eligibility Check	Process /Source	Happy Path (Acute)		Childrens		Problem Registration	
		Check	Time (min)	Check	Time (min)	Check	Time (min)
Secondary Check Sanctions	State Excluded List, OIG List, Medicaid & CHIP Information Sharing System (Integrity/Provider Enrollment)	x	3	x	3	x	3
Prepare Payment Request for EnterpriseOne	EnterpriseOne	X	1	x	1	x	1
EnterpriseOne payment request	EnterpriseOne	x	1	x	1	x	1
Submit and receive EnterpriseOne payment record	EnterpriseOne					x	
D18							
	Total Minutes		57		33		31738
	Days		0		0		66
	Hours		0		0		1
	Minutes		57		33		58

Assumptions and Data Table

The preceding table depicts time estimates for the processes necessary to complete eligibility evaluations. The scenarios shown identify what MIP Operations staff believe to be representative of the breadth of scenarios that Operations staff would encounter processing incentive program requests. To determine these forecasts, MIP Operations staff created an outline of the potential tasks necessary to determine eligibility. Staff then simulated sample activities to determine the time associated with each of the discrete eligibility determination processes. These times were then applied to a range of specific, likely scenarios that will be encountered during the program process. The resultant table displays these scenarios and provides an understanding of the effort necessary to complete a variety of simple and complicated determination processes.

1. A day is equal to 8 hours or 480 minutes.
2. If flags are present and need resolution, time is calculated at 15 days or 7200 minutes. This represents the expected time necessary for a provider to supply a response.
3. Simple process checks (i.e., verifying a name or address line) occur at a rate of 15 seconds per item. All totals are rounded to the next highest minute.

Appendix N: SMHP Change Control Document

CMS Comment	State's Response	Reference to Change
October 3, 2011		
Throughout: Please note that there are differences between the NLR and the CMS Registration & Attestation system; "NLR" is not short-hand for the entire system.	The document has been revised to reflect a distinction made between the CMS Registration & Attestation system and the NLR.	Pages 48, 49, 52 Graphic on page 48
Please include a copy of the hospital calculation within the SMHP or attached as an appendix. This should include an example calculation along with clearly identified data sources for each data point within the calculation.	The hospital calculation document including an example calculation as requested has been added as Appendix L in the revised SMHP.	Appendix L
"As Is' Section: Please provide an overview of Nebraska's broadband landscape, as well as any broadband-related grants and other significant projects.	Additional information regarding the overview of Nebraska's broadband activities was-added in Section 3.4.1 on page 28 of the redlined version. DHHS added a table listing the BTOP grantees and details regarding the results of the Medicaid provider survey related to access to broadband. Also, additional information regarding significant projects is included in the To-Be Section 4.5 on page 40 of the redlined version.	Pages 28 and 29
Pg 35: Please provide more detail of the projects related to the public health initiatives (including syndromic surveillance and immunization registry) listed under section 3.8.	On pages 29 and 30 of the redlined version, Sections 3.4.4.1 and Section 3.4.4.2 provide additional details regarding public health initiatives. Also, DHHS has added new information to Section 3.8 on page 36.	Page 36
General: Providers need to be able to register at the SLR and attest concurrently rather than waiting for the eligibility criteria to be verified. In addition, the timelines for eligibility (for instance, the PV reporting period, hospital-based status) are based on the date of attestation, not registration. Therefore, while these criteria can be verified prior to attestation, they must be rechecked at attestation.	To ensure consistency with direction given by CMS that registration activity occurs only at the federal level, DHHS has adjusted the SMHP language to reflect "enrollment" rather than "registration" as the SLR activity; language and graphics adjusted throughout to reflect that providers have the option to attest at the time of enrollment in the SLR.	There are revisions throughout the document.
Pg 38: Please make clear which processes will be carried out manually throughout the SMHP. Table 10 on page 84 makes clear which verification and audits will be done manually; but it's not clear which other SLR processes are manual. Similarly, it's not clear how providers will register and attest with the SLR- is there a secure portal, or is it paper-based?	Text and graphics revised to provide greater detail on manual nature of some SLR processes.	There are revisions made throughout Section 5.

CMS Comment	State's Response	Reference to Change
Section 5.1.2 (and elsewhere as necessary): Please make clear that the C-5 and D-17 are only for dually-eligible hospitals	Changes were made showing that if the C-5 and D-17 transactions are received processing will not require Meaningful Use data to be provided as part of the Nebraska MIP Attestation process. In addition to the responses, the name of both transactions have been updated to agree with the updated name in the version of the ICD document entitled "Health Information Technology for Economic and Clinical Health Act or HITECH Act System Interactions and Interface Control Document (ICD) State Interfaces Only DRAFT Version: 4.03 A Last Modified: February 22, 2011."	Graphics on pages 48, 46, 69, 72. Content on pages 68, 69, 70, 71, 73. All TOC
Patient volume section: Please note the 20% patient volume exception for pediatricians and include the state's definition of pediatrician.	Section 5.2.3.1 was clarified to include additional information regarding the Nebraska definition of pediatrician. Patient volume exception for pediatricians has been noted in revisions on page 65 of the redlined version. Additionally, Table 9 includes the difference in the incentive payment (2/3 for pediatricians who meet 20% rather than 30%).	Page 63 Page 65
Pg 49: Please include the other two clinic/group patient volume requirements, as per the Final Rule.	The text has been revised to include this information and to expand upon the provider volume guidelines. See pages 63 et.seq.	Page 63
Pg 58: Hospital-based EPs are those who furnish 90% or more of their services in a hospital setting. So, non-hospital based EPs furnish less than 90% of their services in a hospital setting.	Language corrected.	Page 63
Page 58: Patient volume criteria needs to be much clearer. FQHC-based EPs' "needy individual" method needs to be separated out.	Patient volume criteria in Section 5.2.3.1 has been revised to provide greater detail and specificity.	Pages 58 et. seq. Page 67
Pg 59: Under "EHR Incentive Payment Assignment," please explain the specific information that the EP must provide (their own NPI and TIN, as well as the payee's NPI and TIN), as well as the information that DHHS will verify. DHHS should be verifying 1) that a valid relationship exists between the EP and the payee, and 2) that the payee's NPI and TIN are valid.	Text added to provide requested information and greater detail.	Pages 67-68
Page 59: Note that pediatricians who meet 20%, but not 30% only receive 2/3rds of the incentive payment.	Patient volume exception for pediatricians has been noted in revisions on page 65 of the redlined version. Additionally, Table 9 includes the difference in the incentive payment (2/3 for pediatricians who meet 20% rather than 30%).	

