State Medicaid HIT Plan - Update

Version 5.0

June 4, 2014

VERSION NUMBER	DATE	DESCRIPTION / LOCATION OF CHANGE
1.0	2/28/11	Initial Draft
2.0	3/2/11	Updates to flowcharts
3.0	6/20/11	Responses to CMS comments
4.0	Summer 2012	SMHP Update and added Stage 2 amendments section
5.0	6/4/2014	SMHP Update to Include EHR Stage 2 Eligibility & MU Changes. Previous amendments incorporated into document.

Table of Contents

1 Executive Summary

The New Mexico State Medicaid HIT Update Plan (SMHP-U) has been rewritten to update data on provider participation and HIT/HIE initiatives, and add information on Meaningful Use, Stages 1 and 2.

1.1 Overview

In New Mexico, one of every four citizens relies on the state's Medicaid programs for healthcare. Some speculate that the demand for Medicaid services will rise with the execution of health care reform measures. At the same time, emerging technologies provide an unprecedented opportunity to make medical and clinical data more secure, accessible and actionable by providers and patients alike. Indeed, a paper-based health information system seems out of place in the 21st century, and yet public and private programs struggle to achieve dynamic and reliable exchange of information to support the delivery of quality healthcare. The State Medicaid Health Information Technology Plan (SMHP) will become a stepping stone toward a more viable health information technology environment that serves the state's Medicaid populations with advancing technologies to improve health outcomes.

The New Mexico Human Services Department (HSD), through its Medical Assistance Division (MAD) is responsible for the development and execution of its State Medicaid HIT Plan (SMHP). The SMHP presents both a brief historical view and a future plan for its HIT environment, and includes a comprehensive discussion about how HSD/MAD ("the Division") will leverage resources and opportunities to implement its Medicaid Incentive Provider Payment (MIPP) Program to encourage adoption of Electronic Health Record (EHR) technologies among Medicaid providers. Throughout this document, references to the EHR Incentive Payment Program, when discussing New Mexico specifically, will appear as MIPP.

HSD/MAD sees the MIPP as a distinct opportunity to accelerate the development of Health Information Technology and Exchange in New Mexico. HSD/MAD believes that the MIPP will infuse significant stimulus funding into the New Mexico economy, further develop community relationships around HIT, and advance quality of patient care not only within Medicaid, but for all New Mexico residents. MIPP will be the catalyst to change the way healthcare operates.

HSD/MAD will strategically leverage the MIPP program implementation to facilitate the ongoing development of the State Health Information Exchange and propel other statewide initiatives forward. In addition to efforts outside the organization, HSD/MAD will review activities of the MIPP that may drive the refinement of associated Medicaid program processes, looking for opportunities to achieve improvement in the MITA maturity of impacted business processes. Finally, HSD/MAD has and will continue to work with private sector stakeholders in planning and coordinating statewide HIT activities to promote HIE across New Mexico.

1.2 Document Map

The following sections align with CMS guidance for the SMHP document:

2 – Section A – The "As Is" HIT Landscape

3 – Section B – The "To Be" HIT Landscape

4 – Section C – "Activities to Administer the MIPP"

5 – Section D – "The MIPP Program Audit Strategy"

6 – Section E – "The HSD/MAD HIT Roadmap"

7 – Appendices

2 Section A – The "As Is" HIT Landscape

Understanding the levels of HIT adoption among the New Mexico provider population is essential to the effective planning and the development of HSD/MAD's strategic future and that of the state. New Mexico has many ongoing and developing HIT efforts that will continue to impact the face of healthcare for Medicaid clients, providers, and partners throughout the State.

2.1 Provider Survey – EHR Adoption

The New Mexico Health Policy Commission reported 4,689 physicians licensed in New Mexico in 2009. A survey of the Fee-For-Service Medicaid physicians completed in October 2010 indicated that approximately 35% of physicians surveyed utilize Electronic Medical Records. HSD/MAD used various methods to assess the level of current EHR technology within the State and gain an understanding of the expected participation in the MIPP. Environmental scan efforts included interviews with providers, conversations with provider associations, review of existing available research, and completion of a survey of the provider population. Focus groups were also conducted to gain a relative understanding of provider perspectives on Health Information Technology; to determine provider awareness and understanding of the MIPP; and, gain insight to the attitudes toward the incentive program.

2.1.1 Provider Survey, Strategy, and Tools

HSD/MAD contracted with Research and Polling, Inc (RPI) to conduct a survey of the Medicaid FFS physician and dentist population. The survey, completed in October 2010[1], was designed to determine the extent to which physician and dental offices have already implemented EHR technology and the number who are believed to qualify for the EHR incentive program. The study also attempted to identify the level of interest in the incentive program and what perceived barriers, if any, physicians have regarding adopting, implementing, or upgrading an EHR system.

