State Medicaid Health Information Technology Plan
SMHP Update

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<th>Date</th>
<th>Author</th>
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<td>1.1</td>
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<td>December 3, 2014</td>
<td>EOHHS</td>
<td>Update</td>
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<td>February 9, 2016</td>
<td>EOHHS</td>
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<td>2015-2017 Modified Meaningful Use Addendum submitted and approved</td>
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Executive Overview – Background & Purpose

The Centers for Medicare and Medicaid Services (CMS), as part of the provisions of the American Recovery and Reinvestment Act of 2009, have set forth requirements that states must meet in order to qualify for 90% Federal matching funds for administration of their Medicaid EHR Incentive Programs. This document, the Rhode Island State Medicaid HIT Plan (SMHP), represents one of these key requirements. The document describes the State of Rhode Island’s current and future Health IT activities, as well as the path or ‘roadmap’ to their attainment, in support of the Medicaid EHR Incentive Program. In accordance with CMS guidelines, this SMHP is comprised of five main sections:

A. HIT Landscape Assessment – The ‘As-Is’ Environment
B. HIT Future Vision – The ‘To-Be’ Environment
C. Activities Necessary Administer and Oversee the Medicaid EHR Incentive Program
D. The State’s Audit Strategy
E. The State’s HIT Roadmap

Using the above sections as a framework, the document describes the State’s current planning with respect to payment administration, meaningful use, adopt/implement/upgrade considerations, eligibility, and financial oversight/program integrity.

This 2.0 version is an update to Rhode Island’s SMHP which was submitted in November 2011 and approved by CMS in June 2012. It includes program changes approved during the last quarter of 2015, as well as program additions being requested in RI’s IAPD-U which was submitted in December 2016 which are in process of being reviewed by CMS. It should also be noted that Rhode Island has participated in the 13 State MAPIR Collaborative since the start of the Medicaid EHR Incentive program. Rhode Island’s MAPIR system has been processing applications since June 2011 and made its first Rhode Island Medicaid EHR Incentive payment in September 2011. Since then, and as of end of December 2016, the program has paid 1,294 applications with a total of $35m distributed to Rhode Island Medicaid eligible providers and hospitals.

The diagram on the following page depicts the progress we have made with providers participating in the program and how far along they are with meeting meaningful use.
## A. Current HIT Landscape – The “As-Is” Assessment

### A.1 Extent of EHR Adoption

The Rhode Island Medicaid EHR Incentive program has well exceeded its initial estimate of the number of eligible providers that were going to enroll in the program and adoption and meaningful use a certified electronic health record. At the beginning of the EHR Incentive Program, we estimated that 10% (300) of the approximately 3,000 eligible providers in the state would participate, because of the 30% Medicaid patient volume threshold. Since 2016 is the last year to enroll in the program we are now estimating that 23% (700) of the state’s eligible providers are participating in the Medicaid EHR Incentive Program in Rhode Island.

As of December 2016, our state has 930 providers participating in the Medicare EHR Incentive and 632 participating in the Rhode Island Medicaid EHR Incentive program. Rhode Island has a total of 1,562 providers earning an EHR Incentive payments, which shows that providers are accepting HIT as a tool to aid the practice of medicine. This demonstrates that a large number of the state’s providers are making the effort to move toward meaningful use.

Rhode Island has eleven acute care hospitals throughout the state, of which nine are participating in both Medicare and Medicaid programs and one could only participate with the Medicare program because they lacked the 10% Medicaid patient volume requirement. Meanwhile, another hospital in our state was in receivership for several years and was recently acquired by a national healthcare organization. We have been in contact with the hospital to determine if they qualify to participate with the program and encourage them to attest for program year 2016 before the March 30, 2017 deadline.

### A1.1.1 FQHC and EHR Adoption

In Rhode Island nine out of ten FQCH organizations are participating in the Rhode Island Medicaid EHR Incentive program. These nine organizations have 29 practice locations.
throughout the state and serve our neediest individuals with medical dental and behavioral health care services. As a result of FQHC participation, 43% of all eligible providers participating in the Rhode Island Medicaid EHR Incentive program are FQHC providers. As noted, FQHC providers are actively taking part in RI’s EHR’s incentive program as evidenced by the some of the metrics listed below:

- 89% of the FQHC providers participating have attested to Meaningful Use and are active in the program.
- Of all the EP payments made as of December 31, 2016, FQHCs have earned $8.7m from the Rhode Island Medicaid EHR Incentive program. That amount covers 25% of what was disbursed to all providers including eligible hospitals and 48% of all eligible providers.
- An FQHC organization was the first to attest to meaningful use for Dentists in our state in 2015.

### A1.2 State HIT/HIE Self-Assessment Survey Results

With direction from the Department of Health and the Executive Office of Health & Human Services, HealthCentric Advisors (HCA) is contracted to perform a bi-annual survey of how healthcare providers are utilizing their EHR and the state’s health information exchange known as CurrentCare within their practice operations. The objective of the survey is to measure the overall trends associated with HIT adoption and use and more specifically to identify how clinicians use technology while caring for patients, what the greatest barriers are, what will help to enable increased use. The survey was last conducted in 2015, and the data was analyzed in 2016. Additionally, based on survey results and the evolving landscape, the intent is to modified the survey and administer it again in the spring of 2017.

The survey is electronically administered to all RI licensed independent practitioners (LIPS)such as physicians, physician assistants and advanced practice registered nurses (a.k.a. nurse practitioners. The 2015 survey was changed to add patient engagement questions and measures that would evaluate basic and advanced EHR usage.

As can be seen in the graph below, the 2015 HIT Survey response rate remained steady with at least two thirds of our physician population completing the survey.
This survey measured EHR usage among those who responded, but we also calculate a combined measure of the responders and non-responders using the assumption that non-responders had not adopted HIT. The intent of reporting providers who do not respond to the survey as not using an EHR was to help incent providers to fill out the survey since this information is publically reported on the Department of Health’s website. Despite that we know this combined measure is a gross underestimate of EHR adoption and that there are providers with EHRs that do not respond to the survey. This is confirmed by other data points (see Inventory results). Given that it is increasingly clear many non-respondents have adopted EHRs, we may want to eliminate reporting on the combined measure.

Despite the different measures of adoption, it is clear that HIT in the state is becoming integrated into provider’s practices. Close to 90% of the providers participating in the survey indicated they have an EHR and close to 82% are e-prescribing with their EHRs.
2015 was the first year we measured the use of the EHR for patient engagement, and found that 35.7% were using their EHR in this way. The survey also showed that EHR and e-prescribing usage has steadily increased over the past six years.
A1.3 Physicians Utilizing EHRs for Population Health Management

Survey questions were not specific to every meaningful use or clinical quality measure, but touched upon basic population health functions and clinical quality measures that most EHRs had to offer. The diagram below shows to what degree our providers believe they are using their EHR for population health.

![Diagram](image)

Among those who responded to this question, close to 35% indicated that they are using their EHR for population health, an increase of 7.8% since 2014. In addition, those who did not know if they were using their EHR for population health decreased by 7.1% which indicates that there is a shift in the delivery system toward recognizing population health and to managing patient populations with EHR technology.

One of the goals of the physician survey was to identify providers’ ability to utilize the EHR for tracking quality measures and population health. Less than half of respondents were utilizing their EHR to monitor quality, population health, and patient reminder messaging. Our hope is that these amounts will increase in the years to come.
We also measured the barriers preventing providers from using their EHR for population health. The primary reason was that they felt they needed additional staff or financial support to embark on this effort.
In this same survey we found that 63% of office based practices utilize a website to communicate general practice information and education. Only 16.5% of the office-based and 12.6% of hospital-based providers reported having a “Direct” message email address. We suspect this metric is under-reported based on the fact that 55.7% of office-based providers and 61.9% of hospital-based providers did not know whether they had a Direct message address.

Providers were also asked how they most frequently communicated with their patients. Seven method of communication were listed including: Telephone, US Mail, Patient Portal, Email, Fax, Text Messaging, and Video Calling/Conferencing. Although 93% of the providers indicated they communicated with their patients via telephone; 24.4% also indicated that they utilize a patient portal to communicate with their patients.

A1.4 Physicians Utilizing HIE

The HIT Survey also queried respondents about how they utilize the HIE (CurrentCare) and their knowledge of available HIE services. Office-based primary care physicians had a much higher HIE utilization rate compared to office-based non-primary care physicians. This was expected since the initial HIE marketing efforts were focused heavily on primary care practices. It is anticipated that specialists’ knowledge and use of the HIE will improve in the next survey, because the HIE organization (RIQI) which also served as the Regional Extension Center, received a Transforming Clinical Practice Initiative grant which is focused on helping over 1,000 RI specialists prepare for
value based purchasing in health care. As part of RIQI’s work with specialists, they are educating and working to engage the specialists in using the HIE services available in the state.

The survey also indicated that there was no increase in the familiarity with HIE services from 2014 to 2015. This clearly indicates a need to revitalize the marketing and outreach efforts around the HIE services that exist in the state.

The CurrentCare Viewer is a Web-based portal that provides up-to-date clinical information for consented patients from CurrentCare’s data-sharing partners. Patients’ records include lab test results, medication history, imaging results, problem list and diagnosis, vital signs and other data points recorded in a CCD, as well as information about physician, hospital and emergency room visits. The CurrentCare Viewer gives providers access to a rapidly expanding clinical database where practices can access a patient’s latest health history to help make the best possible, most informed decisions at the point of care and reduce duplicative testing.

In addition, CurrentCare Hospital Alerts provides real time notification to primary care providers and care teams when a patient is admitted to, discharged from, or transferred within an emergency department or hospital. Hospital Alerts allow for timely follow-up care that can help improve outcomes, reduce costly re-admissions, and strengthen the patient-provider relationship.

CurrentCare/EHR Integration occurs at some practices and allows for data from CurrentCare to be shared with the provider directly through their EHR. The advantage of this is that the
provider does not have to leave the EHR workflow to view CurrentCare data. RIQI works with both the EHR vendors as well as provider organizations in determining and prioritizing if and when a provider organization’s EHR can share data with CurrentCare.

Survey results indicate that almost 30% of RI’s office based providers know about the features of CurrentCare. It will be important to address this metric and focus on increasing awareness and knowledge of the benefits HIE services can provide to providers and the patients they serve.

![Bar chart showing the percent of physicians familiar with CurrentCare services by setting.](chart)

**A1.5 Statewide Healthcare Inventory Survey performed by RIDOH**

In 2015 the RIDOH conducted a Statewide Healthcare Inventory Survey as part of a legislative initiative to better understand the healthcare system in Rhode Island. This survey was designed in collaboration with the HIT Survey described previously in an effort to ask the right questions of the right people and reduce the burden of surveys conducted by state agencies. Whereas the HIT survey is meant for licensed independent practitioners to respond to, the statewide healthcare inventory is most often filled out by the office manager. A key component of the inventory was HIT adoption and use, and the inventory was able to collect indicative information about HIT use in facilities and practices of all types.

Paired with the HIT Survey, the inventory results can be used as a basis for our roadmap for how Rhode Island can improve HIT adoption rates. According to the first health care inventory
survey which was administered also in 2015, Rhode Island’s EHR adoption across hospitals was 92.3%, across outpatient specialty locations was 72.7%, and across primary care locations was 82.6%. It is clear that while Rhode Island’s average EHR adoption rate across all locations was 77.2%, which is close to the national average of 78%, efforts to increase EHR adoption need to be focused on specialists and behavioral health facilities or providers. Additionally, these rates align more with the HIT survey rates of survey respondents. The table shows EHR adoption rates by location type, illustrating the gaps in EHR adoption rates.

### EHR Adoption Rates, Statewide Healthcare Inventory, 2015

<table>
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<th>Survey</th>
<th>Total Locations</th>
<th>Response Rate</th>
<th>EHR Adoption Rate</th>
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<tr>
<td>Hospital</td>
<td>13</td>
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<td>92.3%</td>
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<tr>
<td>Nursing Facility</td>
<td>89</td>
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<tr>
<td>Outpatient Specialty</td>
<td>418</td>
<td>60%</td>
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<tr>
<td>Primary Care</td>
<td>311</td>
<td>94.5%</td>
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<tr>
<td>Behavioral Health</td>
<td>48</td>
<td>79.2%</td>
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<tr>
<td>Psychologists</td>
<td>108</td>
<td>88.9%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>49</td>
<td>100%</td>
<td>24.5%</td>
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Notes: Not all respondents answered the EHR adoption questions; there is possible overlap between the outpatient specialty and psychologists survey results; and some outpatient specialty practices are co-located with hospitals.

### A.2 Broadband & Internet Access

In general, given the high population density, compact size, and urban nature of the State, access to broadband services within Rhode Island is excellent. A number of recent initiatives have served to foster adoption and access. According to Broadband RI (BBRI), broadband is available for 97% of the state of Rhode Island. However, in the most urban areas 29% of Rhode Islanders do not subscribe to the Internet.

From 2010 – 2014, $4.52 million of federal funding went to establish the Broadband RI (BBRI) initiative with the Rhode Island Economic Development Corporation (RIEDC). BBRI works to create new opportunities by expanding broadband use and digital literacy across Rhode Island. BBRI programs address public awareness and education about broadband and develop plans to increase broadband adoption and usage.
Also with federal support, OSHEAN (Ocean State Higher Education Economic Development and Administrative Network) is deploying 389 miles of high-speed optical fiber throughout the state and Ocean State Libraries is adding 600 new computers and 12 mobile computing labs to the state’s public computing resources.

A.3 Rhode Island FQHC HIT Landscape & HRSA Funding Streams for HIT

There are eight FQHC grantees in Rhode Island which serve 152,000 patients, of which 56.8% are covered by Medicaid. 100% of the FQHCs have EHRs and 88% are PCMHs.

Rhode Island does not have a recipient of the July 2016 Health Center Controlled Network (HCCN), but the FQHCs did receive Delivery System Health Information investments (DSHII) awards in September 2016 for $509,026 to support HIT investments to support value-based care.

A.4 Indian Health Center & Veterans Administration

The Narragansett Indian Health Center is the single IHC in the State. The IHC has adopted certified EHR technology in 2012 for two providers. Since then, the two providers have left the IHC, but they continue to utilize the certified EHR Technology with the providers hired through a contractor. Their plan is to hire a full time physician, and continue to utilize certified EHR technology and eventually become meaningful users of their certified EHR.

The Veterans Administration operates a medical center in Providence. The medical center delivers a broad range of services in medicine, surgery, and behavioral sciences and is currently operating 73 beds. The medical center has approximately 150 board certified physicians and a total of 1038 full-time equivalent employees who complete the health care delivery team of professional, technical, administrative, and support personnel. Veterans can also avail themselves of primary care and some specialty services at the VA Community-Based Outpatient Clinics in Middletown, RI.

RIQI has been working with the Veterans Administration around the sharing of health information given there are a number of patients who are treated both within the VA system and by community providers. HIE data from CurrentCare is currently available to the VA providers through the current viewer. RIQI has also successfully completed the Department of Veteran’s Affairs (VA) certification testing to access VA data in a federated manner. The ability to access VA data through Currentcare is expected to be fully implemented in the next month, Additionally, RIQI is working with the VA to allow VA data to be persisted, in order that RI providers that access CurrentCare data from within their EHRs, can also access the VA data.
A.5 Key Stakeholder State Government Organizations Impacting Health IT

Over the past five years, the state of Rhode Island has made a substantial investment in the advancement of health information technology (HIT) and, as a result, has made significant progress in planning, designing, and implementing healthcare information technology initiatives to improve the quality, safety, and value of healthcare. HIT has been and remains an identified healthcare priority for the Governor, the state’s Secretary for Executive Office of Health and Human Services (EOHHS), Director of Health (DOH), the Health Insurance Commissioner (OHIC), and the state’s Medicaid Director. In 2015, Governor Gina M. Raimondo, along with Senator Sheldon Whitehouse, launched the Governor’s Working Group for Healthcare Innovation, a statewide initiative to innovate healthcare by improving patient care and health outcomes, and lowering cost for all Rhode Islanders. The diagram below summarizes the goals of this initiative. Additional details can be found at: http://governor.ri.gov/initiatives/healthcare/

A.5.1 Rhode Island Executive Office of Health & Human Services

The Executive Office of Health and Human Services (EOHHS) serves as the State Medicaid Agency (SMA) for the State of Rhode Island and is the umbrella organization that oversees and manages publicly funded health and human services in Rhode Island. As part of this role, EOHHS is directly responsible for Medicaid as well as some healthcare innovation initiatives such as SIM Model Test Grant initiatives, Integrated Care initiatives, Medicaid Provider and Beneficiary Oversight, Care Management, and fiscal reporting and oversight. EOHHS has contracted with Hewlett-Packard Enterprise Services (HPE) to provide Medicaid MIS deployment and support and Medicaid claims processing services. In addition, Neighborhood Health Plan and United Health Care serve as Medicaid’s managed care organizations and serve approximately 90% of Medicaid beneficiaries.
The Executive Office of Health and Human Services is driving several initiatives to ensure that Rhode Islanders -- especially our most vulnerable populations -- have access to high quality health and social services that are affordable and sustainable.

While the Affordable Care Act has helped cut Rhode Island’s uninsured rate in half, rising healthcare costs remain a concern for Rhode Island families, businesses, taxpayers and healthcare providers. Rhode Island is building on the strong foundation established by the Working Group to Reinvent Medicaid to spark innovation across our healthcare system to improve patient care and health outcomes, and lower costs for all Rhode Islanders. In 2015, Governor Raimondo’s Working Group for Healthcare Innovation, chaired by Health and Human Services Secretary Elizabeth Roberts, developed recommendations to improve the state’s healthcare system, support better health outcomes, lower costs and provide businesses with more predictability.

That same year, EOHHS received a $20 million State Innovation Model (SIM) Test Grant to implement and test its State Health Care Innovation Plan. As part of SIM, Rhode Island has developed a population health plan based on the results of community health assessments, including the integration of primary care and behavioral health. In addition, the state will fund the following projects to support practice transformation and state data infrastructure needs, as agreed upon by the SIM Steering Committee:

- Community Health Teams
- Child Psychiatric Access Program
- Patient Centered Medical Home (PCMH) Kids program
- Behavioral Health Transformation
  - SBIRT training and screening
  - Integrated Behavioral Health Program with Patient Centered Medical Homes
  - Community Mental Health Center practice transformation
- Healthcare Quality Measurement Reporting and Feedback System
- State Data Ecosystem
- Statewide Common Provider Directory
- HealthFacts RI – RI’s All-Payer Claims Database
- Patient Engagement Tools/Advanced Illness Care Initiative


The SIM grant is helping the state to augment its HIT infrastructure by supporting the continuing development of an all-payer claims database, developing a statewide common
provider directory, a statewide healthcare quality measurement reporting and feedback system, patient engagement tools, and EOHHS data ecosystem.