CMS Comment	State's Response	Reference to Change
Page 59: Patients who are on a physicians panel cannot be double counted as an encounter as well. The formula should be (Medicaid Panel + Non-panel Medicaid encounters) / (Total Panel + Non-panel Total encounters). The key is that encounters cannot include patients on the physician's panel.	Patient volume criteria in Section 5.2.3.1 has been revised to provide greater detail and specificity including the clarification regarding encounters.	Page 65
Section 5.3: There is no AIU data in the C-5. If a hospital attested to Medicare and is receiving an incentive payment from the state, the payment will be a Meaningful Use payment.	References to AIU removed.	Page 72
Section 5.4: The state needs to provide more information how they are going verify many of these criteria. - How will the state verify whether an EP is hospital-based? - How will the state verify patient volume? - How will the state verify that a PA works in an FQHC led by a PA? - How will the state verify patient volume from locations outside the state?	Section 5.8.4 was revised and detail added to clarify source data for these verifications. Table 10 in this section has new column reflecting process for verification of these data points. Section 5.2.3.1 was revised and detail was added to provider type and provider specialty verification information.	Page 97 Section 5.8.3 Page 97 Section 5.8.4 Page 62 Section 5.2.3.1
Pg 65: Please provide examples of acceptable documentation for each part of AIU	Section 5.3.5 was revised and examples added to provide greater detail and specificity.	Page 75 et. seq.
Pg 77: Please provide more details on EnterpriseOne	Section 5.5 was revised; also, additional detail was added to Glossary entry for EnterpriseOne.	Page 89
Pg 81: How long do providers have to appeal?	Section 5.8.2 was revised to reflect a 90 day appeal limit. Administrative code references for Medicaid appeals were also added.	Page 94
HIT Roadmap: For State HIE and NwHIN activities, please provide as much explanation as possible regarding timelines and what resources will be required	Section 6 was revised to add details. Text added to provide additional information about ongoing activities concerning state HIE and NwHIN connectivity.	Page 104 (Updates to Table) Page 107, 108, 110, 110 - updates to Table 12
DHHS Content Added subsequent to CMS Comments		
CMS request that States include a statement in SMHP that designates how long after the end of the associated payment year the state will accept attestation.	Section 5.3 was revised to include the statement that Nebraska will accept provider attestations up to 60 days beyond the end of the associated payment year.	Page 70

CMS Comment	State's Response	Reference to Change
Roadmap Table 13 was updated to reflect completed tasks and schedule updates.	Roadmap table was updated.	Page 106
	Incorporated changes in the language preceding Table 15 to eliminate potentially prescriptive interpretation. Amended Table 15 to more accurately reflect current standards.	Section 6.5.7, p. 111-113.
	Made changes to the name given to Department of Public Health Syndromic Surveillance activities and associated acronyms throughout the document, as DPH has changed the name for these activities since the time of writing.	Page 30
November 14, 2011		
General: Given the number of manual checks involved, please provide estimated times for each step in the process through payment.	Total process time for the manual checks is estimated at 40 minutes. Please see Appendix M of the Second Amended SMHP for more detailed documentation.	Section 5.1.2. and Appendix M.
Page 50: Why is the State requesting documentation verifying adoption, implementation, or upgrading to certified EHR technology at provider enrollment, rather than at attestation?	State clarified language. Providers may attest at time of enrollment or subsequently; AIU documentation is required for attestation.	Section 5.2.2.2.
Page 50: Why are there requirements for providers not enrolled in Medicaid? Being enrolled in Medicaid is one of the requirements of the incentive program. If these requirements are for providers who are paid under Medicaid managed care plans but who aren't actually registered as providers with the State Medicaid Agency, then please specify how the State will enroll these providers.	Some providers of types eligible under the final rule may be providing care for Nebraska Medicaid clients, but not be enrolled as Nebraska Medicaid providers due to State policy. (For example: Physicians Assistants began to be enrolled as Nebraska Medicaid providers in 2011, but were not enrolled previously.) In order to enroll these Eligible Providers, Nebraska Medicaid will utilize an agreement that stipulates requirements for participation and extends existing Medicaid program policy for appeals and payment recoupment.	Section 5.2.2.2.
Page 59: Hospital-based determination is based only on Medicaid claims; no need to worry about other payers.	State clarified language to reflect use of Medicaid claims and Medicaid Managed Care encounter data for this determination.	Section 5.2.3.1.
Page 63: Payee and Assignee are the same thing. The fields are called Provider Tax Identification Number (TIN)/National Provider Identification (NPI) and Payee TIN/NPI on the files; please keep them consistent.	State clarified language.	Sections 5.2.3.1 and 5.8.4, Table 12.

CMS Comment	State's Response	Reference to Change
Page 97: Update the roadmap with current plans.	State updated Table 14 to reflect current timelines for planned activities.	Section 6.1, Table 14.