Given State budget constraints, HSD/MAD wished to obtain survey information in the most cost effective and timely manner possible. Information from 2006 by the New Mexico Health Policy Commission showed that the population of physicians enrolled with FFS Medicaid encompassed as much as 89% of the actively practicing physician population in the State. Though this number is not current, the expectation is that enrollment levels remain unchanged. HSD/MAD actively maintains its provider master file and believes the demographic data has a high degree of accuracy. Previous experience attempting to survey the provider population had shown relative inadequacies in the quality of data from other sources. Thus, it was felt that the FFS population would provide an appropriate, representative population from which to extrapolate the desired level of understanding.

[1] Research & Polling, Inc., *New Mexico Human Services Department/Medical Assistance Division, Health Information Technology (HIT) Environmental Scan, October 2010*

RPI, in conjunction with HSD/MAD, NMHITREC, and NMHIC, refined a survey tool obtained from efforts of a workgroup of the Multi-State Collaborative (an initiative of the National Association of State Medicaid Directors [NASMD]) as a basis. The tool was tested for validity among a sample set of physicians prior to execution of the survey effort.

It is important to note that the population surveyed included only those physicians and dentists practicing either under a group setting or as individuals. The survey did not include those physicians that practice in a Rural Health Clinic or Federally Qualified Health Center Setting.

2.1.2 Provider Survey Response and Findings

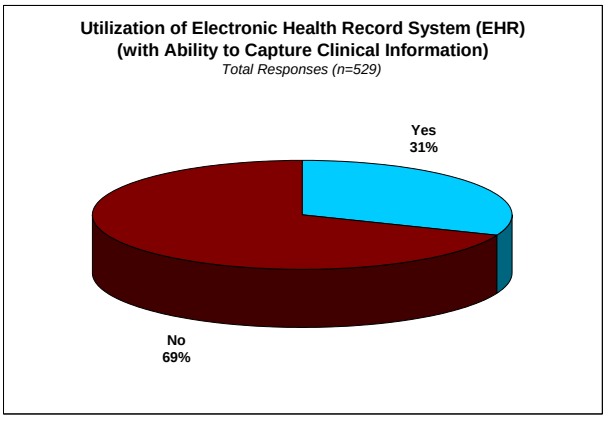
A total of 836 valid records were identified in the provider list after conducting a comprehensive examination of the list and making an initial telephone contact to the physician and dental offices. Of this number, 572 surveys were completed among provider offices in this study. This equates to a response rate of 68% among all records for which a survey could have been successfully completed (572 successful interviews out of 836 records).

After reviewing the responses of the 572 surveys that were completed, 41 were among provider offices that were deemed to fall outside of the scope of study. Excluding these 41 records, the overall response rate for the study was 67% (531 successful interviews out of 795 within the relevant population of provider offices for this study).

2.1.3 Use of Electronic Health Records

Nearly one-third (31%) of practices (35% physician and 18% dental) use an EHR system (with the ability to capture clinical information). Among those with an EHR system, one-third (34% of physician practices and 32% of dental practices) utilize their EHR to electronically exchange health information with other providers, healthcare organizations, labs, government agencies, etc.

Figure 2a – EHR Utilization



The most often utilized EHR vendors are eClinicalWorks (9%), McKesson Provider Technologies (9%), and Amazing Charts (9%). The vast majority of practices report that their EHR includes the following features: patient allergy list (91%), clinical notes (91%), patient medication list (88%), and patient problem list (84%).

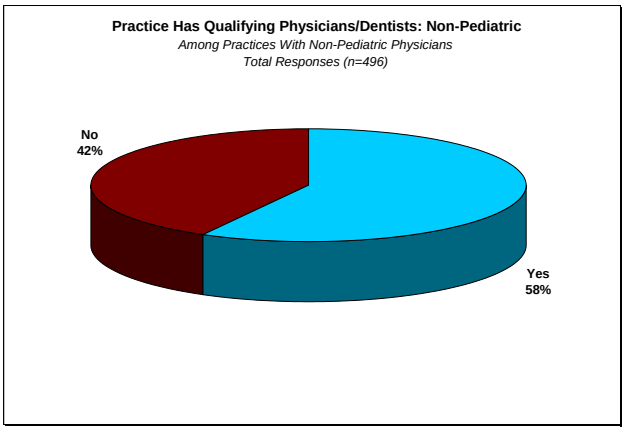
Provider offices with an EHR system are generally more likely to receive summary patient records and structured lab results through their EHR system than they are to send these records through their EHR. Approximately one-fifth (20% of physician practices and 11% of dental practices) report sending summary patient records through their EHR system, while 24% (23% of physician practices and 33% of dental practices) say they receive these records through their EHR. Thirty-seven percent of provider offices (40% of physician offices and 17% of dental offices) report receiving structured lab results through their EHR system, while only 15% (16% of physician practices and 6% of dental practices) send structured lab results through their EHR.