Rhode Island’s SIM Steering Committee requested that a SIM Technology Reporting Workgroup be created to determine whether to fund a statewide quality measure reporting and feedback system. The group assessed clinical quality measurement reporting capabilities within our state, which were relatively low as also evidenced by the HIT survey. The workgroup developed a recommendation to the SIM Steering Committee to proceed with establishing a statewide clinical quality measurement reporting and feedback system. The Steering Committee approved the project, and EOHHS will be issuing an RFP in early 2017 to identify a vendor. The SIM Technology Reporting Workgroup will reconvene to serve as the governance committee for this system responsible for protecting patient privacy and defining additional business requirements. This system is being built based on an aligned set of clinical quality measures to be used by payers in contracting along with other measures that need to regularly be reported on by providers. There was a concerted effort to include the meaningful use measures in the aligned measure set, though they do not fully overlap. Additionally, this system will be built in a manner in which it can be used by providers to meet their attestation to meeting the Meaningful use clinical quality measures.

The Rhode Island All Payer Claims Database (APCD), HealthFacts RI, is jointly managed by the Executive Office of the Health and Human Services, the Department of Health, the Office of the Health Insurance Commissioner, and HealthSource RI. The APCD collects and stores payer enrollment data, medical claims, pharmacy claims, and provider data on a monthly basis. The APCD will be used to ensure transparency of information about the quality, cost, efficiency, and access of Rhode Island’s healthcare delivery system with a special focus on Medicaid access monitoring. SIM funding has established the foundation of the APCD which has allowed us to understand the breadth of the value for Medicaid operations as a primary user of the APCD.

Rhode Island has taken extensive precautions to protect patient privacy, while ensuring that the data is still longitudinal and useful to agencies, legislators, and researchers.

- No patient names, social security numbers or addresses are available in the database – to anyone. A specialized vendor, which is firewalled from the state, assigns individuals a scrambled unique identifier that cannot be traced back to identifying information.
- Publicly available data on the HealthFacts RI website will include only high-level summaries of key public health facts deemed safe for release by the Department of Health and as stipulated by regulations. No one will be able to identify individuals from this data.
- In order for non-state employees to have access to sensitive fields or individual claims, they must sign privacy agreements that prevent publication of identifiable data. In addition, requests must get approval from the state’s Data
Release Review Board, which reviews requests that could potentially identify individuals.

- All eligible residents were notified of their right to opt-out of the database, completely and permanently. Only 2% of people chose this option. Historical data (2011-2013) for about 130,000 people were automatically removed because these people had either moved, become uninsured, died, or were otherwise unable to be contacted.

In addition to the activities described above, the EOHHS, as the State Medicaid Agency, has primary responsibility for state-level funding, staffing, and oversight related to the development of this State Medicaid HIT Plan (SMHP), Implementation Advance Planning Document (IAPD) annual or as needed updates, as well as the administration of the Medicaid EHR Incentive Program described in Section C in this document.

### A.5.2 Rhode Island Department of Health

The Rhode Island Department of Health (DOH) provides critical oversight and liaison functions that ensure alignment of the State’s HIT/EHR initiatives with strategies, policies, and clinical guidelines established at the state government level. In this role, DOH works closely with EOHHS, the State’s designated RHIO known as Rhode Island Quality Institute, and other entities such as HealthCentric Advisors who advise on health care quality and other related issues.

In 2015, Dr. Nicole Alexander-Scott was appointed as the Director of Rhode Island’s Department of Health by Governor Gina Rimando. Following the HIT efforts of the previous directors, Dr. Alexander-Scott continues to direct the state’s public health planning efforts to use technology to improve the quality and safety of care.

The Department of Health manages several key HIT initiatives to support data-focused public health and the EHR Incentive Program. These include:

- **KIDSNET Childhood Immunization Registry** – This meaningful use registry supports the mandatory reporting of childhood immunizations, and the creation of immunization records and administration schedules to support primary care providers. This registry helps EPs and EHs meet the Public Health meaningful use objective.

- **Syndromic Surveillance Registry** – This meaningful use registry supports the communication of early symptomology of patients presenting at the emergency rooms throughout the state, to assist in early intervention and public health response in the case of public health emergencies. This registry supports EHs in meeting the Public Health meaningful use objective.
• **Electronic Lab Reporting** – This meaningful use registry supports the communication of reportable disease from labs to the Department of Health. The Department of Health uses the National Electronic Disease Surveillance System (NEDSS). This registry supports EHS in meeting the Public Health meaningful use objective.

• **Prescription Drug Monitoring Program (PDMP)** – Pharmacies in the state are required to report the dispensing of Schedule II, III, IV, and V medications within 24 hours to the PDMP. The PDMP provides a web-based provider portal for providers and their delegates to review the controlled substances dispensed to their patients before issuing new or continuing prescriptions.

The RIDOH also has hired a Public Health Meaningful Use and Informatics Coordinator to assist with the planning and coordination of Meaningful Use activities that support the Medicaid EHR Incentive Program, including HIE initiatives. This individual works closely with the state’s HIT coordinator, the SIM HIT Specialist and the Medicaid EHR Incentive Program Manager who are all located at EOHHS. The Rhode Island Department of Health (DOH) provides critical oversight and liaison functions that ensure DOH’s alignment with other HIT efforts across the state.

**A.5.3 Department of Behavioral Healthcare Developmental Disabilities and Hospitals (BHDDH)**

The Department of Behavioral Healthcare Developmental Disabilities and Hospitals (BHDDH) has been a strong partner in promoting Health Information technology and the use of Currentcare among the community mental health centers (CMHOs). Most CMHOs have adopted or implemented EHRs. Several years ago, BHDDH partnered with EOHHS and RIQI, the State’s Designated Entity for HIE to develop a process and approach to allow 42 CFR part 2 data (confidentiality of alcohol and drug abuse patient record data) become part of CurrentCare. To help achieve, this BHDDH promulgated through regulations a standard Currentcare 42 CFR part 2 consent form to be used by all CMHOs. This consent form is in addition to the standard Currentcare enrollment form. BHDDH has promoted the use of Currentcare to the CMHOs. BHDDH has been critical in advancing the sharing of health information between behavioral health care providers and physical health care providers. RI remains the only state where 42 CFR part 2 data is currently part of a statewide HIE. Additionally, through SIM funding, all community mental health centers will have real time access via a dashboard, updated every 45 minutes, to identify when their patients are admitted to or discharged from any Emergency Department or hospital in RI. This is a separate service from Currentcare and does not rely on individuals BHDDH received and grant from SAMSHA to implement SBIRT screening across the state and as part of that grant, BHDDH proposes to leverage Currentcare and its connectivity to help centralize the capture of SBIRT results and make share the SBIRT screening results among a patients treating provider.
A.5.4 Office of Health Insurance Commissioner (OHIC)

The Office of the Health Insurance Commissioner provides the state oversight on healthcare insurance providers within the state.

OHIC is responsible for:

- Guarding the solvency of health insurers;
- Protecting the interests of consumers;
- Encouraging policies and developments that improve the quality and efficiency of health care service delivery and outcomes; and
- Viewing the health care system as a comprehensive entity and encourage and direct insurers towards policies that advance the welfare of the public through overall efficiency, improved health care quality, and appropriate access.

OHIC is committed to making RI's healthcare system more affordable and easier to use. That's why OHIC has set standards that will support primary care, transform healthcare delivery, and change the way we pay for care. OHIC plays an important role in supporting HIT adoption by regulating commercial health insurers with standards that require advanced practice methodologies only supported by the use of and EHR and the State’s Health Information Exchange, CurrentCare. The Health Insurance Commissioner also serves as an ex-officio, non-voting member of the RIQI Board of Directors.

OHIC also supports the Care Transformation Collaborative (CTC, formerly the R.I. Chronic Care Sustainability Initiative, or CSI-RI). Standing at the forefront of Rhode Island primary care practice transformation in RI, CTC is an all-payer program that promotes care for patients through the patient-centered medical home (PCMH) model.

A.6 HIT/E Relationships with Other Key Stakeholder Entities

A.6.1 Rhode Island Quality Institute (RIQI) ‘s Center for Improvement Science (Formerly Regional Extension Center but often still referred to as the REC)

RI’s Regional Extension Center (REC), which was operated by RIQI, is now formerly known as RIQI’s Center for Improvement Science. Although RIQI change the name when the ONC’s Regional Extension Center funding ended, many in the community still know it as and refer to it as the Regional Extension Center or REC. The REC offers our provider community with Health IT technical assistance, education, guidance, and information on best practices to support and accelerate health care providers’ efforts to become meaningful users of Electronic Health
Records (EHRs). RIQI’s Relationship Managers meet with providers to help them plan their conversion to a certified EHR. Their services go beyond the implementation of new technology by alerting provider practices about incentives or increased reimbursements from payers, i.e. Medicaid or Blue Cross/Blue Shield, as well as promoting, educating and helping providers engage with HIE services. The REC provides one on one technical assistance as well as group education sessions for providers to share their experiences. In addition, they conduct webinars on specific topics such as conducting Security Risk Assessments and protecting patient health information.

The REC recently enhanced their website presence for providers who want to strengthen their HIT efforts. In early 2015, the REC revised their website (http://www.docehrtalk.org/Home.aspx) to focus utilizing Health IT tools and functions to support practice transformation efforts. One of the major goals of the REC is to help providers understand the benefits of the State’s HIE (CurrentCare), Meaningful Use and how moving towards EHR adoption will help them succeed. REC services include providing guidance and technical assistance on meeting Meaningful Use, becoming a NCQA’s Patient Centered Medical Home, selecting and adopting EHRs, preparing for EHR Incentive audits, assuring privacy and security and conducting a security risk assessment participating in CurrentCare, and using Direct messaging.

Providers who join the REC and obtain their assistance are more likely to meet meaningful use than those providers who do not join. Moreover, the REC’s professional network with Health IT vendors, payers, and a majority of health care provider practices proves to be valuable for the providers they serve and the entire healthcare system. Having access to firsthand experience with advances that work well or not work well, prepares a practices with Health IT endeavors they are about to address.

The REC and RIQI are frequent grant awards recipients. In mid-2015, the ONC awarded a two-year, $2.7 million grant that is supporting the Sharing Health Information for Transitions in Care (SHIFT in Care) project. Leveraging the existing capabilities of RIQI’s CurrentCare and REC services will provide the opportunity to expand the capacity for statewide exchange of health information. The grant supports the integration of electronic health records (EHRs) from long-term/post-acute care (LTPAC) facilities, leading to the ability to alert primary care and other providers in the community when patients are admitted to or discharged from long-term care facilities in the state.

In the fall of 2015, the RIQI was awarded two other grants. A one-year, $100,000 grant to support the Rhode Island Behavioral and Medical Information Exchange project. This initiative will connect behavioral health providers who are ineligible for federal health IT incentives to CurrentCare to expand and improve their ability to electronically send, receive, find and use health information in a manner that is appropriate, standardized, secure, timely, and reliable.
The second grant is a four year $8.3m Transforming Clinical Practice Initiative award that will provide technical assistance to help equip clinicians in Rhode Island with tools, information, and network support needed to improve quality of care, increase patients’ access to information, and spend health care dollars more wisely. As a Practice Transformation Network, RIQI’s goal is to support 1,500 clinicians to expand their quality improvement capacity, learn from one another, and achieve common goals of improved care, better health, and reduced cost. The network will provide practice transformation assistance, care coordination tools and services, and performance measurement, reporting and evaluation to help participating clinicians meet the initiative’s phases of transformation and associated milestones, clinical and operational results.

In 2015, EOHHS contracted with the REC to try and engage and provide technical assistance to eligible providers in RI who had not yet enrolled to participate in the Medicaid EHR incentive program or who had enrolled but had not continued to participate in the program. The overarching goal was to assist Medicaid providers understand how to reach meaningful use and continue to advance to the next stage and program years. The seven measurable tasks that the REC completed in the contract were:

- Assess 100 Medicaid providers to determine the reason they are not progressing through meaningful use, and provide assistance to reducing those barriers
- Create and deliver educational materials for these providers
- Outreach to all Medicaid providers about the RI Medicaid EHR Incentive program via newsletters and Medicaid provider updates
- Provide education events on topics that were identified as barriers to achieving Meaningful Use (e.g. transitions of care, security risk assessments)
- Assist and educate providers about program audit preparation
- Execute program recruitment efforts
- Provide direct, on-site technical assistance to provider practices

The REC has helped RI’s provider community and continues to make a large impact on the HIT goals the State of Rhode Island is pursuing.

The REC is staffed with Relationship Managers who assist practices in redesigning workflow to support implementation of their certified EHR. They share best practices among the practices and help them overcome procedural and technological obstacles. They also educate practices on how to adhere to HIPAA requirements and reduce their risk of a breach. The Relationship Managers are also NCQA Content Expert certified and have prepared many practices to meet Patient-Centered Medical Home (PCMH) certification. Their guidance through the critical process of converting paper-based records to an electronic system have made an impact to EHR Adoption. At the same time, they discover the best ways to incorporate CurrentCare (HIE) tools into each practice’s workflow.
One of the real benefits of the REC is their dedication to education and training. This is the core-value that the REC provides to practices. They actively work to help providers get the most out of their health IT investment as the HIT market rapidly evolves and develops.

A.6.2 HealthCentric Advisors (HCA)

HealthCentric Advisors (HCA) is a healthcare consulting firm headquartered in Providence, Rhode Island and provides services that synchronize healthcare operations and healthcare technology. HCA, formerly RI’s Quality Improvement Organization, now serves as New England’s Regional Quality Innovation Network Quality Improvement (QIN-QIO) organization, having been awarded a 5-year contract by the Centers for Medicare & Medicaid Services (CMS). Their teams of clinical, analytic and quality improvement experts provide tools, education and assistance to support providers in Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont.

HCA also delivers improved patient care healthcare models and solutions to Assisted Living, Home Health, Hospitals, Nursing Homes, and to Physician and Ambulatory Care practices. Their services include:

- Data Analytics for Quality Improvement reporting
- Practice transformation that directs health care providers towards Meaningful Use, Patient Centered Medical Home, PQRS, and EHR system conversions.
- Safe Transition program improves a practice’s ability to move a patient from one healthcare setting to another. HCA frequently improves practice care transitions by implementing evidence-based interventions developed with feedback from stakeholders from all care settings.

EOHHS and the Department of Health contract with HCA to perform the annual physician Health IT Survey that provides a snapshot of how healthcare technology is used by providers in Rhode Island, which was described in section A.1.2. Additionally, the CEO of HCA serves on the Board of the Rhode Island Quality Institute, staff from HCA assist the State’s HIT Coordinator in convening RI’s hospital CIO’s on a quarterly basis to share among themselves and with the state, important information and feedback HIT initiatives, trends and needs across the state.

A.7 Health Information Exchange Organization

A.7.1 Rhode Island Quality Institute (RIQI) - RI’s State Designated Health Information Exchange Organization

The Rhode Island Quality Institute (RIQI) is a not-for-profit organization that was founded in 2001 through a collaboration of leaders in the RI community, with an established mission to
significantly improve the quality, safety, and value of healthcare in RI. This collaboration includes consumers, consumer advocacy groups, integrated delivery systems and community hospitals, health insurers, physicians, professional associations, the Medicare Quality Innovation Network Quality Improvement (QIN-QIO) organization, behavioral health professionals, community health centers, skilled nursing and long-term care facilities, employers, academia, and RI state government officials. In 2004 at the request of and in collaboration with RIQI, the RI Department of Health (DOH) applied for and received funding from the Agency for Healthcare Research and Quality (AHRQ) to be one of six states nationally to be awarded a $5 million, six-year “State and Regional Demonstration Project in Health Information Technology” contract. The goal of this initiative was to develop a statewide health information exchange system that would integrate patient health data from various healthcare organizations, to create longitudinal record and make it accessible to the patients authorized healthcare providers in order to allow providers to provide high quality health care by having the information they need at the point of care as well as to allow them to manage their patient population and reduce gaps in care.

Through a RFP process that was completed in 2007, RIQI was designated as the State’s Health Information Exchange (HIE) Organization, to complete the building of as well as operate Rhode Island’s the Statewide Health Information Exchange (HIE), known as CurrentCare. CurrentCare is a secure electronic system which allows doctors and other care givers immediate access to a patient’s up-to-date health information in order to provide the best possible and most comprehensive care.

Rhode Island Quality Institute is a leader in health information technology committed to improving the quality of healthcare in Rhode Island. As the state’s Health Information Organization (HIO), RIQI is responsible for developing, implementing, and operating the statewide HIE. RIQI, which had also been designated by the Governor to serve as the State’s Designated Entity (SDE) for the ARRA HIE funds in 2010, works closely with the SMA in developing the HIE Strategic & Operational Plan for the State of Rhode Island. Great strides have been made with the development of CurrentCare. With a concerted effort from the Secretary of Health and Human Services in 2013 and the RIQI Board of Directors, a $1 Per Member, Per Month (PMPM) voluntary multi HIE funding model initiative was agreed upon and includes public, private and self-insured payers throughout the state. This HIE funding sustainability model has been an approach after which other states are attempting to model their HIE efforts.

RIQI had also been selected as one of the seventeen Beacon Communities and based on the State’s HIT participation with CurrentCare, they were able to demonstrate that HIT is a critical tool in improving health care outcomes. The fact that RIQI has successfully obtain numerous major grant initiatives, which are all synergistic provides them with unique opportunities to closely collaborate with Medicaid and its EHR incentive program participants.
RIQI has also been nationally recognized for promoting and integrating the use of Direct Messaging into their infrastructure. RIQI has leveraged direct messaging by relying on that as the standard for transmitting CCDs to and from CurrentCare.

A.7.2 CurrentCare – Rhode Island’s Health Information Exchange (operated the RIQI)

Many individuals see several doctors, take multiple medications, and go to several locations for medical tests. CurrentCare ensures that all of an enrolled patient’s healthcare providers have the information they need to coordinate the best possible care. Most significantly, CurrentCare contributes to the reduction of medical errors, prevention of avoidable hospitalizations and emergency room visits and improved care coordination between providers.

CurrentCare operates as a centralized HIE. Health care data on enrolled individuals is sent to and stored in CurrentCare by data submitting partners (labs, hospitals, provider offices, radiology, pharmacies via surescripts etc.), creating a longitudinal health care record for that patient. Providers can access the information with the consent of individual by logging into the Currentcare Viewer (portal) or through their own EHR if bidirectional exchange capabilities have been established.

The use and operation of CurrentCare is governed by the Rhode Island Health Information Exchange Act of 2008. As expressed in the HIE Act, the State of Rhode Island views CurrentCare as the means to promote patient-centered care, allow widespread utilization of electronic health records by health care providers, improve the quality, safety and value of health care, keep health information secure and confidential, and progress toward meeting public health goals.

Participation in CurrentCare participation is voluntary for both patients and health care providers. Individuals need to consent and actively enroll to have their Health information be shared via CurrentCare. Additionally, health information may only be released from CurrentCare in one of the following three scenarios:

1. In an emergency, to the treating provider(s)
2. With the consent of the patient
3. To a public health authority for those purposes in the interest of the public’s health

Furthermore, when a patient enrolls in Currentcare, they are required to identify (consent) to who can access their CurrentCare record. There are three options available: in an emergency
only, all treating providers (like HIPPA) or only certain providers (identified by the patient) and in an emergency. As evidenced above the types of potential data users are limited in the law. Last year the HIE Act of 2008 was modified to allow health insurers to access CurrentCare for care management (when patients choose all treating providers which accounts for 98% of those enrolled) and for quality improvement purposes. The statute was also amended to clearly articulate that patients’ can authorize the sharing of their data to caretakers, family members and others of the patients choosing.

Health care Providers who participate in CurrentCare have signed a data sharing agreement with RIQI which includes a HIPAA compliant agreement.

**CurrentCare for Me:** Consumers now have the ability to access their own data in CurrentCare to view lab results, prescribed medications, condition information, and office-visit summaries, along with the ability to view and download their entire health record in either HTML or CCD formats. This is enabled through a patient portal known as “CurrentCare For Me (CurrentCare4ME)”. Individuals can also request to see who has accessed their CurrentCare (though that is not yet part of CC4Me). RIQI is also working on a project entitled “no wrong Door” which would be enabling single sign on to all of a patient’s patient portals. It is anticipated that CurrentCare for me will help drive CurrentCare enrollment. As more patients enroll in CurrentCare, more data accumulates and more providers have access to health data to coordinate care, Rhode Islanders will benefit from better, more efficient healthcare.

Funding to continue CurrentCare development and operations is largely based on a multi-payer model. The model is based on payers and self-funded employers contributing a $1 per member per month (PMPM) based on their number of lives they cover for health insurance. This supports a fair share approach to funding the state’s HIE. All of the state’s major commercial healthcare insurance providers contribute along with approximately 23 large private self-funded organizations who provide their employees’ health coverage. Naturally, Medicaid pays their share based on the number of Medicaid covered lives and this portion is and has been eligible for a FFP 90/10 share. It is important to note that Medicaid’s contribution in this multi-payer model varied based on the amount of dollars that are appropriated for State match. As a result of Medicaid expansion including more individuals then initially expected, the Medicaid PMPM has varied and has ranged from 75 cents to 85 cents per member per month. In addition to the PMPM funding, RIQI has been successful in obtaining grants that continue to build new services off of CurrentCare and its HIE infrastructure. This includes TCIP and SIM dollars along with other ONC grants and some private foundation funding.

CurrentCare has come a long way since it started it’s HIE endeavor in 2007. As shown in the diagram below, CurrentCare has the ability to exchange many types of health information over a secure network. The goal is to enhance the patient care for the provider and the patient.
CurrentCare promotes the sharing of a large amount of data received from many providers in the state and more recently from surrounding states. Such accomplishments include but is not limited to obtaining:

- 90% of the Rhode Island prescription data from retail pharmacies in the state. This greatly enhances a provider’s ability to reconcile patient medications.
- 90% of the lab results which are coming from both hospital laboratories as and the majority if independent clinical laboratories in the state.
- EKG Imaging and Diagnostic Imaging reports from numerous imaging facilities and hospitals throughout the state and beyond
- 100% of RI’s admit discharge and transfer data (ADT feeds). All acute care hospitals send their ADT data in real time.

Hospital Alerts, one of RIQI’s HIE services, can notify a provider when their patient has an been admitted, discharged, or transferred to an emergency room and/or hospital. The real benefit for the provider is that they can have immediate information to help provide more coordinated care and reduce re-admission rates by reaching out to the hospital and or patient to discuss the patient’s situation, medications and diagnosis. This proactive sharing of care information allows providers to determine if the patient needs to remain in the ED and or be admitted to an acute care facility. This service is available to all providers. Who subscribe for their patients who are enrolled in Currentcare. Additionally, since providers wanted this service to be available for their entire patient panel. RIQI has created the ability provide ED/Hospital Alerts to a provider
for their entire patient panel by implementing BAAs with the hospitals and those providers interested in purchasing this service.

Importantly, CurrentCare is also able to Continuity of Care documents from 16 EHRs platforms:

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and is receiving Continuity of Care documents from a majority of the acute care hospitals in the state. The CCD allows providers to view problem and medication lists, allergies and sometimes vitals, procedures, and other practice specific information in a longitudinal summary. In addition, several large behavioral health providers have access to information regarding substance abuse when patients have consented to share this information with CurrentCare. A growing number of the EHRs in the state are able to bi-directionally share data with CurrentCare allowing providers to be able to access CurrentCare data from within their own EHR.

The CurrentCare Guidebook is a wonderful resource that RIQI developed to communicate who its data sharing partners are and what they are contributing, as well when new data types and/or data sharing partners are likely be on-boarded next. The link for the guidebook is: http://www.currentcareri.org/Portals/0/Uploads/Documents/CurrentCare%20Information%20Sources.pdf
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<th>ADTs*</th>
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*ADTs*: Allergy Data Transfer System

A.7.3 The Role of MMIS in the Current Environment

RI’s Medicaid Management Information systems (MMIS) is an integral part of the state’s HIT Initiatives. It supports and integrates with MAPIR, given that RI is part of the 13 state collaborative that uses MAPIR as the state’s EHR incentive program attestation system. Additionally, the MMIS system generates a quarterly file of all Medicaid enrollees and sends to RIQI so that it can be matched against the CurrentCare enrollee file. This allows the state to track the percent of Medicaid beneficiaries that are enrolled in Currentcare and to try and determine strategies for increasing enrollment in Currentcare among the Medicaid population. Currently about 38% of Medicaid beneficiaries are enrolled in Currentcare. This compares to 46% for the state overall. Lastly, MMIS is used to support the state’s All Payer Claims Database (APCD) known as HealthFactsRI by submitting all of the Medicaid claims the APCD.
A.7.4 State Activities to facilitate HIE and EHR Adoption

State activities to facilitate HIE and EHR Adoption are described in Sections A.5 and A.6

A.8. State HIT Coordinator

RI’s State HIT Coordinator position is located within EOHHS and facilitates the coordination of Health IT initiatives across the state that supports health care reform through promoting the adoption of Electronic Health Records, participation in the EHR Incentive Program, development, implementation and the utilization of the Health Information Exchange Services (HIE) across the state as well as the development of the state’s All Payer Claims Database and other relevant HIT projects. The State HIT Coordinator also serves as the state’s point of contact to Federal Agencies focused on HIT and/or HIE initiatives. In addition, the Health IT Coordinator is the EOHHS liaison for the state’s Regional Health Information Organization (RHIO) the Rhode Island Quality Institute (RIQI).

The State HIT Coordinator is working to align statewide HIT efforts across and within Rhode Island, and oversees the state’s Medicaid EHR Incentive Program and its program manager. The State HIT Coordinator also oversees the state’s SIM HIT work plan, and serves on additional multi-agency HIT projects, such as the APCD Interagency Staff Workgroup and the Provider Directory Advisory Commission.

The operational functions of the Rhode Island Medicaid EHR Incentive program have been under the supervision of the State HIT Coordinator at EOHHS Since 2013. At that time, the decision was made to separate the audit function for this program and have the audit function be the responsibility of EOHHS’s Office of Program Integrity (see chart below).

A.9. Medicaid Activities That May Impact the EHR Incentive Program

There are numerous efforts underway to continue to align and coordinate various initiatives and efforts within Medicaid and across EOHHS. EOHHS has recently clarified its organizational structure and has created a Data and Analytics Team which is separate from the its Implementation and Policy Team. Although the HIT work cuts across both areas, the State HIT Coordinator position is officially part of the Data and Analytics Team. While the state HIT coordinator works with many initiatives across EOHHS, its agencies and the state, locating the position within this unit helps to foster ongoing efforts to assure that HIT and HIE efforts continue to influence and become a critical aspect of all Medicaid activities and vice versa. As RI Medicaid moves towards implementing Accountable Entities and its health system transformation system program, Medicaid staff have consulted with the EHR incentive program manager, the State’s SIM HIT specialist (who also reports to the state
HIT Coordinator) and the state HIT Coordinator. Additionally, RI’s Medicaid program will be undergoing a MITA 3 self-assessment and the above HIT staff will participate where appropriate to assure the EHR incentive program is represented and any resulting work is accomplished over time

A.9.1. RI Bridges (UHIP)
RI Bridges (formerly known as Unified Health Infrastructure Project, UHIP) is designed to be a single technical platform that supports eligibility and enrollment for Medicaid, the state’s health insurance exchange known as HealthSource RI, and most recently many of the other state’s human service programs (SNAP, TANIF, etc.) by collecting consumer information in a through a centralized system. RI Bridges is an interagency initiative between HealthSource RI, the Executive Office of Health and Human Services (EOHHS), and the Office of the Health Insurance Commissioner (OHIC). Although there have been significant unanticipated challenges during the initial deployment of RI Bridges, these challenges have not impacted the operations of the HER Incentive program. Moreover, a significant amount of time and energy is going into improving and fixing the aspects of RI Bridges that were not working correctly.

A.9.2. Re-inventing Medicaid in Rhode Island
In February 2015, Governor Raimondo established the Working Group for Reinventing Medicaid with the duty to review the current Medicaid program and recommend specific quality improvement and cost containment measures for redesigning Medicaid. The group identified many shortcomings of the current program, including misaligned incentives across the delivery system, fragmented and non-coordinated service delivery, and an inability to address social determinants of health, that ultimately result in high costs and less than favorable outcomes. The Working Group’s final report includes ten goals based on four principles: 1) Pay for value, not for volume; 2) Coordinate physical, behavioral, and long-term healthcare; 3) Rebalance the delivery system away from high-cost settings; and 4) Promote efficiency, transparency, and flexibility. The working group recognized the importance of leveraging Health Information Systems and Technology to ensure the delivery of high quality and coordinated care. Goal 7 of the working group specifically addresses this and indicates that specifically states that “One of the most critical pieces to achieving a successful coordinated care health system is the proper use of available health information technology. Rhode Island is leading the way in supporting patients and providers with CurrentCare, a secure electronic network that gives authorized medical professionals access to their enrolled patients’ most up to date health information, including lab results, medications, and hospital visits”. Given the above, the report sets a target such that 75 percent of Medicaid members will be enrolled in CurrentCare by 2018. And states that the “broadening adoption of sophisticated electronic health record (EHR) systems will also help provide this kind of connectivity and data-sharing”. Additional information is available at: http://reinventingmedicaid.ri.gov/
A.10. State Laws and Regulations

In the 2016 state legislative session, a bill was passed to amend the Health Information Exchange Act of 2008. Two changes were made to the law. The first change clarified that individuals enrolled in Currentcare can choose to have their Currentcare record shared with individuals they designated such as caregivers and family members. The second change allowed for health insurers to see their members’ CurrentCare data for the purpose of care management or quality improvement activities.

Also in the 2016 state legislative session a bill was passed to amend the prescription drug monitoring program (PDMP) law to allow for data to be shared with technology vendors. Before this change, EHR and/or HIE integration with the PDMP through electronic interfaces was not legally allowed under the statute. With this law now in place, HIE integration activities with the PDMP are ramping up.

Other than the above, there have not been any statutory changes or regulations that impact the implementation of EHRs or the EHR Incentive Program. EOHHS requires no additional authority to administer the EHR Incentive Program other than to obtain budget authority to use and distribute EHR incentive program funding and for a state match appropriation.
A.11. HIT/HIE Activities that Cross State Borders

Rhode Island participates in the 13 state MAPIR collaborative, which has and continues to provide significant cost savings to the state for administrating the EHR Incentive Program. This multi-state effort allows information sharing including best practices among the partner states.

Additionally, Rhode Island’s HIE, CurrentCare, has begun to engage in cross border data sharing efforts. As a result of some hospital mergers, RIQI is now collecting data from Connecticut (Lawrence & Memorial hospital and soon to be acquired by Yale New Haven hospital). RIQI is also working with the SouthCoast health system (in southeastern MA) to obtaining ADT feeds as well as other data. Such efforts expand the utility and value of CurrentCare not just for Rhode Island but to the other states as well.

A.12. State Immunization Registries & Public Health Surveillance Databases

The Rhode Island Department of Health (RIDOH) is an active and valuable partner to EOHHS in advancing state HIT goals and in supporting the public health components of the EHR Incentive Program. RIDOH has the electronic capability to support some but not all of the public health meaningful use objectives that providers are asked to attest to. The Department of Health’s Public Health Informatics and Meaningful Use Coordinator works with and coordinates across the various public health programs which a related public health meaningful use objective. Additionally, RIDOH is evaluating if other program databases, such as the states birth defects registry could be considered “other registries” under the meaningful use program. The status of each of current public health programs which EPs or EHs need to attest to are described below.

A.12.1 Accepting Electronic Immunization Files

KIDSNET is a secure child health database links and integrates information from 10 different public health program for every child born in Rhode Island as well as those that move to the state. It serves much like an HIE for child public health programs. In addition to serving as the state’s childhood immunization registry, it also contains relevant individual level data from vital records, all 3 newborn screening programs (metabolic, hearing and developmental screening), birth defects registry data, home visiting data, early intervention data, and data from the supplemental nutrition programs for women, infants and children (WIC). KIDSNET allows pediatricians, other authorized health care providers, and RIDOH program staff to access information to ensure that all children in Rhode Island are as healthy as possible by getting the right health screenings and preventive care at the right time.
Currently, KIDSNET, which is RI’s immunization registry can only accept data on patients 18 or younger. KIDSNET accepts Immunization HL7 2.5.1 messages from provider’s EHR systems, and has and continues to onboard EPs and EHs if they vaccinate at least one patient 18 years old or younger in reporting period. All other EPs and EHs can claim an exclusion for the immunization registry component of the public health objective. RIDOH is seeking to expand the immunization registry component of KIDSNET, turning it into a life-long registry as well as create bidirectional interface with CurrentCare.

EOHH works closely with the KIDSNET program staff. Designated KIDSNET staff oversee and manage the immunization onboarding process, and communicates progress with the EHR Incentive Program Manager so that he can verify for the programs pre audit process which EPs and EHs have been able meet applicable Meaningful Use requirements. KIDSNET staff request that registration of intent for the Immunization meaningful use Stage 2 objective is received no later than the 60th day from the start of the eligible provider or hospital’s reporting period. The RIDOH staff work with the EP or EH to test that HL7 immunization messages are successfully being sent to KIDSNET and to establish and/or maintain ongoing immunization HL7 messaging.

A.12.2 Electronic Syndromic Surveillance Files

The RI DOH has the capacity to accept Syndromic Surveillance data from emergency room hospital admissions in HL7 format as they occur. Hospitals who want to participate register their intent with the RIDOH and work with the RIDOH staff through the onboarding process to test and send ongoing HL7 syndromic surveillance messages.

A.12.3 Electronic Lab Results and Reportable Diseases

RI DOH’s Division of Infectious Disease and Epidemiology currently accepts electronic laboratory results data related to reportable diseases from eligible hospitals and clinical laboratories in HL7 format. Similar to syndromic surveillance, registration and test messaging or ongoing submission of reportable diseases is required.

A.12.4 Cancer Registry

RIDOH’s cancer registry is maintained by the Hospital Association of Rhode Island (HARI). There is no electronic reporting capability at this time, although there have been some initial discussions about how to collect the depth and complexity of data that HARI currently collects on paper. One of the major barriers which is diminishing over time is that the EHR adoption rate among oncologists is perceived to be lower than other specialists.
A.13. State HIT-Related Grants

A.13.1. SIM Test Grant

In 2015, Rhode Island was one of 24 states to receive a State Innovation Model (SIM) Test Grant from the federal Centers for Medicare and Medicaid Services (CMS). The state received $20 million with the expectation that the funds would be used to transform the way healthcare is delivered and paid for – and to improve Rhode Island’s population health. SIM’s funds are investing in three categories of activities: improving the primary care and behavioral health infrastructure, engaging patients in positive health behaviors and self-advocacy, and expanding the ability of providers and policy makers to use and share data. Rhode Island’s SIM believes that by transitioning to a system of value-based care that addresses social and environmental determinants of health, SIM can support Rhode Island in enhancing the physical and behavioral health of the population, improving the experience of care, and spending our healthcare dollars in a smarter way.

Rhode Island SIM is led by a team of staff from several state departments, including the Executive Office of Health and Human Services, and its member agencies and programs (Medicaid, and the Departments of Health (DOH), Human Services (DHS), Children Youth and Families (DCYF), and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). SIM participants also include the Office of the Health Insurance Commissioner (OHIC), and HealthSource RI (HSTI). SIM is officially governed by a Public- Private Steering Committee made up of a diverse range of stakeholders, including providers, insurance carriers, patient advocates, and community organizations. We encourage stakeholders and interested individuals to participate in the various working groups that SIM convenes on specific topics related to healthcare transformation.

The vision of the Rhode Island SIM Test Grant represents the desired future state resulting from a transition to value-based care in the state. Our vision statement, borrowed from the Triple Aim, reads: Continuously improving Rhode Islanders’ experience of care (including quality and satisfaction), enhancing the physical and behavioral health of all Rhode Island’s population, and smarter healthcare spending. There is a strong focus on HIT investments as part of the SIM grant, including several of the projects discussed in other sections of this plan (statewide common provider directory, care management dashboards, HealthFacts RI eCQM Reporting and measurement system, EOHHS EcoSystem). SIM has also provided funding for EOHHS to hire an HIT Specialist who works as part of the SIM staff team but is supervised by the State HIT Coordinator and is located within EOHHS. The HIT Specialist assists the State HIT Coordinator with the management of HIT contracts under SIM and strategic planning for HIT within Rhode Island.
A.13.2. Department of Health Grants

The RIDOH receives numerous grants to help support public health information systems, especially for Electronic Lab Reporting (ELR), Syndromic Surveillance, and the Prescription Drug Monitoring Program (PDMP). EOHHS coordinates with RIDOH through the Meaningful Use/Public Health Informatics Coordinator to align HIT strategies across EOHHS agencies.

A.13.3. SBIRT Grant

The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) received an $8,291,875, 5 year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) which began in October 2016. This grant will promote the use of Screening, Brief Intervention, Referral and Treatment (SBIRT) throughout Rhode Island, with a goal of conducting 250,000 screenings over the five-year period.