The vast majority of provider offices that have an EHR system report that they are either very satisfied (37%) or somewhat satisfied (50%) with their current EHR system. Just 13% say they are dissatisfied (7% very dissatisfied).

2.1.4 EHR Incentive Program Qualification

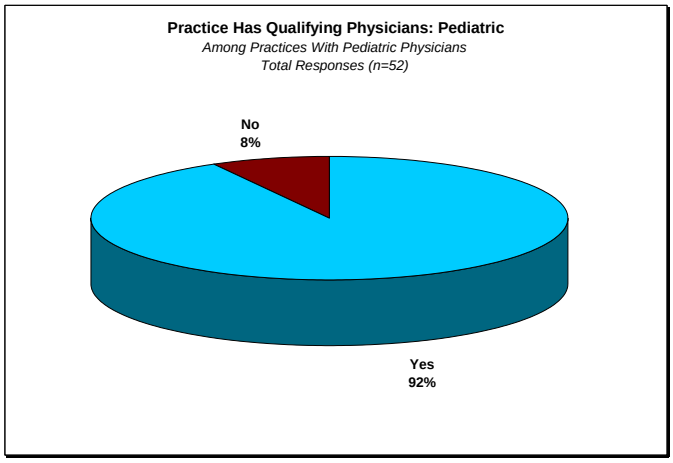
Non-Pediatric physicians and dentists in New Mexico can qualify for the Medicaid EHR incentive if they practice at least 10% of the time outside of a hospital setting and at least 30% of their patient load is among Medicaid patients. Nearly three-fifths of the practices interviewed (58%) report that at least one of the non-Pediatric physicians in their practice is a "qualifying physician/dentist". This translates to 849 non-pediatric physicians and 148 dentists that expect to qualify for stimulus funding among those surveyed.

Figure 2b – Qualifying Physicians



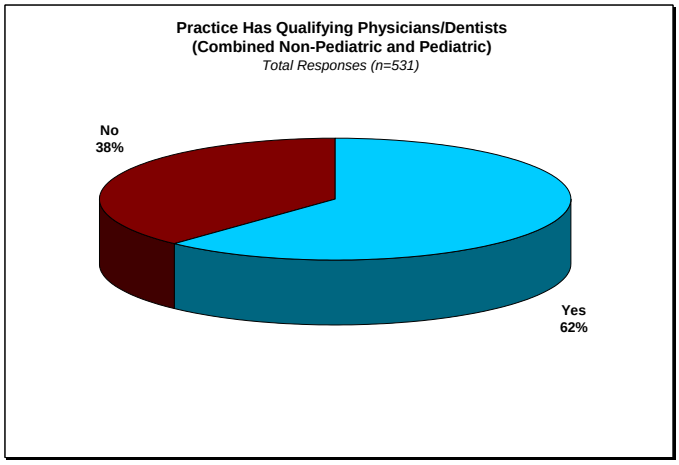
The qualifying criteria for Pediatric physicians in New Mexico is if they practice at least 10% of the time outside of the hospital setting and have at least 20% of their patient load among Medicaid patients. Among physician practices with Pediatricians, 92% report that at least one of their Pediatric physicians expects to qualify for the Medicaid incentive (this translates to 196 pediatricians among those surveyed).

Figure 2c – Qualifying Pediatricians



When looking at the results among non-Pediatric and Pediatric physicians combined (including dentists), over three-fifths (62%) of the physician and dental practices that accept Medicaid patients in New Mexico report having at least one physician/dentist (whether they be non-Pediatric or Pediatric) expect to meet the qualification criteria for the Medicaid EHR incentive. There are in total 1,193 physicians and 152 dentists that expect to qualify for incentives among those surveyed.

Figure 2d – Qualifying Professionals



The study included responses from physician practices that represent 2,040 non-Pediatric physicians and 188 dentists in New Mexico who accept Medicaid patients. Of these physicians, 86%, or 1,762 physicians, practice more than 10% of their time outside of a hospital setting. Furthermore, 42% of these physicians and 79% of these dentists practice more than 10% of their time outside of a hospital setting and have at least a 30% Medicaid patient load. This translates to a total of 849 New Mexico non-Pediatric physicians and 148 dentists in the study who qualify for the Medicaid EHR incentive program.