A key component of this grant included investing a portion of the funding in Health Information Technology that allows for screenings to be conducted electronically and shared among treating providers. BHDDH is collaborating with SIM to contract with a consolidated operations vendor for both SBIRT and SIM Community Health Team (CHT) activities. The contracted vendor will conduct an HIT assessment of the capabilities of SBIRT screening sites (PCP practices, EDs, CHTs etc.). This will help inform how to appropriately and effectively capture and share SBIRT screening results. The current plan is to build a screening tool module as part of the HIE, but this strategy is subject to change if the implementation sites do not have a need for the module (already capture this data in their EHR etc.).
B. To-Be Assessment – The Future HIT/HIE Landscape

B.1. Five Year Vision Overview
Over the next five years, we are looking to achieve five main goals:

1. Continue a positive trend toward adoption of Electronic Health Records, with 90% of hospitals, primary care providers, and outpatient specialists adopting CEHRT by 2021.
2. Achieve a 75% meaningful use conversion rate among RI Medicaid Eligible Providers (from AIU to MU) by 2021.
3. Continue to increase the number of Rhode Islanders participating in Currentcare, with:
   A. 90% of Rhode Islanders having a Currentcare record by 2021
   B. 80% of all Medicaid beneficiaries with a Currentcare record by 2021.
4. Continue to increase the value of the Health Information Exchange by increasing awareness and use of the CurrentCare, with 75% of physicians knowing of and using CurrentCare by 2021.
5. Continue to expand Health Information Exchange services and increase the interoperability among the state’s HIT services (includes HIE services and EHRs and other HIT systems such as APCD) where appropriate, with a goal of increasing efficiency and utility while decreasing duplication.

B.2. HIT Future Initiatives (includes several beginning to be implemented)

EOHHS is continuing to invest in state HIT systems that help support practice transformation, inform policy, and support operational needs for the state and the community. The goal is to support the data and analytics needs of both state agencies and the healthcare community. Additional detail of the enhancements to be made follows.

B.2.1 Electronic Clinical Quality Measurement Reporting and Feedback System
Clinical Quality Measurement (CQM) reporting and feedback is a critical component in quality improvement efforts, in transforming the health care system and has and continues to be an important part of the Medicaid EHR incentive program. Providers often have to report similar yet different quality measures to measure the same outcome, and they need to report them to numerous different entities. Providers, ACOs and facilities in Rhode Island have noted the number and variety of reporting requirements is likely to continue to increase under a value based payment system. Numerous sources support the assumption that analytic resources and capabilities are insufficient in the state to empower providers and organizations to most effectively use their ever-growing and extremely valuable data.
Furthermore, numerous organizations in the state are working toward creating their own quality measurement systems that will meet their needs, including payers, practices, and practice transformation organizations.

Given the above environment and given that the initial SIM HIT plan had anticipated the need for a statewide eCQM reporting and feedback system, the SIM Steering Committee convened a SIM Technology Reporting Workgroup to verify whether a statewide Clinical Quality Measurement reporting and feedback system was needed and would be desired in RI.

The SIM Technology Reporting Workgroup was comprised of payers, quality improvement organizations, the state’s designated HIO, data and analytic staff from large provider practices, and a few practicing providers and state staff. After several meetings the SIM Technology Workgroup recommended funding the development of a statewide electronic quality reporting system with the goals of:

• Improving the quality of care for patients and driving improvement in provider practices by giving feedback to providers, provider organizations and hospitals about their performance based on quality measures
• Producing more valuable and accurate quality measurements based on complete data from the entire care continuum
• Leveraging centralized analytic expertise to provide valuable and actionable reports for providers and to drive improvements in population health
• Reducing the duplicate reporting burden upon providers and provider organizations by having a common platform for reporting
• Publically reporting quality measurements in order to provide transparency and support patient engagement in making informed healthcare decisions
• Using existing databases, resources and/or systems that meet the various stakeholders needs, rather than building from scratch

The workgroup has determined that in order to achieve these goals, the system would need serve as a common platform for quality measurement, quality improvement, and reporting. It would need to be able to accomplish the following, at a minimum:

• Easily capture data (electronically) in a standard and consistent manner (no extra work for providers)
• Calculate measures based upon the SIM harmonized measure set and relevant national measure sets, including those used in the meaningful use program
• Become a Qualified Clinical Data Registry (QCDR) to allow the reporting of results directly to CMS, NCQA, and the payers, and fulfill additional reporting obligations on behalf of providers
• Benchmark providers at the provider level and the provider organization level
• Consist of detailed, individual level data from multiple sources matched to a single person, and make that data available to providers to improve individualized care while appropriately protecting confidentiality
• Share analyses and results back to providers, provider organizations, payers, state government, and, eventually, the public

This project will begin to focus on collecting data from practices with Electronic Health Records (EHRs). In addition, the state must set up a governance structure with adequate community and provider engagement to determine what data is shared to whom and how it is shared. EOHHS just has issued and RFP for the development and ongoing operations of this system. EOHHS envisions the system will be developed and operated by a third party data intermediary, especially given the system is anticipated to serve all providers for a number of different programs over time. As this work gets underway, there will be an analysis of how to streamline work and interface this system with MAPIR such that over time providers do not need to enter their MU CQMs into MAPIR.

B.2.2. HealthFacts RI Conversion

The first phase of HealthFacts RI, Rhode Island’s All Payer Claims Database went live in February 2016. This tool contains the most comprehensive collection of health care claims data that the state has ever had. It will illuminate how Rhode Islanders use the healthcare system, the effectiveness of policy interventions, and the health of our communities.

The most powerful feature of HealthFacts RI is that it collects, organizes, and analyzes health care data from nearly all major insurers who cover at last 3,000 individuals in Rhode Island. The existing RI APCD is currently a stand-alone database, hosted and stored externally by an outside vendor and managed by multiple state agencies.

Given the analytic value the APCD has to Medicaid, specifically including EOHHS/Medicaid to integrate data-driven, evidence-based programmatic decisions into its daily Medicaid operations, and to ensure sustainability for effective reform initiatives beyond SIM funding. EOHHS has proposed to leverage these existing APCD processes and infrastructure by converting the RI APCD into a Medicaid IT Enterprise module, through the following activities:
- Enhancing the database with data elements for Medicaid Program monitoring, reporting and evaluation purposes;
- Converting the existing database into a Medicaid IT Enterprise module and moving it into a state-operated, Medicaid IT Enterprise environment;
- Transitioning management and control of the database solely to the Medicaid Program, with operational support from other agencies; and
- Building new analytic capabilities that are not yet developed, using Medicaid Enterprise tools.

The HealthFacts RI module will enable analytic functionalities necessary for RI Medicaid to meet federal reporting requirements, measure provider performance to evaluate payment reform initiatives, operate the Program more efficiently, and achieve Medicaid's health system transformation goals. Specifically, the database will provide:

- Comprehensive views of former and current Medicaid beneficiaries through longitudinal, cross-payer utilization, provider, and payment data;
- Payment and utilization comparisons for provider benchmarking and rate restructuring purposes;
- Data to evaluate and inform healthcare reform efforts for Medicaid in relation to SIM initiatives;
- Comparative cross-payer utilization and payment data to evaluate Section 1115 Medicaid Research and Demonstration waivers, in accordance with federal requirements; and
- Access to an integrated, longitudinal utilization and payment dataset for Medicaid-Medicare dual-eligibles.

Additionally, the database will streamline Medicaid analytic capabilities by:

- Re-using the Medicaid Enterprise-wide, state-licensed analytic platform;
- Building nimble, broad and deep Medicaid analytic capability that is currently unavailable to Medicaid program managers and decision makers; and
- Leveraging cost effective, interoperable data architecture that promotes future integrations and avoids vendor lock-in by installing the database in a state-hosted Enterprise environment and maximizing Medicaid state and federal investments to date.

With access to claims, enrollment and provider data from multiple payers, as well as value-added enhancements that will be applied for Medicaid purposes, the HealthFacts RI module will allow for necessary reporting and analytics, such as comparative analysis and benchmarking that would otherwise not be possible.
B.2.3. Statewide Common Provider Directory

The ability to obtain and keep up to date information on health care providers including practice and payer affiliations is very challenging. Numerous health care organizations in the state create and maintain their own provider directory to the best of their ability but there is often no consistent method for keeping the data updated, resulting in different data in different organizational provider directories. Furthermore, many provider directories do not track affiliations and organizational hierarchies which are needed for analytics such as when providers were under operating under different payment models.

As part of the State’s SIM HIT plan, the state proposed to develop a single statewide common provider directory. Since RI’s state designated entity for HIE, RIQI was already well underway in building a provider directory with affiliations and organizational relationships for CurrentCare, EOHHS decided to contract with RIQI to leverage the work done to date, and have them serve as the vendor to build maintain and operate the Statewide Common Provider Directory. This directory will consist of detailed provider demographics as well as identifying both relationships between providers and organizations and organizational hierarchies. This organization hierarchy being built into the provider directory is unique and is an essential aspect to being able to maintain not only provider demographic and contact information, but their relationships to practices, hospitals, ACOs, and health plans. The intent of this project is to:

- Allow for the mastering and maintenance of provider information and organizational relationships to only occur once in the state in a central location;
- Use the web-based tool that was developed to allow a team of RIQI staff to manage and maintain provider import files and data survivorship rules, error check flagged inconsistencies or mapping questions, and manually update provider data or enter new providers;
- Develop and institutionalize the appropriate data mastering and maintenance system to allow for useful data export via a flat file.
- Provide iterative data exports that allow for hospitals, payers, and state agencies to incorporate the centrally mastered provider data within their own databases; and
- Increase ability for consumers and providers to have up to date and accurate information about providers by having a consumer portal and a provider portal.

As part of EOHHS contract, RIQI will increase the number of provider files imported and provided a number of data exports. Discussion are underway to assess the ability to import Medicaid provider’s files as well as to determine how Medicaid can use the data from the statewide common provider directory and Medicaid’s ability to receive and use a mastered file.
Other deliverables include operational support to continuously master and verify the data, provide required infrastructure support, and develop a public facing website. The public facing websites are still under development and the anticipated go-live mid-2017.

Over the next five years, the provider directory will need to be continually developed to serve a growing number of needs, including but not limited to support accurate referrals, serving as a single update point for providers that then disseminates updates to interested parties, supporting analytics activities, and helping consumers choose insurance plans.

### B.2.4. Integrated Health and Human Services Data Ecosystem

Rhode Island lacks a modern system for integrating person-level information across our EOHHS agencies (Medicaid, the Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH), the Department of Children, Youth and Families (DCYF), the Department of Human Services (DHS), and the Department of Health (RIDOH)), and then turning that holistic information into action. These agencies share a mission of providing essential services, safety net support, and public health promotion, while often serving the same people and collecting large amounts of data on these beneficiaries. If we are able to combine and better analyze these data, we can obtain critical information about the needs of our population, the effectiveness of our programs, and how to responsibly spend valuable public resources.

With funding from SIM, Rhode Island will take informed, project-based steps that reflect iterative learning and sophistication to build our new data ecosystem using the agile processes and methodology in order to integrating data across our agencies and driving policy with those data. Rhode Island is planning a light, simple and adaptive solution.

Our approach will build on an ongoing assessment of our entire data ecosystem, which includes our current Medicaid data warehouse and our processes for collecting, managing, and using data, as well as lessons learned from other states. Funding from SIM may be able to support some of the initial work for this project, though it is anticipated that the ecosystem will become another modular component of RI’s Medicaid enterprise system and will support answering policy and evaluative questions needed to improve the work of the Medicaid program. EOHHS is beginning to identify what if any existing infrastructure can leveraged for this purpose, and how this system would relate Healthfacts RI and Currentcare given differing and fairly stringent statutory requirements around sharing of PHI. EOHHS anticipates issuing and RFP to select a vendor to create the ecosystem data warehouse by collecting only the required data elements to answer a specific policy question. Using the agile methodology will allow each policy question to serve as the basis for an agile sprint. EOHHS will also work with the vendor to develop a complete
modernization staffing and structure plan to guide the state during the transition to full ownership of the solution.

B.2.5. Care Management Dashboards

Transforming the health care system requires providers to know when their patients have been admitted to or discharged from the ED or Hospital. The ability to promptly share this information is expected to facilitate targeted, appropriate clinical interventions, improve care coordination and reduce re-admissions. Given this, and the work that RIQI already had engaged in not only to send a hospital alerts via direct messaging to a provider, but also to create a real time dashboard showing a providers which of their patients were in a RI ED or acute care hospital in real time, EOHHS has decided to use SIM dollars to funding RIQI to implement this real-time communication system at all of between Rhode Island’s Community Mental Health Organizations (CMHOs), as well as for the Medicaid’s community health team which is coordinating for Medicaid FFS beneficiaries. RI’s CMHOs are mutually responsible for the care of approximately 8500 publicly insured individuals with serious mental illness. This prompt information sharing is expected to facilitate targeted, appropriate clinical interventions, improve care coordination and reduce re-admissions. Ongoing funding for operation of the dashboard will come through a PMPM cost to the CMHCs.

B.2.6. Ongoing HIE Development

RIQI, serving as the State’s designated HIE Entity is continuing to develop additional technology tools to assist healthcare providers increase their efficiencies in providing care to patients throughout their care continuum. Some of these tools are separate from Currentcare and can be implemented for an entire provider’s patient panel not just those enrolled in CurrentCare) using BAA agreements. In doing so RIQI seeks to leveraging the existing technical infrastructure used for CurrentCare but firewalls off the data where needed. Additionally, RIQI is continuously working to increase in HIE enrollment, adoption and use as noted below.

The work to integrate various data types from RI’s adult behavioral health hospital into the CurrentCare environment continues with an emphasis on enabling Observation Result (ORU) or Lab related data. This effort, funded by an ONC Interoperability Grant, will also integrate Admission Discharge and Transfer (ADT) and Continuity of Care Documents (CCDs) from the behavioral health hospital. The initial phase of this project includes a technical effort to incorporate these data-types into CurrentCare for enrolled individuals. The subsequent phase of this project will be to engage Community Mental Health Organizations (CMHO’s) to adopt the use CurrentCare (such as CurrentCare Viewer and
Alerts), especially given that they often have a hard time getting this data from the behavioral health hospital in a timely manner.

RIQI is also focusing on working with long term and post-acute care facilities (LTPAC). While there was a previous effort to engage with LTPACs (around 2010 funded by special Medicaid Transformation grant dollars) the majority of LTPACs did not have EHRs and the effort to engage them with CurrentCare was not able to be sustained after grant funding ended. Considering that most LTPACs have an HER, and that there are primarily two EHR vendors supporting RI’s LTPACs, technical discussions with Matrix Care and Point-Click-Care are underway to integrate ADT data along with CCDs into the CurrentCare environment. This effort is funded by a separate ONC grant. Integration of these data types from these organizations is an integral part of Transition of Care (TOC).

Although, RIDOH serves as the regulator for the RI’s Regional Health Information Organization (RHIO), EOHHS is the state agency which now designates the State’s RHIO and oversees the RHIO designation contract. The designation contract outlines annual deliverables to encourage continued development and these deliverables align with those that need to be met for HIE enhanced match funding. These deliverables are organized in 5 categories and evolve each year to include new focus areas and identified high priority needs. The 5 categories are:

1. Increase Enrollment in CurrentCare
2. Increase Data Availability in CurrentCare
3. Improve Data Access and Utilization
4. Engage Consumers by Leveraging the CurrentCare Infrastructure
5. Leverage CurrentCare for Population and Public Health
6. Maintain CurrentCare

Setting deliverables for RIQI each year will continue. As some deliverables are completed, state leadership determines new goals to be added under the above categories. This process ensures that the state is constantly encouraging innovation and further development for CurrentCare and able to monitor the progress over time.

**B.2.7. Expanded HIE Activities**

EOHHS is requesting enhanced Federal Financial Participation for several projects to further enhance HIE services in Rhode Island under the expanded opportunities in SMD #16-003. This includes the following projects which are also detailed in RI’s IAPD-U that was submitted in December and is pending approval:
Advanced Emergency Department Alerting - Embed HIE data into the EHRs of all hospital EDs in Rhode Island so that the data can be easily accessible to ED providers and to have the HIE data pre-analyzed so that it can alert to ED providers to patients at risk of certain conditions like substance use disorders. All hospitals in RI are already sending ADT data on all patients (not just those enrolled in CurrentCare) to the Rhode Island Quality Institute, the state’s designated Health Information Organization (HIO). These data are shared under HIPAA Business Associate Agreement with RIQI, and go beyond the consent-based HIE to include all patients with treating relationships to the hospitals. The embedded data will consist of an alert flag in the ED tracker board which will highlight PDMP information, treating relationships with PCP or community mental health organizations, ED utilization history, relevant clinical history, and risk modeling based upon the design requested by clinicians in the ED.

Connecting the Statewide EMS Reporting System to the HIE - Establish a bi-directional connection between the statewide EMS reporting system operated by the Department of Health and CurrentCare in order to assist with the transition of care from the EMT to the hospital as well as inform the PCP and other providers. Implementing this functionality will require funding to support RIDOH in paying their EMS software vendor to establish a bi-directional connectivity which would allow EMTs to access information from CurrentCare on patients they are responding to, as well as have run report data electronically included in CurrentCare and therefore be accessible to the patient’s medical providers through a variety of methods (alert, CCD sent to a providers EHR, CurrentCare viewer).

Connecting the Medicaid Community Health Team to the HIE - Establish a data feed from CareLink’s Eccovia Solutions ClientTrack system to CurrentCare which sends care management records automatically to the HIE once documentation is complete.

Develop, Implement and promote the use of an Electronic (e)Referral System - Design, develop and implement an electronic referral system to facilitate referrals between EPs and EHS and other Medicaid providers which is connected to or leverages the provider directory’s underlying data and infrastructure.

Expand RI’s Current Childhood Immunization Registry to Include Adults – Although the Rhode Island Department of Health (RIDOH) has had a childhood immunization registry since 1997, as of 2015, Rhode Island was one of only three states that does not include adults in its immunization registry. Currently EPs and EHS that do not administer vaccines to children or adolescents take an exemption for the immunization reporting MU objective.
- **Connect KIDSNET Immunization Registry to the HIE** - KIDSNET, RIDOH’s integrated child health information system, which includes the childhood immunization registry; vital record birth data; newborn developmental, heel stick, and hearing screening information; WIC program data; and early intervention data does not interface or connect to CurrentCare. Creating some bi-directional exchange capabilities between KIDSNET, including the adult immunization registry, and the HIE would be facilitate the electronic data sharing to and from the immunization registry (providers could send the data to the HIE which could then share it with the statewide immunization registry or vice versa). Additionally, all of the other important health and social determinants data contained in KIDSNET could be integrated into CurrentCare for enrolled children, making this data available to providers’ EHRs through a bi-directional exchange with CurrentCare or helping to reduce provider portal overload and have the data be viewable through CurrentCare viewer instead of having to go to the standalone KIDSNET portal.