Included in this study are also responses from physician practices that represent 295 Pediatricians in New Mexico who accept Medicaid patients. Of these Pediatricians, 84%, or 248 physicians, practice more than 10% of their time outside of a hospital setting. Two-thirds of these physicians practice more than 10% of their time outside of a hospital setting and have at least a 20% Medicaid patient load. This translates to a total of 196 New Mexico physicians in the study who qualify for the Medicaid EHR incentive program as Pediatricians.

Table 2a – Overall Number of Providers Surveyed

Physicians/Dentists Qualifying for Medicaid Incentive							
	Non-Pediatric Physicians		***Dentists***		***Pediatric Physicians***		
Number of Providers	2,040		188		**Number of Providers**	295	
Providers Who Practice More Than 10% Outside of Hospital Setting	1,762	86%	188	100%	**Providers Who Practice More Than 10% Outside of Hospital Setting**	248	84%
Non-Hospital Providers Who Have at Least 30% Medicaid Patient Load	849	42%	148	79%	**Non-Hospital Providers Who Have at Least 20% Medicaid Patient Load**	196	67%

2.2 Hospitals, FQHCs and IHS Facilities

2.2.1 Hospitals

Excluding IHS facilities, New Mexico has 45 hospitals currently enrolled with Medicaid. Thirty-five (35) of these facilities are Acute Care hospitals falling in the CCN range qualified to participate in the MIPP. Additionally, there is one Veterans Administration Hospital. There are no Children's hospitals currently operating in New Mexico.

HSD/MAD worked closely with the New Mexico Hospital Association to survey the level of HIT adoption readiness and expectation to participate in the MIPP. Of the responses received, 29 of 31 hospitals are in the process of upgrading software and expect to meet MIPP requirements in 2011. Many of the hospitals further expect to meet meaningful use requirements within this same time frame.

An inquiry of the hospital EHR products demonstrate a variety of equally distributed product offerings. The EHR products being used include CPSI, Cerner, Meditech, McKesson, HMS, Healthland, and Phoenix Systems.

Program Update: As of April 30, 2014, 39 unique Eligible Hospitals are participating in the New Mexico Medicaid EHR Incentive Program, including seven IHS hospitals. See Section 2.6.4 for more details.

2.2.2 FQHCs

The New Mexico Primary Care Association (NMPCA) is an organization representing New Mexico FQHCs and has also been actively supporting the implementation of EHR systems among its members. NMPCA is a statewide membership organization representing 20 organizations with over 150 medical, dental, and school-based clinical sites in 90 communities throughout the state.

Fifteen of NMPCA-supported organizations are Federally Qualified Health Centers and receive federal funding through HRSA. Within these organizations, forty-two percent (133 of 314) of the FQHC medical providers in New Mexico have implemented and are utilizing Electronic Health Records (EHRs). The remaining 181 are expected to complete implementation in the next 12 months.

Program Update: As of April 30, 2014, 420 unique EPs from all 16 FQHCs are currently participating in the NM Medicaid EHR Incentive Program. See Section 2.6.4 for more details.

Those facilities that have implemented EHR systems have utilized a combination of Federal and State funding to purchase their EHR systems. NMPCA received a $2 million HRSA HIT grant in June 2010 to assist four centers to implement EHRs and provide common reporting and clinical innovations across the network membership.

NMPCA operates a Health Center Controlled Network and works with eleven member organizations in the areas of integrated practice management and HIT.

2.2.3 IHS/Tribal Facilities

There are forty-three (43) Indian Health Service (IHS) or tribal 638 health facilities in New Mexico registered with Medicaid FFS. HSD/MAD has been working with representatives from IHS and has identified that 34 sites are currently utilizing some form of EHR technology. Of these sites, 22 are currently utilizing RPMS EHR, the version of software necessary to meet EHR Incentive program requirements. Four additional facilities are planning to adopt the RPMS EHR product.

Program Update: As of April 30, 2014, all seven IHS hospitals in New Mexico and 188 unique EPs from IHS New Mexico sites are currently participating in the New Mexico Medicaid EHR Incentive Program. See Section 2.6.4 for more details.

2.3 Provider Focus Groups

HSD/MAD contracted with Research and Polling, Inc. to conduct two focus groups comprised of provider populations from Northern and Southern New Mexico. The overall objective was to assess awareness and understanding of and attitudes toward the Electronic Health Records (EHR) Medicaid incentive program. HSD/MAD also attempted to elicit understand of the awareness of the existence and availability of services from the REC. The focus groups were conducted among office managers and practice administrators of New Mexico physician and dental offices that accept Medicaid patients. Attention was given to recruiting from a diverse mix of provider offices in each region based on particular demographics, including percent Medicaid patient load; solo versus group practice; and medical specialty.

The findings from the focus groups varied significantly between the two regions in which they were conducted. Providers from Southern New Mexico had a greater relative awareness and understanding of the EHR Incentive programs (both Medicare and Medicaid).

The sessions demonstrated that providers have a general awareness of EHR Incentive Program existence, but significant misconception regarding the program details. Participants overall acknowledged the potential benefits of automating patient records (e.g. enhanced workflow and time savings). There was also a modest agreement that an EHR system could reduce errors within a practice, but recognition that human error continues to be a problem in the EHR environment. Participants identified the following as challenges to EHR adoption:

- technology costs
- staff resources
- impact on patient load
- resistance to change
- overwhelming volume of choice
- lack of technical knowledge
- lack of technical support

As it relates to the New Mexico HIT/HIE environment, few participants demonstrated awareness of either the Regional Extension Center Services or the State HIE. Perhaps the most significant item of note, there was a lack of confidence in the ability of government to effectively execute the program for providers to receive payments. This, paired with the lack of knowledge of the program, provides strong

indication that extensive outreach and education efforts will be needed. It also presents a challenging scenario for achieving maximum program success in a time of limited State resources.

2.4 Broadband Availability in New Mexico

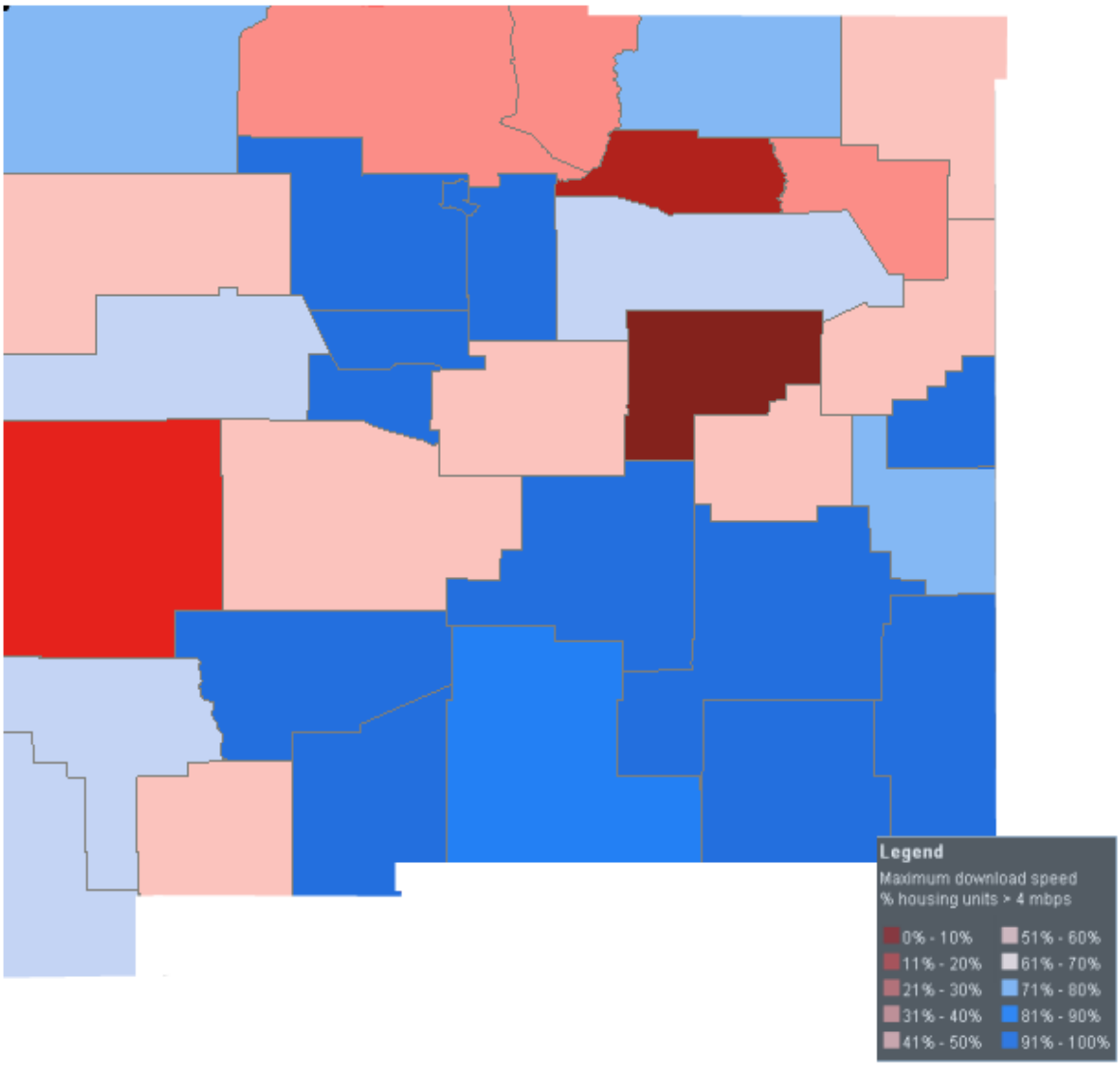
As might be expected, broadband penetration in New Mexico is greater in urban areas than in small and rural parts of the State. In a recent survey of providers, it was shown that 89% of providers surveyed utilized broadband internet in their practice.[2] Though provider connectivity is relatively high, challenges exist for households and the future potential for individual electronic access to Personal Health Records (PHR). The Southwest Telehealth Access Grid (SWTAG, an initiative funded by the FCC outside of ARRA), is an initiative focused on coordination of broadband expansion initiatives in the Southwest. SWTAG was awarded $15,561,181 to develop high speed network to over 500 health care facilities in New Mexico, Arizona and Southwest Indian Health Service Areas. This coordinated effort will provide support for EHR and HIE adoption in our rural state.