- **Develop a Registry Module for the HIE** - Build a registry module on the HIE which allows for extensible care coordination add-ons to the HIE data for public health and health information exchange purposes. This registry module will operate as a data sharing tool for HIPAA covered entities under a BAA with the RIQI as the RHIO, and thus will support data sharing for all patients, regardless of their participation status in the HIE.

The information that would be part of these registries are data types that EHRs struggle with capturing because they are not well structured or may be relevant only in Rhode Island. The data is essential to the effective treatment and care coordination of patients. Each data type mentioned above, is at its most basic level, an advanced form which requires a provider or patient to input information and in some cases may compute results for the user. Because of these commonalities, RI is proposing to build a registry module rather than individual registries for each use case. This registry module would be able to efficiently support all three proposed uses as well as future additional uses and could serve as a specialized registry for Meaningful Use.

The registry module will consist of an advanced form builder which would be used by the technical support staff to create forms for the users. The results of these forms can then be shared via Direct secure messaging or through the HIE if the patient is a participant. Three use cases are identified to support this initial build: SBIRT registry module to support the SBIRT grant discussed previously, eMOLST registry to support the RIDOH Medical Order for Life Sustaining Treatment form, and Shared Care Plan registry to support the work for community health teams.
B.2.8. Enhancements to CurrentCare for Me

Patient engagement is an important component of a transformed health care system and patient portals and other HIT tools can help support patients in actively monitoring their own health. Recognizing that patients may easily have numerous patient portals attached to different EHRs, and that patients may be interested in seeing what is in their Currentcare record, RIQI has worked with their software vendor to develop CurrentCare for Me (CC4ME). CC4ME allows enrolled individuals to access their Currentcare record and in the future to be able to add patient generated data such as family history, advanced directives etc. More specifically, RIQI is working to enable CC$ME to include:

- The ability to upload consumer generated data such as health assessments
- Digital health device data
- Advance Directives/MOLST documents
- Medical history.
- Test messages about Admission, Discharge or Transfer alerts for caregiver proxies.

RIQI is also considering including patient-centered shared decision making, advanced illness care planning and behavior change support tools. Tools being considered would be evidence-based incorporating readiness to change, social determinants of health and health confidence.

Lastly, RIQI is in the early conceptual design phase of a “No Wrong Door” approach to patient portals. This concept would allow patients to seamlessly navigate their multitude of patient portals without having to sign in to each portal separately.

B.2.9. Assisting Providers with Meeting Meaningful Use

Given that 2016 was the last year to register for the Medicaid EHR incentive program, there is no longer need to focus on bringing new providers to the EHR Incentive Program. Also, EOHHS has decided to end its contract with RIQI to provide technical assistance and outreach to Medicaid providers related to the Medicaid EHR incentive program. RIQI continuously offered its services and many Medicaid providers have already taken advantage of these services. With that said, the interest in these services was waning and it did not seem prudent to continue the contract. Providers needing assistance can still work with RIQI or other practice transformation organizations in the state on a fee for service basis. Additionally, other statewide HIT projects, such as the Electronic Clinical Quality Measurement Reporting and Feedback System and the Provider Directory, will support providers in meeting some of their Meaningful Use goals. The Medicaid EHR incentive program will continue to use the HIT Survey to achieve a greater understanding
of the barriers to meeting Meaningful Use and strategize methods of assisting providers, especially where it may involve enhancements to our HIT infrastructure.

**B.2.10. PDMP HIE/EHR Integration**

With legislative changes in the 2016 legislative session, it is now legally allowable for Prescription Drug Monitoring Program (PDMP) data to be shared with providers and their EHR vendors. This has opened the door for integrations between the PDMP and CurrentCare, as well as between the PDMP and providers’ EHRs. SAMHSA and CDC have both awarded grants to the RIDOH to facilitate some of this connectivity.

In collaboration with EOHHS, RIDOH will be working with RIQI to use the CurrentCare infrastructure to connect the PDMP to EHRs for all the providers’ patients, not just those enrolled in CurrentCare. This will dramatically reduce the expense to providers to connect to the PDMP and facilitate an efficient way to leverage existing technology. The first connections are expected to be completed by September 2017, with a goal for continual grant-funded integrations through the end of 2018.

**B.2.11. Future Development of MAPIR**

Rhode Island will continue to participate in the 13 State MAPIR collaborative to support EP and EH attestations for the EHR Incentive Program. Since 2011, Rhode Island has participated in MAPIR and based on the recently CMS approved MAPIR IAPD, RI has been approved 90/10 funding until September 2018.

Our goal is to continue to participate in the MAPIR Collaborative until the program sunsets in 2021. Based on the value-added results we have experienced in the past six years; we are confident that the MAPIR collaborative will continue with CMS’s support. We appreciate the support our MAPIR collaborative and MAPIR development team provides by ensuring release changes comply with statute and regulations approved by CMS. Typically, the MAPIR team has developed and deployed system modifications within a three to six-month timeframe. This includes system quality assurance testing both on the core and individual state levels.

Upgrades to MAPIR will follow the MAPIR collaborative schedule, allowing time for customizations if needed. Importantly, as the Electronic Clinical Quality Measurement Reporting and Feedback System is being considered and discussed amongst the collaborative.
B.2.12. Future HIE Governance Structures

The governance of Rhode Island’s HIE is not anticipated to change significantly and continues to exist at several levels. RIQI is the state’s designated RHIO has a board of directors composed of a diverse set of health care leaders in the state including representatives from hospitals, systems, payers, private providers, employers, business community, consumer groups, long term and home health care and government (as ex office non-voting members). There are also some board level committees which then present full recommendations to the board for approval (operating, legal, nominating, sustainability). RIQI also has a number of community based advisory committees that make recommendations about Currentcare and other RIQI HIE services to RIQI leadership. These committees include consumer advisory, Currentcare advisory, Currentcare user group, provider directory advisory, and employer advisory.

RIQI also works closely with state officials. There are weekly calls with the state HIT coordinator and SIM HIT specialist to monitor projects, align initiatives and troubleshoot any areas needed. Meeting are also being set up between the public health informatics coordinator and RIQI staff to monitor specific projects under way the RIDOH. On a quarterly basis RIQI leadership meets with cabinet level state officials including the Secretary and Deputy Secretary from EOHHS, the Health Insurance Commissioner, the Director of Health and the state Medicaid director. These meetings are to assure that the state’s priorities and RIQI’s priorities and strategies align at all levels. Lastly, the SIM steering committee which is the governing body for SIM project introduces another form of governance over those projects which are from the SIM HIT plan. The SIM HIT plan clearly aligns with the other statewide HIT efforts being supported and driven by EOHHS. Although the HIE governance may sound cumbersome it is important to remember that RI is a small state and many of the same individuals serve on these various committees, and that the State HIT coordinator, the SIM HIT specialist, the RIDOH public health informatics coordinator and the Medicaid EHR Incentive Program Manager all work closely with each other, with RIQI, and with other community partners to keep the HIT projects aligned, synergistic and avoid any duplication.

B.2.13. Next 12 Months: Improving CEHRT Adoption

There is considerable pressure on payers to support practice transformation, value-based payment arrangements, and patient centered medical homes. This pressure continues to trickle down to the providers who are seeking CEHRT to remain relevant with providers. It is also likely that MACRA and MIPS payment adjustments will serve as a major motivator.
Although EOHHS will not be funding any specific practice transformation efforts to encourage CERHT adoption, there are numerous activities occurring in the state, including several of the RIQI grants described earlier, SIM initiatives, activities undertaken by HIC on care transformation and activities undertaken by HealthCentric Advisors as the QIN-QIO. RIQI and HCA serve as experts in the state to help support how adoption of CEHRT supports practice transformation efforts and to provide extra assistance to providers who may not know where to start.

B.2.14. Leveraging FQHC HRSA HIT/EHR Funding

All FQHCs in the state have adopted Certified EHR Technology. If HRSA HIT/EHR funding opportunities occur over the next five years which encourage collaborating with state agencies or the HIE, EOHHS will support the FQHCs in applying for the opportunities and achieving their goals where possible.

B.2.15. Assessing and Providing Technical Assistance to Medicaid Providers - see B.2.9

B.2.16. Populations with Unique Needs

As part of the states SIM test grant, an initial population health plan has been developed. This plan is a work in progress and is seeking to integrated information related to social determinants of health into numerous projects including some HIT initiatives (Currentcare for Me, provider directory, ED alerting etc.). Additionally, there has and continues to be a strong focus on integrate the delivery of physician and behavioral health and this includes needing to having this information integrated in EHRs and The state’s HIE. RI was the first and perhaps still the only state to have been able to integrate behavioral health and substance use data into CurrentCare to assure appropriate care is delivered to this population. As HIT efforts continue to address the needs of various unique populations, this section of the plan will be updated further.

B.2.17. Leveraging HIT-Related Grant Awards

Wherever possible, Rhode Island has leveraged HIT-related grant awards from federal agencies, and also sought IAPD funding for applicable items. Program staff at EOHHS, OHIC, RIDOH, and BHDDH are constantly on the lookout for additional funding opportunities which may support meeting state goals.
RIQI has also been extremely successful at receiving federal and private foundation grant awards that have supported continual HIE development, practice transformation activities that support adoption to CEHRT, and innovation opportunities that expand the breadth of our HIE work.

In the coming year, EOHHS will also be seeking foundation grants to support the 10% state match of some of the HIE projects described in section B.2.

**B.2.18. Anticipated Needs: State Laws and Regulations**

EOHHs, OHIC and RIDO have initiated discussions related to changing RI’s consent model for Currentcare. The model being considered is referred to as “consent to view/disclose” and would allow all providers to send their data to Currentcare and individuals would need to consent to who the data could be disclosed to. Currently there is a legal analysis underway at both the state and RIQI to determine if statutory changes are needed to the HIE act of 2008, if regulatory changes are needed or if it is just a matter of policy changes. If statutory changes are needed, EOHHs is prepared to work with the governor’s office to have legislation introduced to achieve this. Such a change would allow Currentcare to be leveraged a used for a significant amount of public health purposes including serving and a CEHRT component for public health reporting of MU requirements.

In the 2016 legislative session, a bill was passed which requires the update and administrative simplification of all existing regulations. This will include updating the HIE and HealthFacts RI regulations. This opportunity will be used to clarify and simplify some components of the regulations which have proven to be unintentional barriers. For example, the HealthFacts RI regulations have limited the sharing of certain data elements which do not necessarily put privacy at risk and could prove valuable to analysts.

There has been some initial discussion with SIM technical assistance staff at ONC about the integration of claims and clinical records. There are legislative barriers which prevent this integration in Rhode Island, notably that HealthFacts RI is a de-identified data set with extensive sharing restrictions, and the HIE is only a partial clinical data (due to having slightly less than half of the state enrolled). These restrictions would not necessarily serve all the needs that could be met with an integrated claims and clinical system on all patients (such as risk assessment on an entire patient panel).

EOHHS will continue to discuss the options for legislative change with stakeholders in the community and determine if there is consensus to seek these types of changes to our HIT legislation.
C. Administrative Oversight of the EHR Incentive Program

C.1. Verification of Eligible Providers

C.1.1. Eligible Providers

Eligible providers are categorized into two broad groups-Eligible Professionals (EP) and Eligible Hospitals (EH). To receive the initial payment, EPs and EHs must adopt, implement or upgrade (AIU) to Certified EHR technology, meet a specified Medicaid patient volume, and be one of the eligible professionals or facilities. To receive subsequent annual payments, EPs and EHs must demonstrate meaningful use of the EHR technology. The eligibility requirements and the state’s methods for verifying that they are met follows final rule CFR42 requirements.

C.1.2. Eligibility Requirements and Verification of Eligible Professionals

Eligible Professionals are individuals who are fully enrolled in the Rhode Island Medicaid program, are free from sanctions, do not render more than 90% of their covered services in a hospital (non-hospital-based); and are licensed or eligible to practice their profession in the state as one of the following:

1. A physician,
2. A pediatrician,
3. A dentist,
4. A certified nurse-midwife,
5. A nurse practitioner, or
6. A physician assistant who practices in a rural health clinic (RHC) that is led by a physician assistant.

To receive an incentive payment, eligible professionals must first register at the CMS Registration and Attestation System (R&A) and indicate that they want to apply for a Rhode Island Medicaid EHR Incentive. The R&A then sends a B6 file to the Rhode Island MMIS. It is then matched to the Medicaid provider’s NPI to locate whether an active Medicaid provider record exists within the MMIS. Between MAPIR and the provider account in the MMIS, it is determined whether the provider is an eligible professional (EP) based on the Medicaid provider type and specialty.

If a match is found, MAPIR creates a record and sends an email to the provider email address provided in the B6 file to invite the provider to attest for the RI Medicaid EHR
Incentive. This email has a link for the eligible professionals to log into MAPIR via the MMIS web portal. If a match is not found, the provider will not receive an email from our system and will not be able to enter an attestation. Our program administrative staff will contact the provider and inform them that they need to register as a Medicaid provider in order to participate in the program. In the first few years in the program, this was typical with a Nurse Practitioners who do not bill their services directly to Medicaid, however, once the provider completes the Medicaid registration in the MMIS, the provider will be able to participate in the program. This approach strengthens our ability to prevent fraud and abuse and prevent anyone from access the system without validity.

C.1.3. Eligibility Requirements And Verification of Eligible Hospitals
Eligible hospitals are acute care hospitals, critical access hospitals and children’s hospitals. Like EPs, eligible hospitals first register at the National Level Registry. The R&A determines if the hospital/applicant is an eligible hospital based on the following:

- Acute Care and Critical Access Hospitals- have a CMS Certification Number (CCN) with the last 4 digits of 0001 – 0879 or 1300 – 1399.
- Children’s Hospital-have a CCN with the last 4 digits of 3300 – 3399.

Once the hospital has been determined eligible, the R&A sends the registration to the eligible hospital. It is matched by MAPIR to the MMIS like the EPs and a record is created in MAPIR if a match is found.

C.1.4. Identification of Hospital-Based Providers
As described in C.1.2, the MMIS provider record is used to determine whether or not eligible providers are hospital-based by confirming the provider type and specialty.

C.1.5. Verification of Overall Content of Provider Attestations
As described in B.10 the EHR Incentive Program Manager oversees the execution and operations of the RI Medicaid EHR Incentive Program. This position is primarily responsible for ensuring that providers are meeting the CMS guidelines as set forth in the final rule. More specifically this position oversees program outreach activities, policy development and implementation of MAPIR to support the various stages of MU attestation, and pre-payment review and approval. The Program Manager is currently provided by Conduent (previously Xerox Healthcare) and is contracted by EOHHS.
C.1.6. Communication to Providers

Communication to providers about the EER incentive program happens through various channels and is primarily the responsibility of the program manager. Outreach to providers occurs through a monthly Medicaid provider newsletter which is developed by HPE team who is RI’s Medicaid fiscal agent. The EHR Incentive program manager, HPE staff that support MAPIR, and RIQI will develop articles or communicate program updates about MAPIR and the EHR incentive program as part of the Medicaid Monthly newsletter.

Under a contract with EOHHS (aka, RI Medicaid), RIQI has been providing technical assistance to Medicaid providers by assisting them to meet and attest to meaningful use. They provide ongoing communication, conduct training and webinars to the provider community. Additionally, RIQI supplies a great deal of information about meeting AIU and meaningful use that is available from their website’s provider knowledge center section. EOHHS also has a dedicated website pages that provides up to date program information to the provider community. Lastly, if there is an important announcement or deadline, the program manager will send a blast email to those participating in the program to inform them of important events, program changes and deadlines.
C.2. Calculating Patient Volume

C.2.1. Patient Volume Requirements for Eligible Professionals

To qualify for an incentive payment EPs must meet the required Medicaid patient volume or medically needy volume if practicing predominately at a Rural Health Clinic or a Federally Qualified Health Center. Patient volume is calculated by dividing the number of Medicaid encounters by the total number of patient encounters over a continuous, 90-day period in the prior calendar year, or, effective, 1/1/2013 for the 2013 program year and beyond, a 90-day period in the preceding 12 months during attestation.

For the purposes of this program, an encounter is any one day where Medicaid paid for all or part of the service or Medicaid paid the co-pays, cost-sharing, or premiums for the service. However, effective January 1, 2013 for program year 2013 and beyond, that definition was expanded to include all encounters with a Medicaid enrolled patient, paid or unpaid. EPs can attest to the required patient volume using encounters attributable to Medicaid that are services rendered on any one day to a Medicaid enrolled individual regardless of payment liability. This will include zero pay claims and encounters with patients in Title XXI funded Medicaid expansions and in the state of Rhode Island that includes CHIP program encounters. CHIP encounters are not identifiable because they do operate separately from the Medicaid Title IX program. As noted in the diagram below Eligible Professionals are required to meet Patient Volume thresholds.

<table>
<thead>
<tr>
<th>Non Hospital Based Eligible Professionals</th>
<th>90-day Medicaid Patient Volume Percentage Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>30%</td>
</tr>
<tr>
<td>Pediatrician</td>
<td>20%</td>
</tr>
<tr>
<td>Dentist</td>
<td>30%</td>
</tr>
<tr>
<td>Certified Nurse Midwife</td>
<td>30%</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>30%</td>
</tr>
<tr>
<td>Physician Assistant in a Rural Health Clinic so led by a Physician Assistant</td>
<td>30%</td>
</tr>
</tbody>
</table>

Note: Eligible professionals practicing at least 50% of the time in an RHC or FQHC can include “needy individuals” in the Medicaid numerator when calculating patient volume. EPs that practice at an RHC or FQHC can use encounters attributable to needy volume. EPs have the option to choose whether they will use their individual patient volume or their group’s patient volume to determine if they have met the required Medicaid patient volume.
C.2.2. CHIP Patient Volume Reduction for Program Years 2011 & 2012

As is the case in many other states, Rhode Island’s Medicaid program beneficiaries utilize the same identification cards for Medicaid and CHIP, so there is no way for a provider to distinguish which program the beneficiary is in. As noted in the final rule (page 44489 - 44490 of the Federal Register/Vol. 75, No. 144/July 28, 2010/Rules and Regulations), the methodology for estimating Medicaid patient volume is based on Medicaid and not CHIP enrollment. To address this inability to distinguish Medicaid/CHIP enrollment on the basis of available data, CMS has prescribed an approach to adjust patient volumes for impacted providers who apply for the program.