Another initiative that will impact broadband availability is the ENMR-Plateau Middle Mile project, a program funded under the Broadband Technology Opportunities Program (BTOP). The ENMR-Plateau Middle Mile project intends to enhance broadband capabilities for critical community anchor institutions in eastern New Mexico and west Texas by lighting a more than 1,600-mile ring of fiber and constructing 74 miles of new fiber in five communities. The project plans to connect more than 200 anchor institutions – including educational institutions, public safety organizations, healthcare facilities, and government agencies – at speeds of up to 1 Gbps. In addition, the network intends to offer wholesale services and facilitate broadband expansion to an estimated 20 communities and an area with nearly 700,000 homes, over 36,000 businesses, and 263 anchor institutions.

The following map details the estimated general level of connectivity in the State.

[2] Research & Polling, Inc., *New Mexico Human Services Department/Medical Assistance Division, Health Information Technology (HIT) Environmental Scan, October 2010*

Figure 2e - Percentage of Housing Units with 4Mbps Broadband Availability[3]



[3] http://www.broadband.gov/maps/availability.htm

2.5 MITA Initiatives

New Mexico completed a full MITA State Self Assessment (SS-A) to analyze the alignment of its key business processes with the MITA business model, establishing maturity levels for relevant business processes. Since the initial assessment, completed in year 2009, did not anticipate the challenges of implementing the MIPP Program, a partial refresh of MITA maturity was completed with the development of this SMHP, including assessment of the 20 MITA business processes impacted by the new program. Those business processes are listed in Table 2b below, and include:

Table 2b – MITA Business Processes Impacted by MIPP Implementation

ID #	MITA Business Process Name	New Mexico Business Process Name
Business Relationship Management		
BR01	Establish Business Relationship	Memorandum of Understanding Execution
Operations Management		
OM07	Audit Claim/Encounter	Adjudication/ Claim Resolution
OM09	Prepare Remittance Advice/Encounter Report	Remittance Advice
OM10	Prepare Provider EFT/Check	Prepare Provider EFT/Check
OM18	Inquire Payment Status	Claim Status Inquiry
OM19	Manage Payment Information	Accounting and Financial
OM24	Manage Recoupment	Mass Adjustment Process
Program Management		
PG05	Develop and Maintain Program Policy	Program Benefit Changes
PG15	Perform Accounting Functions	Accounting and Financial Subsystem
PG16	Develop and Manage Performance Measures and Reporting	Monitor Service Level Agreement (SLAs)
PG18	Draw and Report FFP	
PG19	Manage FFP for Services	Manage FFP for Services
Program Integrity Management		
PI01	Identify Candidate Case	Health Spotlight and EFADS
PI02	Manage Case	Manage Case
Provider Management		
PM01	Enroll Provider	Provider Enrollment
PM02	Disenroll Provider	Provider Enrollment
PM04	Manage Provider Communication	Provider Relations Call Center
PM05	Manage Provider Grievance and Appeal	Fair Hearings Process
PM06	Manage Provider Information	Provider File Updates
PM07	Perform Provider Outreach	Provider Outreach