At the start of the Medicaid EHR Incentive program, the final rule required state programs to implement a rule that would reasonably remove any Children’s Health Insurance Program (CHIP) activity from the Medicaid Patient Volume because CHIP was not considered a Title IX program. The CHIP reduction would be applied to the Medicaid Patient Volume numerator. This reduction was applied to all EPs, however those providers who did not provide care to children could elect to not apply the reduction should it place them below the patient volume threshold requirement and provide proof that the patients they encountered were not younger than 18 years.

For 2011 & 2012 a CHIP reduction factors were developed using the total number of CHIP child beneficiaries in each county and the total number of Medicaid child beneficiaries in each county. By dividing the two amounts, percentage reductions were computed for each of the five Rhode Island counties. The 2011 and 2012 percentages were based on enrollment data as of December 31, 2010 and December 31, 2011, respectively.
In 2013 CMS issued FAQ 7537 (click on hyperlink) that allowed states without a standalone CHIP program can include CHIP encounters as part of their Medicaid patient volume. As a result, the CHIP reduction was eliminated for program on or after 2013.

CHP Reduction Example:
Over a 90-day period in the previous calendar year a pediatrician claims to have a total of 2,468 encounters and 747 of those encounters were for Medicaid beneficiaries. The practice is located in Providence County and will incur a CHIP reduction of 10%. The following calculation will be performed to determine the adjusted Medicaid Patient Volume requirement:

\[ 747 - (747 \times 0.10) = 672 \]
\[ \frac{672}{2,468} = 0.272 = 27\% \]

27% adjusted Medicaid Patient Volume will qualify the pediatrician for 2/3 of the total incentive payment amount.

<table>
<thead>
<tr>
<th>County</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bristol</td>
<td>12.3%</td>
<td>18.3%</td>
</tr>
<tr>
<td>Kent</td>
<td>13.1%</td>
<td>17.6%</td>
</tr>
<tr>
<td>Newport</td>
<td>11.4%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Providence</td>
<td>10%</td>
<td>12.7%</td>
</tr>
<tr>
<td>Washington</td>
<td>11.3%</td>
<td>16.8%</td>
</tr>
</tbody>
</table>
C.2.3. Attestations using Individual Patient Volume

Each attestation the provider can decide to determine program eligibility on an individual or group basis. The individual option is based on the provider’s NPI entered in MAPIR and their program year application. As noted earlier, providers must meet a 30% (20% for Pediatricians) Medicaid Patient volume threshold.

MAPIR will allow the provider to enter the 90-day period from either the previous calendar year or twelve months preceding the attestation date. In addition, MAPIR will ask the applicant to enter patient volumes for all the provider’s practice locations for the specified time period and whether each location utilized certified EHR Technology. To complete the Patient Volume attestation, the applicant is asked to enter the Medicaid encounters (numerator) and total encounters (denominator) for the individual provider. MAPIR will not allow the application to proceed if the percentage falls below the threshold. However, MAPIR rounds upward if the amounts fall within 0.5%.

C.2.4. Attestations using Group Patient Volume

As noted in the final rule § 495.306 (h), clinics or group practices are permitted to calculate patient volume at the group practice/clinic as defined in the Medicaid MMIS. The MAPIR system allows enrollees to enter their patient volumes using their group practice affiliation based on the Group’s NPI as defined in the MMIS.

The practice EPs must use only one methodology (Individual, Group or Patient Panel) in each program year. The practice group must use the entire practice’s patient volume and not limit it in anyway. Should an EP practice in both group and outside the group practice, then the practice patient volume will include only those encounters associated with the group.

C.2.5. Attestations using Patient Panel

On a case by case level, we will allow providers to attest using a patient panel approach. The EP will need to submit a patient roster listing for a 90-day period that shows more than 30% of patients on their panel are Medicaid beneficiaries.

While MAPIR is scalable to allow patient panel attestations, we have elected not to activate this option because of its infrequency. However, should we find patient panel attestation increase in occurrence, we would then consider activating this option in MAPIR. In addition, if a provider or provider group find it easier to submit a patient panel, they can
submit a request in writing and we will accept a patient panel listing as part of their patient volume attestation.

C.2.6. Volume Requirements for Eligible Hospitals

Acute care hospitals and critical access hospitals must have an average length of patient stay of 25 days or fewer and have at least a 10% Medicaid patient volume. Children's hospitals do not have a patient volume requirement.

The calculation for patient volume is the Total Medicaid patient encounters in any representative continuous 90-day period in the previous hospital fiscal year / divided by Total patient encounters in that same 90-day period] * 100. For purposes of calculating hospital patient volume, the following are considered Medicaid encounters:

- From 2011 – 2012, services rendered to an individual per inpatient discharges where Medicaid or a Medicaid demonstration project under section 1115 paid for part or all of the service or part of their premiums, co-payments, and/or cost-sharing.
  - However, starting in 2013, as long as the individual was an active Medicaid beneficiary at the time of discharge, they would be considered a Medicaid encounter;

- From 2011 – 2012, services rendered to an individual in an emergency department on any one day where Medicaid or a Medicaid demonstration project under section 1115 of the Act either paid for part or all of the service; or part of their premiums, co-payments, and/or cost sharing.
  - However, starting in 2013, as long as the individual was an active Medicaid beneficiary at the time when services were rendered to an individual in an emergency department, they would be considered a Medicaid encounter;

Eligible Hospitals can attest a combined patient volume for both inpatient discharges and services rendered in an emergency department or for any one previously mentioned categories as long as the numerator and denominator are calculated in the same manner. On the following page is a screenshot of an example of a Hospital Patient Volume attestation from MAPIR.
As noted on our SMHP Addendum submitted on January 15, 2016, Eligible Hospitals will attest on a calendar year basis starting in 2015. In previous years, EHs attested meaningful use based on the Federal Fiscal Year (October – September). As a result, our program will accept 2015 meaningful use attestations with patient volumes from October 1, 2014 to December 31, 2015.
C.3. Verifying Patient Volume

C.3.1. Verification of Patient Volume for Eligible Professionals

Whether an application has an individual or a group patient volume entry, each application is required to enter a 90-day Medicaid patient volume amount and a 90-day total patient volume amount. The screen shot below is an example of the patient volume entry screen for an application:

Once the application is submitted a data query request is sent to MMIS for the 90-day patient volume period based on an individual or group practice attestation. The Patient Volume query counts total encounters for attesting provider in Rhode Island’s MMIS database, which consist of ‘Fee for Service’ and ‘Managed Care’ Medicaid claims data. The query used varies by attesting provider application type; EP/EH/EP-Individual/EP-Group. Encounter calculations are further refined to insure only unique data points are observed within attesting provider’s given Patient Volume date range.

As further defined in our Audit Strategy, this first level of review compares the query results against the “Medicaid Only In State” amount to determine if the amounts align. Should the amounts not align, the next step is to request a detailed patient volume listing from the provider or provider group that reflects their 90-day patient volume attestation. A detailed patient volume listing is usually requested for provider types that submit claims under a supervising physicians in which the query cannot effectively return a reasonable or auditable amount. Circumstances in which cause disparities with our first level of review are typically from

- Behavioral Health Providers who bundle their claims and all service dates (encounters) cannot be counted.
- Nurse Practitioners and Certified Nurse Midwives may bill under a supervising physician.
• Providers who bill on a Global Billing rate are likely to have more encounters than what was planned for billing.

More claims are submitted because amounts could be billed to a supervising physician, claims are bundled common to behavioral health providers.

During the prepayment review process, the patient volume listings are evaluated to ensure that the patient volume meets the threshold requirements. We also perform a sample validation of Medicaid beneficiaries from this listing to confirm the patient was active at the time of the encounter date. A second level of patient volume listing review is also performed by the Program Integrity group when a patient volume falls below the 30% or 20% threshold or if it is within 3% above the threshold.

C.3.2. Verification of Volume for Eligible Hospitals

The administrative staff verify that acute care hospital meets the average length of stay of less than 25 days’ requirement by using the cost reports submitted to Medicaid for rate setting purposes.

Similar to Eligible Professional Patient Volume attestations, MAPIR query counts total encounters for attesting provider in Rhode Island’s MMIS database, which consist of ‘Fee for Service’ and ‘Managed Care’ Medicaid claims data. The query used varies by attesting provider application type; EP/EH/EP-Individual/EP-Group. Encounter calculations are further refined to insure only unique data points are observed within attesting provider’s given Patient Volume date range.

The query results are compared to the attestation during the pre-payment review process. Similar to the EP attestation, a patient volume listing is requested if the query result does not align to the amounts on the MAPIR attestation screen. This listing will be evaluated to ensure that the patient volume meets the threshold requirements. We also perform a sample validation of Medicaid beneficiaries from this listing to confirm the patient was active at the time of the encounter date. In addition, a second level of patient volume listing review is also performed by the Program Integrity group when a patient volume falls below the 10% threshold or if it is within 3% above the threshold.
C.3.3. Verification That Eligible Professionals Meet the Practices Predominantly Requirement

In most cases, our FQHC’s meet the initial 30% Medicaid patient volume requirements. However, if there is an instance where they need to use the practice predominately option to meet the 30% requirement, we will request a “Needy Individual” patient volume listing from the provider or provider group for the given 90-day patient volume period. This list will be used to validate this portion of the patient volume requirement.

C.3.4. Verifying AIU – Adopt, Implement or Upgrade Certified EHR Requirements

MAPIR accepts provider attestations for the AIU component of the incentive payment. During registration, MAPIR requires providers/applicants to attest that they have adopted, implemented or upgraded to a certified EHR technology and to provide a valid EHR certification number. MAPIR verifies the certification number through an interface with Office of the National Coordinator’s (ONC) Certified Health IT Product List (CHPL). If the certification number is invalid, MAPIR will not allow the application to proceed.

Providers are also required to upload copy of a business record that demonstrates the provider has purchased or contracted with a third party the EHR system. The administrative team reviews the business record during prepayment review before authorizing payment.

A business record for the documentation for *purchased* systems must include the following elements:

- The provider’s name
- The system name and version
- The financial obligation
- A timeframe for adopt, implement or upgrade

Examples of documentation for *purchased* systems are:

- Copy of a paid invoice from the CEHRT vendor;
- Executed upgrade agreements for which a cost and timeframe are stated;
- A CEHRT vendor letter only if it contains the provider name, the system name and version, the financial obligation, a timeframe for adopt, implementation or upgrade, and is signed by the vendor. The vendor letter in essence becomes a legally binding document such as a contract or agreement.
A business record for the documentation for “free” EHR systems may include:

- A copy of the license agreement with the CEHRT system.
- A copy of the EHR system’s screen that displays at a minimum the provider’s name and the name of the free CEHRT software.
- A vendor letter is acceptable if it contains the practice name and/or the provider’s name; the name of the software and the version of the software.
- The “welcome email/letter” that is sent by the CEHRT vendor upon signing up.

A business record for documentation of arrangements in which the EHR system from another practice is used:

- A copy of the agreement between the owner of the system and the applicant indicating the name and version of the software
- A screenshot from the EHR system indicating the software’s name and version

C.3.5. Verifying Meaningful Use Requirements

To receive payments for meaningful use eligible providers must demonstrate meaningful use of their EHR technology.

From 2011 – 2013 Meaningful Use Requirements were as follows:
EPs had to report on 20 of 25 Meaningful Use Objectives which include 15 core and 5 out of 10 menu measures for Stage 1, but for Stage 2 EPs had to report 17 core and 3 out of 6 menu measures. In addition, all meaningful use attestations required at least six clinical quality measurements (CQM) to be reported from the certified EHR technology.

EHs and CAHs had to report on 19 of 24 Meaningful Use Objectives which included 12 core measures and 5 out of 10 menu measure. In addition, all 15 CQM measures needed to be reported from their certified EHR technology. EIHs who had attested for meaningful use via the Medicare EHR Incentive program were deemed eligible for the Medicaid meaningful use EHR incentive payment and can receive payments from both Medicare and Medicaid.

Meaningful Use reporting periods for the first year of MU reporting was for any 90-day period. Subsequent years a full year (365 days) of meaningful use reporting was required for each program year.

On December 15, 2015, Meaningful Use requirements were modified. CMS issued a final rule that reduced the meaningful use measure requirement for program years 2015 – 2017. The meaningful use measures were set to Stage 2 level requirements for all meaningful use attestations, reduced the number of measures to ten and eliminated the menu set measures. For program year 2015, providers were able to attest for 90-days of
meaningful use and if they were scheduled to do Stage 1 for 2015, they could attest meaningful use with alternate measures.

In spring 2016, MAPIR was upgraded to accept the 2015-2017 Modified Meaningful Use rule changes. An SMHP addendum for this change was submitted to CMS on February 9, 2016.

**C.3.6. Proposed Changes to the MU Definition**

There are no proposed changes to the MU Definition as permissible per rule-making at this time.

**C.3.7. Verification of Providers’ Use of CEHRT**

As described in C.8., MAPIR verifies the certification number through an interface with Office of the National Coordinator’s (ONC) Certified Health IT Product List (CHPL). If the certification number is invalid, MAPIR will not allow the application to proceed.

**C.3.8. Collection of Providers’ Meaningful Use Data**

For the past 5 years, Rhode Island has contracted with HPE to provide MAPIR, the state level registration tool for the RI Medicaid EHR Incentive program. MAPIR is a web-based application that allows providers and/or their delegates to complete EHR Incentive Attestations. MAPIR was designed and developed by a thirteen multistate collaborative workgroup to accept applications and distribute payments to eligible providers.

We do not anticipate changing the method of data collection at this time, with the possible exception for the collection of electronic clinical quality measures which may be collected for some providers through the Electronic Clinical Quality Measurement Reporting and Feedback System described earlier.
C.4. Alignment of Data Collection and Analysis Processes

As mentioned above, as part of RI’s SIM efforts, the state embarked on and facilitated a measure alignment process. The purpose of this initiative was to create a harmonized set of measures in order to streamline and reduce the total number of different measures providers need to report on. EOHHS contracted with Ballit Associates to facilitate the community process which engaged a large number of provider and payer stakeholders. In order to scope the project, the aligned measure set was developed to be used for by payers with providers in contracting. Representatives from Medicaid participated in this process and as a result there were some measures identified to be specific Medicaid measures. The process included looking at many existing measures sets used by providers including meaningful use (MU) measures. The final measure set include a core and a menu set of measures. Not all of the final measures chosen align with MU but many do. The menu set is updated annually and will continue to evolve over time. As described previously in this document, the state is also embarking in developing a ECQM reporting and feedback system which will obtain data directly from EHRs, calculate a variety of measures including the aligned measure set and all MU measures, benchmark and feedback the measures to providers and their organizations and send them to those agencies for whom they need to be reported to. This process will help to standardize data collection and analysis across program and in a manner which has not previously been done.

C.4.1. IT Systems Used to Implement the EHR Incentive Program

As described in C.12. Rhode Island uses MAPIR as its IT system to implement the EHR Incentive Program. MAPIR integrates with the state’s Medicaid Management Information System (MMIS) and receives files from CMS’ Registration and Attestation (R&A) system, a.k.a. the NLR (National Level Registry).

Eligible providers or their designees access MAPIR using Rhode Island’s MMIS provider web portal. During registration they are asked to attest that they meet all the requirements for payment and to upload documentation that supports their attestation. The EHR incentive payment administrative team reviews the submitted documentation as well as other information that validates the provider’s eligibility. The administrative team then authorizes or denies payment based on their review. MAPIR sends a file to the CMS R&A system for validation and payment approval. If the provider has been approved to receive a payment, the R&A validates the provider has not received payment in another state or from Medicare, and notifies the state to proceed with paying the provider. MAPIR then electronically pays the provider using the MMIS financial system.
The MAPIR system will provide the majority of the necessary technical functions to implement the EHR Incentive Program. MAPIR integrates with the State’s MMIS and links to the CMS Registration and Attestation System (R&A). The R&A has the functionality to guard against duplicate provider payments.

Data transfers and interfaces between MAPIR, the R&A, and MMIS will determine provider applicant eligibility. Upon submission of a completed registration for a Medicaid EHR Incentive payment. Upon program administrative approval, the MMIS will issue the incentive payment to eligible professionals and hospitals once program regulations for payment have been met. Our MAPIR system will track and monitor application and payment information. MAPIR also communicates with registrants on the status of their application via an email address provided by the applicant.

MAPIR has an application user interface for providers who want to submit an EHR Incentive application and an administrative user interface for use by Rhode Island Medicaid EHR Incentive Program support staff. Providers have one point of access via the secure Medicaid Provider Portal. The portal is a communication, data exchange and self-service tool for the Rhode Island Medicaid provider community. Additionally, Rhode Island’s Medicaid EHR Incentive Program staff is able to use MAPIR to track application and decision status, enter notes and upload electronic documents to provider applications, and if necessary, generate provider correspondence. When a payment approval has been made, a file (D16) is sent to the R&A, which will then confirm and register the payment from CMS and authorize the state to make the Medicaid EHR Incentive payment. To complete the application process, the MMIS generates an electronic EHR incentive payment that can be identified with a 247 reason code on the providers’ RI Medicaid remittance advice.

C.4.2. IT & MAPIR System Changes for Implementation

MAPIR is configurable to our state’s systems environment and is customized with state-specific requirements. In the next five years, MAPIR will need to upgraded to support any changes in the EHR Incentive Program requirements and potentially to connect to other new State HIT Infrastructure such as the clinical quality measurement reporting and feedback system.

C.5. IT Timeframe for Systems Modifications

Since 2011, the MAPIR collaborative and MAPIR development team ensure that release changes comply with statute and regulations approved by CMS and based on past experience, the MAPIR team was able to develop and deploy system modifications within a
three to six-month timeframe. This includes system quality assurance testing both on the core and individual state levels.

Moreover, the collaborative conducts weekly meetings to discuss program changes and how they will be addressed within MAPIR. We also communicate any defects the system may have and the MAPIR development team will correct the problem within several weeks with a patch or upgrade.

C.6. Interface with the CMS NLR
The MAPIR systems’ interface with the CMS NLR is complete.

C.7. Accepting Registration Data from the CMS NLR
The MAPIR system accepts registration data from the CMS NLR through a daily interface.

C.8. Websites for Enrollment and Program Information
MAPIR is a web-based application that assists providers with enrollment and attestation. The EHR Incentive Program provides other information to providers on the EOHHS website, available at: http://www.eohhs.ri.gov/ProvidersPartners/ElectronicHealthRecordsEHRIncentiveProgram.aspx

C.9. Anticipated Modifications to the MMIS
There are currently no anticipated modifications to the MMIS that will impact the EHR Incentive. However, should an MMIS change impact MAPIR, the MAPIR Collaborative, the MAPIR development team and all local state MAPIR support teams are informed of any changes and address any MMIS or MAPIR issues that could arise.

C.10. Call Centers/Help Desks
Our Fiscal Agent, HPE, who oversees our MMIS administration and support, is available as a first level triage should providers have questions about access to MAPIR or program requirements. The program manager is the second level triage for issues that cannot be resolved by the first level. The program manager has technical support from HPE should back door corrections are needed for MAPIR and/or the MMIS.
C.11. Appeals & Administrative Redetermination

Providers may request appeals regarding eligibility determinations, incentive payments, and determinations regarding the demonstration of adopting, implementing, or upgrading and meaningfully using certified EHR technology using MAPIR.

Appeals will initially be handled via the re-determination function in MAPIR. Once a provider has followed the appropriate steps, the administrative staff will assess the information and render an Administrative Re-determination. Decisions that stand as originally rendered, yet are still disputed by the provider, will be referred to the Agency’s Office of the General Counsel and required to follow the state’s administrative procedure for formal appeals.

In most disputes an informal discussion is first recommended. This discussion allows the state HIT coordinator who oversee the EHR incentive program to discuss the situation with the provider and program staff and determine if there is any resolve within the confines of the federal program regulations. If the outcome is still unsatisfactory to the provider an informal and/or formal administrative appeals are offered. The informal appeal allows both parties along with legal counsel to present their case. Should the state render an unfavorable decision, a formal appeal can be requested in writing and within 15 calendar days of a written notice. The appealing party must send this written request to the Office of Appeals and include a “Request for a Formal Hearing” form (DHS-121). Should an unfavorable decision be rendered, the provider can pursue the final step and request the decision be appealed and entered by the hearing officer for judicial review. A complaint with the Superior Court must be filed within thirty (30) days of the date of the formal decision in accordance with RIGL 42-35-15.

C.12. Assuring that Federal Funding is Accounted for Properly

EOHHS has a fiscal unit and team that works to assure that all federal funding is accounted for properly. The EHR incentive program has its own federal as well as state match accounts and all charges for this program are charge to those accounts. There are processes in place so that when vendors such as HP or RIQI submit bills, a program person reviews and signs off on the bills prior to them being paid. Any staff, such as the state HIT Coordinator whose time is partially allocated to this program tracks their time in 15-minute increments as part of EOHHS Medicaid cost allocation.
C.13. Anticipated Frequency of EHR Incentive Payments

C.13.1. Process to Issue Incentive Payments

Payments are issued according to existing MMIS processes. EPs and EHs meeting program requirements will be paid an incentive payment unless they have been sanctioned or excluded from receiving payments or previously received payment from Medicare or another state.

The following table shows the activities and actors associated with issuing a payment.

<table>
<thead>
<tr>
<th>Disbursing EHR Incentive Payments</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>System Activity</td>
<td>Personnel Activity</td>
</tr>
<tr>
<td>Verify Payment Meets Requirement</td>
<td>Attestations information are verified against program requirements prior to submission and payment</td>
<td>EP or EH attest to meeting program requirements</td>
</tr>
<tr>
<td>Verify Assignment is Voluntary</td>
<td>With an electronic signature, MAPIR captures information for EPs who have assigned their incentive payment to verify that the assignment was voluntary.</td>
<td>The EP/EH attests at the SLR, MAPIR, if the payment is voluntary. If not, payment is withheld and EP/EHs can change Payee selection at the CMS R&amp;A system</td>
</tr>
<tr>
<td>Confirm Payment with CMS’ R&amp;A prior to</td>
<td>MAPIR interfaces with the R&amp;A and sends a D16 payment</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Disburse Payment</td>
<td>MAPIR issues an electronic incentive payment via an MMIS Remittance Advice with a 247 Reason Code</td>
<td>Payee TIN/Assignee receives payment as noted on the EP/EH incentive application</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>disbursing payment</td>
<td>notification file. MAPIR receives a payment confirmation (D18) to proceed with EHR Incentive payment. This activity prevents payments being made by another State or Medicare</td>
<td></td>
</tr>
</tbody>
</table>
C.13.2. Incentive Payments for Eligible Professionals

Eligible professionals can receive an annual payment over six years for the adoption, implementation and meaningful use of an EHR technology. Payments are made once in a calendar year, however EPs do not have to apply for payments in consecutive years and are allowed to skip payment years.

Eligible professionals can register to receive the payment directly or reassign payment to a Medicaid enrolled group provider with which they have contractual arrangement that allows the group to bill and receive payment for the EP’s covered professional services.

The following chart displays the payment amount for AIU and meaningful use that is available during the program.

<table>
<thead>
<tr>
<th>Payment Year</th>
<th>Maximum Payment</th>
<th>EHR Attestation Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>$21,250</td>
<td>Adopt, Implement, Upgrade or 90 consecutive days of Meaningful Use</td>
</tr>
<tr>
<td>Year 2</td>
<td>$8,500</td>
<td>90 or 365 consecutive days of Meaningful Use</td>
</tr>
<tr>
<td>Year 3</td>
<td>$8,500</td>
<td>365 consecutive days of Meaningful Use</td>
</tr>
<tr>
<td>Year 4</td>
<td>$8,500</td>
<td>365 consecutive days of Meaningful Use</td>
</tr>
<tr>
<td>Year 5</td>
<td>$8,500</td>
<td>365 consecutive days of Meaningful Use</td>
</tr>
<tr>
<td>Year 6</td>
<td>$8,500</td>
<td>365 consecutive days of Meaningful Use</td>
</tr>
<tr>
<td>Total</td>
<td>$63,750</td>
<td></td>
</tr>
</tbody>
</table>

Note: Due to program rule changes, Program Year 2014 & 2015 only required a demonstration of 90 days of Meaningful Use. In addition, annual payment amounts are reduced by 2/3 for pediatricians whose patient volume falls below 30%, but is over 20%.

For payment years two through six, EPs will attest to Meaningful Use according to the applicable rule. EPs will attest to two years of Stage 1 measures, followed by two years of Stage 2 measures. EPs that skip a year will also have two years at each stage. Requirements for subsequent stages have yet to be determined. The online application will be updated to comply with all changes in rule.
D.13.3. Incentive Payments for Eligible Hospitals

Incentive payments to eligible hospitals are based on a complex formula in which a base incentive amount of $2,000,000 for each hospital is modified by the number of Medicaid discharges, bed days and other factors. Eligible hospitals can receive incentive payments over 3 years. The allocation of the aggregate hospital incentive payment will be 50% in the first participation year, 40% in the second, and 10% in the third. Hospitals participating in multiple states must choose only one state to receive payments from. Additionally, hospitals meeting Medicare meaningful use requirements are deemed eligible for Medicaid incentive payments and can receive payments for both Medicare and Medicaid.

MAPIR calculates the incentive payment for hospital based on the data entered by the hospitals. For verification, the administrative staff compares the submitted data to the data taken directly from the hospital cost reports. Any discrepancies between the submitted cost report and what was entered in their MAPIR attestation are resolved before incentive payments are issued.

The Rhode Island Medicaid EHR Incentive Payment hospital aggregate incentive amount calculation will use the equation outlined in the proposed rule, as follows:

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

The amounts for the above formula are pulled from the Eligible Hospital’s cost report for the first year of participation and verified by the review staff prior to payment. Should the year’s cost report data fields used to calculate the total hospital incentive be adjusted or corrected will require an update to the incentive payment amount. Each application year, MAPIR offers the attester to enter revised cost report entries and will automatically adjust the total EHR Incentive for the hospital.

C.13.4. Other Considerations

Not at this time.
C.13.5. Reporting Medicaid EHR Incentive Payments to CMS

Within each quarter, Rhode Island Medicaid EHR Incentive payments are report to the CMS 64 report. Payments to eligible hospitals, FQHCs and eligible professionals are reported separately.

C.13.6. Incentive Payment Recoupment

In the event RI Medicaid EHR Incentive program determines that disbursements have been inappropriately or inaccurately made, the existing refund process will be leveraged to recover the funds. MAPIR currently has the ability to perform an adjustment transaction to certain program year’s application or to all program years the provider has participated. MAPIR will create a transaction file for the recoupment which will result in an Accounts Receivable (AR) record that will be associated with the appropriate provider. The provider would then be requested to directly refund the appropriate incentive amount. To date there have been no payment recoupments. This likely due to having implemented an intensive prepayment audit and verification process conducted by the EHR program manager. In several instances the program manager has had to recommend providers abort their application because they did not pass the prepayment audit process. this has occurred after the program manager has worked extensively with the provider to determine if they have sufficient evidence to pass the pre-audit. Examples of a provider have had to either be denied payment or abort their application include inability to verify and prove sufficient patient volume, or sufficient documentation for a security risk assessment.

C.13.7. Assuring the Recipient of Medicaid Provider Payments

MAPIR is our system that manages our RI Medicaid EHR Incentive program and is fully integrated with our MMIS. If a provider is not entered as an active Medicaid provider, they will not be able to apply for a RI Medicaid EHR Incentive. If a provider does want to apply, they will need to register as a Medicaid provider via the MMIS registration system.
C.13.8. Assuring Payments Used to Promote the Adoption of Certified EHR Technology

MAPIR validates each application of its ONC EHR certification during the application process. As previously mentioned, our program requests a copy of a paid invoice or written validation that the provider has access to the certified EHR technology. After payments are issued, we circulate electronic communication or provide events to educate our provider community on how they can meet meaningful use.

C.13.9. Dispersing EHR Incentive Payments through Medicaid Managed Care Plans

Usually on a bi-weekly basis, Rhode Island Medicaid electronically disperses the EHR Incentive payments directly through its MMIS system and does not disperse the payments through Medicaid Managed Care Plans.

C.13.10. Assurance that Calculations and Incentives Are Consistent with Statute and Regulations

With our 13-state MAPIR collaborative and access to our CMS regional manager, we are provided with solid guidance that assures we are in compliance with regulations. Rhode Island is very active with the Community of Practice programs, monthly CMS All-State calls and CMS quarterly and annual meetings. In addition, the program manager and the MAPIR collaborative share regulation information that come through the CMS listserv or during the proposed rule-making process.

In addition, our MAPIR collaborative and MAPIR development team ensure that release changes comply with statute and regulations approved by CMS. For instance, the upcoming 2017 release 6.0 will allow our provider community to attest to Stage 3 meaningful use regulations approved on January 1, 2017.
C.14. Role of Existing Contractors with Implementation

The relation of existing contractors with the implementation of the EHR Incentive Program is noted throughout this SMHP. In summary is a list of contractors and the services they implement for our program(s):

- HPE provides technical support for MAPIR and the MMIS.
- Conduent, formally known as Xerox Healthcare, provides EHR Incentive oversight and assures that the program meets regulations set forth by CFR42.
- Rhode Island Quality Institute (RIQI) provides support and outreach to our provider community and have been a great contributor to helping providers meet meaningful use with their certified EHR technology.
- HealthCentric Advisors assists us with understanding our HIT landscape with their bi-annual physician technology surveys.

C.15. Assumptions

CMS will continue to develop and support the National Level Repository, provider outreach and help desk support through the end of the program and that MAPIR will be able to continue interface with the NLR.

ONC will continue to certify CEHRT and EHR vendors will continue to develop their products and pursue certification.

Sufficient state match will be appropriated to EOHHS to support the EHR incentive program.

HP will continue to serve as the Medicaid Fiscal agent. The current contract ends in December 2017 and there are three extensions before a re-procurement is required, unless the state chooses not to execute on an optional year. If the vendor changes the state will need to assess how to continue with the EHR incentive program.

RIQI will continue to serve as the states regional health information exchange organizations and operate CurrentCare.
D. Audit Strategic Plan

D.1. Audit Methods

D1.1. Introduction

An effective audit capability is critical to the success of the EHR Incentive Program. This is evidenced by the numerous CMS requirements that either address the audit function by name, or by the many instances of “ensure,” “assure,” and “verify” used to describe the required level of substantiation. Rhode Island EOHHS operates a comprehensive set of audit activities, conducted during pre- and post-payment of Medicaid EHR Incentive applications. This approach provides the level of assurance necessary for the program changes and complexities. The following graphic presents the flow of audit activities surrounding the issuance of eligible professional and hospital incentive payments.

The overall set of business processes proposed for Rhode Island Medicaid EHR Incentive Program (as presented in Section C of the SMHP) reflect a balance between efficiently issuing incentive payments while not issuing inappropriate incentive payments, and protecting against fraud and abuse. The set of audit activities we perform make every attempt to understand both ends of this spectrum.

It is the intent for Rhode Island’s Medicaid EHR Incentive Program audit activities to limit the burden of program participation on eligible professionals and hospitals. Reliance on pre-payment system verifications minimizes disruptions to the daily operations of program participants. On the same premise, post-payment audit verifications will also be carried out in the least intrusive manner possible. However, we will not sacrifice the due diligence necessary to gain an understanding of participant compliance with program requirements. Our goal, for example, is to perform appropriate desk audits and if necessary conduct an on-site audit so that we can be the least intrusive to our provider community.
D.1.2. Implementation Steps for Audit

MAPIR provides numerous pre-payment verification and auditing controls and supports the level of program integrity as outlined per the CMS Guidelines. Specific program integrity features are embedded throughout the program’s business processes and the audit sub-process also addresses requirements identified in the guidelines. Pre-payment system verifications in combination with random and targeted post-payment audits ensure overall program integrity. Rhode Island EOHHS’ Program Integrity office will conduct post payment audit. The first audit strategy was submitted and approved in October 2013.

At the start of the RI Medicaid EHR Incentive Program, provider attestations were reviewed with a pre-payment review. While this increased the time for payment, issues were addressed in the forefront for each application, especially the obvious ones. Our mission with the program was to trust and validate and not to pay and chase. With an influx of applications to be reviewed by limited staff, we eventually submitted a formal Audit Strategy to CMS in early 2013 as noted in the chart below.

<table>
<thead>
<tr>
<th>Audit Implementation Tasks</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAPIR Installed – Start of Pre-Payment Review</td>
<td>July 2011</td>
<td>July 2011</td>
</tr>
<tr>
<td>Initiated Pre-payment review as defined within in SMHP</td>
<td>July 2011</td>
<td>Ongoing</td>
</tr>
<tr>
<td>SMHP Version 1 Approval</td>
<td>June 2010</td>
<td>January 2012</td>
</tr>
<tr>
<td>Audit Strategy Development and Approval Version 1</td>
<td>January 2013</td>
<td>April 2013</td>
</tr>
<tr>
<td>EHR Incentive Audit Staff hired by Office of Program Integrity</td>
<td>March 2013</td>
<td>June 2013</td>
</tr>
<tr>
<td>Random and Targeted Desk Audits</td>
<td>August 2013</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Initiate Post Payment Desk Audits</td>
<td>September 2013</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

D.1.3. Approach to Pre-Payment and Post Payment Audit Activities

The following describes the pre- and post-payment audit activities.

- Pre-Payment Audit Activities rely on the following:
  - Automation between MAPIR and the MMIS
  - Validation of participants’ certified EHR systems providing reliable Meaningful Use and Clinical Quality Measures data
  - Access to internal and external sources of data.
- Post-Payment Audit Activities will be conducted on a random and targeted basis to assess provider compliance. The post payment audit selection process and audit activities will largely be manual processes performed by the Office of Program Integrity.
A key to the effectiveness of the EHR Incentive Program will be the extent to which the pre- and post-payment audit activities work together to ensure participant compliance with program requirements. The eligibility verification process detailed in the next section covers the full set of pre-payment audit activities.

Internal and external data sources for prepayment and post payment audit activities include; Rhode Island’s MMIS system, claims, encounters and provider information for eligible providers and eligible hospitals. Hospital cost report data submitted to CMS will be cross referenced. New sources of external and internal data and data sources may be identified while the program is in place. Further details of the audit can be found in the CMS approved audit strategy that was submitted separately and is not available for public use.

D.1.4. Targeted Post Payment Audits

The audit selection pool for post-payment audit will be risk based and composed of providers identified during pre-payment checks that had marginal Medicaid volume. Risk based elements will be identified to assess which AIU and MU measures are likely to be subject to incorrect information. A risk assessment scoring is utilized to identify those providers who are subject to a Rhode Island Medicaid EHR Incentive audit.