The MITA refresh analysis first looked at the impacted business processes listed above to determine if system changes and/or process improvements had been implemented since the completion of the initial assessment, and perhaps resulted in an increased "As Is" MITA maturity rating. The refresh analysis next considered potential changes to both business and technical processes to support MIPP implementation, and assessed the potential for MITA maturity improvement. For a full discussion of the MITA updates, see companion deliverable *MITA SS-A Update 2010.*

The enrollment, payment and auditing of the MIPP program will be more fully automated than the current processes for Medicaid FFS providers. HSD/MAD anticipates being able to eventually leverage the added MIPP web functionality to provide a greater degree of automation for Medicaid FFS applicants, which would result in a change (increase) in MITA maturity for related business processes. Likewise, the enhanced web portal infrastructure and required interfaces may serve to more fully automate other processes that are beyond the scope of the MITA refresh activity. Indeed, increased web functionality, enhanced data sharing through interfaces and a process for collecting and monitoring stakeholder satisfaction will all play a big role in obtaining higher maturity levels across a number of processes. It is anticipated that the MITA maturity assessment will be revisited in year 2015 and will likely once again impact maturity of many business processes. System enhancements, in concert with the potential availability of clinical data for continuity of care, will provide significant MITA maturity for HSD/MAD business processes.

2.6 Existing HIT/E Relationships

HSD has always had a presence in the evolving HIT efforts in New Mexico. HSD staff has been involved in statewide HIT activities since 2005, when it began participating in the Telehealth and Health Information Technology Commission being run under the auspices of the New Mexico Department of Health (NMDOH). Providing the Medicaid agency perspective on the Commission's activities, HSD has supported and participated in the development of a state health information exchange (HIE) network which will facilitate the private and secure exchange of patient health care information among the community of providers.

Centennial Care is an effort to modernize Medicaid while enhancing the relationship with the Managed Care Organizations. One of the principles of Centennial Care is a comprehensive service delivery system. The Managed Care Organizations focus is to have a comprehensive care coordination process which includes behavioral health to maximize integration of care. The goal is to assure Medicaid recipients receive the right amount of care at the right time, in the most cost-effective setting while ensuring that quality care is purchased rather than quantity of care.

2.6.1 New Mexico Health Information Technology (HIT) Coordinator

The HIT Coordinator role was retired in January 2014. HIT functions are disbursed among several state agencies and non-profit organizations within New Mexico. HSD will continue to work with its sister agencies and other stakeholders to further its goals using health information technology.

2.6.2 New Mexico Health Information Collaborative (NMHIC)

In 2009, the Governor also selected the New Mexico Health Information Collaborative (NMHIC), created in 2004, as the State Designated Entity (SDE) to coordinate health information exchange (HIE) activities and continue the development and expansion of HIE capacity among providers (hospitals and medical practices) in New Mexico.

HSD is a member of the LCF Research Board of Directors which is the non-profit organization that staffs and operates the New Mexico Health Information Collaborative (NMHIC). Among its LCF Research Board of Director responsibilities, HSD/MAD is an active member of the NMHIC-HIT Committee which provides direct oversight and governance for the HIE network. The staff of HSD has also worked closely with the LCF Research staff in the creation and updates to the New Mexico HIE Strategic and Operational Plan. This HIE plan was developed in response to the State HIE Cooperative Agreement Program (CAP) FOA issued by the Office of the National Coordinator of Health Information Technology (ONC). New Mexico became the first state in the nation to meet all ONC requirements for a State HIE Strategic and Operational Plan in February 2010. Because New Mexico met all ONC requirements, it has been able to accelerate the expansion of the NMHIC HIE network during 2010.

The stakeholders of NMHIC have supported HIE development with considerable time and funding. The collaborative includes New Mexico stakeholders representing health care providers, payers, employers, state agencies and consumers (see Table2.c below). NMHIC's grants for the HIE cooperative program and the Regional Extension Center ended in 2014. The organization is still moving forward with the implementation of the statewide HIE and is including regional extension center services.

Table 2c – New Mexico Health Information Collaborative Board Members

OFFICERS		
Mayer, Robert	Interim CEO	LCF Research, Interim CEO
Gleeson MD, Jeremy	Board Chairman	ABQ Health Partners, Physician
Maruca, Robert	Secretary (interim)	Community Representative
Sowards, Paul	Treasurer	Vice Chairman, Century Bank
BOARD of DIRECTORS		
Angellis, MD, Dennis		Presbyterian Healthcare Services, Medical Director- Process Excellence
Buchanan, Holly Shipp		UNM Health Science Center, Vice President of Knowledge Management and IT
Dye, Jeff		NM Hospital Association, President and CEO
Forney, Stephen		Lovelace Health System, Vice President and CFO
Gonzales PhD, Arturo		Sangre de Cristo Community Health, Executive Director
Hickey MD, Martin		NM Health Connections, CEO
Hofstetter, Peter		Holy Cross Hospital, CEO
Jornigan, Glen		UNM Hospital, Administrator of IT
Kandalaft, Kevin		UnitedHealthCare Community NM, Executive Director
Kanig MD, Steven P		CustomEHR, President and Developer
Kehoe, Patty		Molina Healthcare, CEO and President
Kleefish, Boyd		HealthInsight, Senior VP of Corporate Operations
Ortega MD, Ricardo		Private Practitioner, MD
Roddy, David		NM Primary Care Association, CEO
Weinberg, Julie		NM HSD-MAD, Division Director