<table>
<thead>
<tr>
<th>Eligibility Requirements</th>
<th>EP</th>
<th>EH</th>
<th>Statute</th>
<th>Final Rule</th>
<th>Pre-payment Verification Process and Data Elements</th>
<th>Post-payment Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. EP or EH must be one of the permissible professional or hospital types</td>
<td>✔</td>
<td>✔</td>
<td>42 USC § 1395b(1)(2) (A-B)</td>
<td>§495.368 (a)(1)(i) Combating fraud and abuse</td>
<td>Verify that the applicant’s provider type meets eligibility requirements. Based on provider type, MAPIR restricts non-eligible providers from applying. However, staff will verify the applicant’s provider type in the MMIS provider file. Staff will verify that Physician Assistants (PA) who apply meet the requirement of leading a FQHC or RHC. Staff will retain evidence to confirm FQHC/RHC is so led by a PA.</td>
<td>Random and targeted desk audits or onsite audit activities</td>
</tr>
<tr>
<td>Eligibility Requirements</td>
<td>EP</td>
<td>EH</td>
<td>Statute</td>
<td>Final Rule</td>
<td>Pre-payment Verification Process and Data Elements</td>
<td>Post-payment Verification</td>
</tr>
<tr>
<td>--------------------------</td>
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<td>----</td>
<td>---------</td>
<td>------------</td>
<td>--------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>2. EP or EH must be licensed to practice in the state</td>
<td>✓</td>
<td>✓</td>
<td>§ 496.368 (a)(1)(i) Combating fraud and abuse</td>
<td>MAPIR validates licensure from the Rhode Island MMIS. Active licensure can be validated with Rhode Island’s Department of Health’s license website</td>
<td>Random and targeted desk audits or onsite audit activities</td>
<td></td>
</tr>
<tr>
<td>3. EP or EH must be a Medicaid provider in that State.</td>
<td>✓</td>
<td>✓</td>
<td>§ 496.304 (a) Medicaid provider scope and eligibility</td>
<td>MAPIR verifies against the MMIS provider file. If it does not exist, an application cannot be entered.</td>
<td>Random and targeted desk audits or onsite audit activities</td>
<td></td>
</tr>
<tr>
<td>4. EP or EH cannot be excluded, sanctioned, or otherwise deemed ineligible to receive payments from the State (i.e. incentive payment made by another State)</td>
<td>✓</td>
<td>✓</td>
<td>§ 496.368 (a)(1)(i) Combating fraud and abuse</td>
<td>MAPIR verifies against the MMIS provider file. Additional verification is conducted with CMS’ R&amp;R system prior to release of payment.</td>
<td>Random and targeted desk audits or onsite audit activities</td>
<td></td>
</tr>
<tr>
<td>5. EP must have at least a 30% Medicaid patient volume (or 20% for pediatrics), unless s/he is practicing predominantly in an FQHC or RHC</td>
<td>✓</td>
<td>✓</td>
<td>42 USC § 1396b(1)(2)(A) Medicaid provider scope and eligibility</td>
<td>The Medicaid numerator for all EPs will be verified via a MAPIR Query request to the Medicaid MMIS claims database and compared to the EP’s application. Staff will contact other states should the applicant’s cut of state Medicaid patient volume requires validation.</td>
<td>Random and targeted desk audits or onsite audit activities</td>
<td></td>
</tr>
<tr>
<td>6. EP must have at least a 30% needy individual patient volume, if s/he is practicing predominantly in an FQHC or RHC</td>
<td>✓</td>
<td>✓</td>
<td>42 USC § 1396b(1)(2)(A) Medicaid provider scope and eligibility</td>
<td>Should the Medicaid patient volume not meet the required threshold, a needy individual patient volume listing will be requested from the EPs and reviewed prior to payment.</td>
<td>Random and targeted desk audits or onsite audit activities</td>
<td></td>
</tr>
<tr>
<td>7. EP must have more than 50% of 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</td>
<td>✓</td>
<td>✓</td>
<td>§496.303 (b)(4) Financial oversight and monitoring of expenditures</td>
<td>If necessary, a patient encounter listing from the FQHC/FHC will be requested and reviewed prior to payment.</td>
<td>Random and targeted desk audits or onsite audit activities</td>
<td></td>
</tr>
<tr>
<td>8. EH must have at least 10% Medicaid patient volume (acute care hospital only)</td>
<td>✓</td>
<td>✓</td>
<td>42 USC § 1396b(1)(2)(E) Medicaid provider scope and eligibility</td>
<td>The Medicaid numerator for all EHs will be verified via a MAPIR Query request to the Medicaid MMIS claims database and compared to the EH’s application.</td>
<td>Random and targeted desk audits or onsite audit activities</td>
<td></td>
</tr>
<tr>
<td>9. EP must not be hospital based (no more than 90% of his/her Medicaid claims are inpatient with a POS 021)</td>
<td>✓</td>
<td>✓</td>
<td>42 USC § 1396w-4(a)(1)(C)(ii) Medicaid provider scope and eligibility</td>
<td>Verification via an MMIS query request that compares POS 021 claims against all claims and ensures that participating providers fall below 90%. If not, they will be targeted for a post payment audit.</td>
<td>Random and targeted desk audits or onsite audit activities</td>
<td></td>
</tr>
<tr>
<td>Eligibility Requirements</td>
<td>EP</td>
<td>EH</td>
<td>Statute</td>
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</tr>
<tr>
<td>10. EP must practice in a PA-led FQHC or RHC if she is a Physician Assistant (PA)</td>
<td>✔</td>
<td></td>
<td>42 USC § 1395b(t)(3)(B)</td>
<td>§ 495.304(b) Medicaid provider scope and eligibility</td>
<td>Staff will verify that Physician Assistants who apply meet the requirement of leading a FQHC or RHC that is PA led.</td>
<td>Random and targeted desk audits or onsite audit activities</td>
</tr>
<tr>
<td>11. EH must have an average length of stay of 25 days or less to be considered an acute care hospital</td>
<td>✔</td>
<td></td>
<td>§ 495.332(b)(5) State Medicaid HIT plan requirements</td>
<td>Verification through submitted cost report.</td>
<td></td>
<td>Random and targeted desk audits or onsite audit activities</td>
</tr>
<tr>
<td>12. EP or EH must adopt, implement, or upgrade (AIU) certified EHR technology capable of meeting meaningful use</td>
<td>✔</td>
<td>✔</td>
<td>42 USC § 1395b(t)(6)(ii)</td>
<td>§ 495.366 (c) Financial oversight and monitoring of expenditures</td>
<td>Verify attested to status of Adopted, Implemented, Upgrade for the EHR system. The state will access uploaded documentation that identifies the specific certified EHR technology and coincides with the CMS Certification number provided on the application. The certified EHR technology has been acquired or purchased with the CEHRT vendor, or with third party arrangement. Signed contract and recently paid invoices from the CEHRT are requested.</td>
<td>Random and targeted desk audits or onsite audit activities</td>
</tr>
<tr>
<td>13. EP or EH must meaningfully use (MU) certified EHR technology</td>
<td>✔</td>
<td>✔</td>
<td>42 USC § 1395b(t)(6)(ii)</td>
<td>§ 495.366 (c) Financial oversight and monitoring of expenditures</td>
<td>Meaningful Use Reports must be uploaded with the application. Reports must include numerator and denominator measures for Core, Menu and CMM measure sets.</td>
<td>Random and targeted desk audits or onsite audit activities</td>
</tr>
<tr>
<td>14. Managed care providers must not receive EHR incentive payment that exceeds 105 percent of their capitated rate if Medicaid is the payer, unless incentives are documented and actuarily sound.</td>
<td>✔</td>
<td></td>
<td>42 CFR 438.6(c)(5)(iii) Special contract provisions. 42 CFR 438.6(c)(4)(B) (iv) Documentation.</td>
<td>§ 495.366 (e)(7) Financial oversight and monitoring of expenditures (See also § 438.6 (c)(v)(5)(iii))</td>
<td>MCOs are not making incentive payments to providers under Rhode Island’s Medicaid EHR Incentive program.</td>
<td>Random and targeted desk audits or onsite audit activities</td>
</tr>
</tbody>
</table>
D.2. Identification and Tracking Overpayments

Tracking overpayments to providers is addressed in this section. Incentive payments made inappropriately or fraudulently obtained will be recouped using the existing agency recoupment process. The Agency will comply with CMS guidelines that require the Medicaid Agency to track the total dollar amount of overpayments identified by the State as a result of oversight activities conducted during the fiscal year.

A primary goal of the EHR Incentive Program processing procedure is to limit overpayments to a minimal number, and therefore to a limited amount. The activities that occur during the Eligibility Verification process are designed to prevent overpayments. The Agency acknowledges that regardless of the system, some overpayments or inappropriate may be made. Therefore, audit post-payment activities conducted are intended to identify overpayments. The Agency has a systematic ability to track overpayments on an individual provider basis, and to report on overpayments in the aggregate for a specified time period.

D.3. Fraud and Abuse Mitigation

Potential fraud and abuse issues that relate to the EHR Incentive Program will be investigated by the Office of Program Integrity (OPI). Fraud is defined as any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him/herself or some other person. For example, in the case of the EHR Incentive Program, fraud may include the intentional inclusion of false information on the registration and attestation form. Abuse is any practice that is inconsistent with sound fiscal, business or medical practices, and that results in an unnecessary cost to Medicaid. Abuse also includes when a provider misstates a part of their application and attestation form.

OPI will take one of two actions, depending upon whether fraud or abuse is detected:

- **Fraud:** When fraud is suspected, the Program Integrity Group will conduct an investigation. This may include internal discussions with involved parties. If the group finds a credible suspicion of fraud, findings will be summarized and referred to the Medicaid Fraud Department and the Rhode Island Attorney General’s office for further investigation.

- **Abuse:** These cases are reviewed and decided upon internally by the Program Integrity Group after an investigation. This will involve activities such as internal discussions with involved parties, discussions with the provider under review, review of existing data, and review of existing documentation. If the
group detects abuse, an administrative action such as requiring a Corrective Action Plan (CAP) and/or recovery of the incentive payment(s) based on the nature of the finding will be initiated.

When fraud or abuse is detected, the group will determine what actions are required on a case-by-case basis. CAPs would be developed for providers who are determined to have violated regulatory compliance. Recoupment activities will pursue any overpayments from fraud or abuse. The provider may also be subject to disenrollment from the Medicaid program and listing on the federal and state sanction provider list.

We anticipate that meaningful use audit findings will be issued on a ‘pass-fail’ basis. Providers will have an opportunity to remediate identified issues within a 60-day time window; if they are unable to remediate issues, the incentive payment recoupments processes described above will be invoked with respect to penalties. If the audit finds that there was a false attestation by the provider who completed it, a refund amount will be determined and incentive funds, relative to the appropriate incentive stage, must be refunded. If these steps are not completed, providers may face sanction and/or prosecution as per existing processes.

**D.4. Leveraging Existing Data Sources**

The use of various data sources to verify the eligibility and accuracy of provider information is described in the table in Section D.1.5. These data sources include MMIS, Department of Health Licensure Database, and the CMS R&A system, and various uploaded documents from the attesting provider.

**D.5. Sampling Methodology**

This topic is addressed in a separately submitted audit strategy that is approved by CMS.
D.6. Reducing Provider Burden

Being part of the MAPIR collaborative and having the MAPIR system in place for the past six years, we have significantly reduced provider burden during the application process. Here is how:

- MAPIR and MMIS connectivity – Providers cannot participate in the program if they are not in the Medicaid MIS system as an active Medicaid Provider. Furthermore, and when it is necessary, MAPIR validates MMIS information during the application entry process.
- MAPIR Status Control – With MAPIR the SRA has the ability to change the status of an application prior to payment. So if there is an entry error, the application can be re-opened and the applicant can make the necessary modifications and re-submit their application.
- Electronic Payments made through the MMIS – Once the application is approved for payment in MAPIR, MAPIR will send a payment file request to CMS for approval. Once an approval is approved MAPIR will send a file to the MMIS to make an electronic EHR Incentive payment on the provider’s remittance advice.
- Audits Tracked in MAPIR – The audit staff is utilizing the audit functions available within MAPIR. This function reduces redundancies in the audit process that may pose an additional burden to the provider. It also helps us avoid asking questions that are already in the MAPIR system. This capability improves our desk audit function.

We have also reduced provider burden by allowing our state’s REC to assist providers who are struggling to meet meaningful use and assist the provider community with workflow changes. The regional managers from the REC would also encourage our providers to apply for the EHR Incentive and help them with their submission. Their efforts have greatly reduced provider burden and over time, providers were able to consistently meet meaningful use.
D.7. Program Integrity Operations

Rhode Island has a separate Office of Program Integrity (OPI) which ensures compliance, efficiency, and accountability within the health and human services programs administered by the State of Rhode Island by detecting and preventing fraud, waste, and program abuse and ensuring that state and federal dollars are spent appropriately, responsibly, and in accordance with applicable laws.

The Office of Program Integrity is also committed to identifying fraud, waste and abuse in Medicaid and in all health and human service programs. The OPI actively pursues any leads indicating fraudulent practices and uses them as a source to begin investigations. To increase our effectiveness, the OPI is partnering with Medicare and Medicaid insurance companies to share information about fraudulent activity and to conduct joint investigations. Their oversight of the Rhode Island Medicaid EHR Incentive program plays a significant role and has dedicated staff to audit the program and ensure payments made are within the regulations of the program. Below is a hierarchical staff diagram that shows a separation between operational and audit oversight that is strictly enforced. While we share information with rule changes and system updates, the operational staff does not partake in the audit functions.

The roles of organizational staff are described below:

**Administrator** – Office of Program Integrity – Ensures program oversight and is responsible for the EHR program audit staff performance. In early 2013, the Rhode Island Executive Office of Health and Humans Services (EOHHS) formed the Office of Program Integrity similar to an internal audit team that provides regulatory oversight and prevents fraud and abuse within all Medicaid programs.

**Principle Auditor** – This position oversees the EHR Incentive audit functions, conducts higher risk EHR incentive program audits and reviews audits performed by the staff.
The Principal Auditor is also responsible for developing and maintaining the RI Medicaid EHR Incentive Program Audit Strategy. Currently this position is serving as the only auditor for the program since the staff auditor position is vacant.

**Staff Auditor** – this position assists by performing EHR Incentive audits for all providers who are participating in the program. This position evaluates applications based on a defined risk assessment as defined within the CMS approved EHR Incentive Program’s Audit Strategy. In most cases, the auditor performs desk audits, but will perform onsite audits when required. This position is currently vacant.

**State Health IT Coordinator** – Responsible for overall management of the RI Medicaid EHR Incentive Program Oversees except for the audit functions. Works collaboratively with the auditors and program integrity administratively to coordinate overall program efforts, communicate programs changes or challenges, and review program progress.

**EHR Incentive Program Manager** – Oversees the daily operations of the RI Medicaid EHR Incentive Program. This position ensures that providers are meeting the CMS guidelines set forth in the final rule, oversees program outreach, policy development and implementation, and payment review and approval. This position works closely with the principal auditor when questions arise, to assure proper documentation is uploaded and to discuss any questions related to prepayment audit processes. This position is a Xerox employee.

**HPE MAPIR Business Analyst** – provides technical support for the MAPIR system and is a Hewlett Packard Enterprise employee. This position troubleshoots front end or backend EHR Incentive application issues within our MAPIR system. The business analyst is involved with testing and upgrading MAPIR to meet program regulatory requirements. In addition, this position requires ongoing collaboration with the MAPIR Collaborative. This position works with the principal auditor to assure the proper functioning of the audit racking system within MAPIR.

**HPE MAPIR Project Manager** – provides administrative oversight for any large system implementation and upgrades to MAPIR and is a Hewlett Packard Enterprise employee. The MAPIR Project Manager is also responsible with requesting project task approval from the Health IT Coordinator when projects arise for the program. Works with the audit team as needed to assure proper functioning of MAPIR as it relates to audit functions.
E. Medicaid HIT Roadmap

E.1. Where we are today and where we expect to be in Five Years

As described in section A in more detail, Rhode Island has invested considerable resources into establishing HIT systems to support a variety of business needs for state government and for community stakeholders. The diagram below shows a snapshot of many of these systems as of the end of 2016. Communication pathways are typically unidirectional and from one system to another. Consumers interact either directly or indirectly through staff at agencies and organizations with these systems.

As we look toward 2021 and our ideal state, there are several strategic projects that are yet to be fully defined. Additional information about these high priority projects will help solidify RI’s approach to the expansion and integration of RI’s overall HIT environment.

Once the following information is available, a longer term strategy and ideal state will become clearer:

• Who will be the vendor for the eCQM Reporting and Feedback System and how will they interface with the state’s HIT ecosystem
• What are the components of the EOHHS State Data Ecosystem that needs to be developed in order to fully serve the state’s policy and operational needs, versus what components already exist and can leveraged or modified to meet the intended goal.
• Whether legal and or regulatory changes can be made to remove some of the barriers to health information exchange that the state faces today, and to promote the ability to link claims and clinical data for operational and analytic uses

The future state will continue to evolve over time as these questions are answered. EOHHS ‘s focus will remain on increasing statewide interoperability both within and external to state government, improving the services and utility of existing HIT systems, and improving the collective ability of Rhode Islanders of all type to use data to improve the quality of care.

Despite the unknowns outlined above, EOHHS is prepared to and has begun to invest in achieving additional HIT infrastructure for 2021 as diagrammed below.
The “Future state” schematic above clearly identifies several components and features that are planned but not yet developed and or integrated into the overall picture. These include:

- Establishing an Integrated HHS Data Ecosystem.
- Establishing The eCQM Reporting and Feedback System.
- Connecting HealthFacts RI and possibly CurrentCare to the eCQM Reporting and Feedback System.
- Having the HIE connected to the PDMP at RIDOH.
- Having the statewide common Provider Directory supplying data to HealthFacts RI, the eCQM Reporting and Feedback System, MMIS, RI Bridges, HSRI and RIDOH Licensure.
E.2. Expectations for EHR technology and HIE Adoption Over Time with Annual Benchmarks

GOAL 1: 90% of hospitals, primary care providers, and outpatient specialists adopting CEHRT by 2021.

Annual Benchmarks:

<table>
<thead>
<tr>
<th>Baseline</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>59%</td>
<td>65%</td>
<td>75%</td>
<td>80%</td>
<td>85%</td>
<td>90%</td>
</tr>
</tbody>
</table>

GOAL 2: Achieve a 75% meaningful use conversion rate among RI Medicaid Eligible Providers (from AIU to MU) by 2021.

Annual Benchmarks:

<table>
<thead>
<tr>
<th>Baseline</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>55%</td>
<td>60%</td>
<td>65%</td>
<td>68%</td>
<td>70%</td>
<td>75%</td>
</tr>
</tbody>
</table>

GOAL 3A: 90% of Rhode Islanders having a CurrentCare Record by 2021

Annual Benchmarks:

<table>
<thead>
<tr>
<th>Baseline</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>46%</td>
<td>54%</td>
<td>62%</td>
<td>71%</td>
<td>80%</td>
<td>90%</td>
</tr>
</tbody>
</table>

GOAL 3B: 90% of all Medicaid beneficiaries having a CurrentCare Record by 2021

Annual Benchmarks:

<table>
<thead>
<tr>
<th>Baseline</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>38%</td>
<td>50%</td>
<td>62.5%</td>
<td>75%</td>
<td>77.5%</td>
<td>80%</td>
</tr>
</tbody>
</table>

GOAL 4: Increase awareness and use of CurrentCare, with 75% of physicians knowing of and using CurrentCare by 2021

Annual Benchmarks:

<table>
<thead>
<tr>
<th>Baseline</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>30%</td>
<td>39%</td>
<td>48%</td>
<td>57%</td>
<td>66%</td>
<td>75%</td>
</tr>
</tbody>
</table>

GOAL 5: Increase Interoperability among the state’s HIT services where appropriate.

Annual Benchmarks:

<table>
<thead>
<tr>
<th>Year</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>Prescription Drug Monitoring Program (PDMP) integration with the HIE.</td>
</tr>
<tr>
<td>2018</td>
<td>Kidsnet Immunization Registry integration with the HIE.</td>
</tr>
<tr>
<td>2019</td>
<td>One additional integration, TBD.</td>
</tr>
<tr>
<td>2020</td>
<td>One additional integration, TBD.</td>
</tr>
<tr>
<td>2021</td>
<td>One additional integration, TBD.</td>
</tr>
</tbody>
</table>
E.3. Benchmarks for Audit and Oversight Activities

**GOAL:** Each year, complete pre-payment application review for all RI Medicaid EHR Incentive applications.

**Annual Benchmarks:**

<table>
<thead>
<tr>
<th>Baseline</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**GOAL:** Each year, we plan to complete post payment application audits for 10-12% of the RI Medicaid EHR Incentive applications. As the program sunsets in 2021 and most providers have completed their six years of attestations, we expect a decrease of audits especially for program years 2020 and 2021.

**Annual Benchmarks:**

<table>
<thead>
<tr>
<th>Baseline</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>12%</td>
<td>10-12%</td>
<td>10-12%</td>
<td>10%</td>
<td>8-10%</td>
<td>6-8%</td>
</tr>
</tbody>
</table>