2.6.3 Other HIT/E Activities in New Mexico

In December 2009, the New Mexico Department of Health (NMDOH) recognized the New Mexico Health Information Collaborative (NMHIC) as a designee in the e-Reporting Project to allow electronic transfer of routine notifiable conditions and other conditions of public health significance, as required by law, to NMHIC. NMHIC, in turn, provides the public health data electronically to the NMDOH in a standardized format. NMHIC began forwarding laboratory results for notifiable conditions from the state's largest reference laboratory and a rural hospital to NMDOH in June 2010. NMHIC has since expanded to forward laboratory results from the state's second largest reference laboratory and the state's third largest integrated healthcare delivery system to NMDOH. Emergency department situational surveillance information from three of the state's largest integrated healthcare delivery systems and a rural hospital is sent electronically to NMDOH. To date, NMHIC has captured 8,563 notifiable conditions laboratory results and 157,756 emergency department encounters for situational surveillance reporting.

Program Update: As of December 17, 2013, the NMHIC HIE has captured 181,488 notifiable conditions laboratory orders and 1,699,578 emergency department encounters for situational surveillance reporting, since the implementation of the NMHIC – NMDOH e-Reporting Project in June 2010. NMHIC currently forwards notifiable conditions laboratory results on behalf of 24 laboratories, and forwards emergency department situational surveillance encounter data on behalf of 17 hospitals, to NMDOH.

The State of New Mexico currently operates the New Mexico Statewide Immunization Information System (NMSIIS), a computerized Internet database application that was developed to record and track immunization dates of New Mexico State's children and adults. The program goal is to provide assistance for keeping New Mexicans on track for recommended immunizations. Initial statewide release occurred in August 2007 with a major upgrade in August 2009. NMDOH is working to allow the immunization registry to receive immunization data via HL 7 v 2.3.1 with expected functionality available in the summer of 2011. Bidirectional exchange of immunization data is expected to commence in the summer of 2012 when HL7 v2.5.1 files will be accepted.

Program Update:

Number of Sites Currently Sending in Data		*Sites in Testing*	
Walgreens	*70*	*Health Fusion*	*4 sites*
After Hours PEDS	*2*	*Athena Health*	*50 sites*
BEHR	*53*	*Athena Health*	*40 sites*
ABQHP	*28*		
PRES	*31*		
TCCY	1		
FPAT	1		
BCA	2		
Unity Medical	1		
Total	**189**		

New Mexico has been actively developing Electronic Prescribing (E-Rx) activity in the state since 2006. Though a collaboration of all the major health payers in the state, New Mexico has incentivized adoption of E-Rx and provided both education and support. HSD/MAD received and executed a Medicaid Transformation Grant from 2007 to 2009 developing technical readiness to exchange electronic prescription information and support adoption activities. SureScripts currently ranks New Mexico as 43 (up from 49) in the nation for electronic prescribing activity. It is estimated that roughly 90% of New Mexico pharmacies participate in E-prescribing and penetration among physicians is approximately 20%.

Program Update: New Mexico pharmacies enabled to accept e-prescriptions increased to 96% through June 2012.

2.6.4 Current EHR Provider Incentive Payment Program Participation

Early in 2011, New Mexico estimated approximately 300 eligible professionals and 30 eligible hospitals would participate in the EHR Provider Incentive Program for FFY 2011. We estimated incentive payments totaling of $47,135,266 for FFY 2011. New Mexico launched the EHR Incentive Program in August 2011, but payments were not actually disbursed until November of FFY 12.

As of April 30, 2014, 1,679 unique EPs are participating in the New Mexico Medicaid EHR Incentive Program: 1665 who attested to AIU in their first year and 14 who attested to MU in their first year. The program has received a total of 752 EP MU attestations, including those of the 14 EPs who attested to MU in their first year. Of the 752 MU attestations, 180 were for EPs in their third year of the program who attested to a 12-month EHR Reporting Period. Of the currently participating EPs, these 180 will be able to attest to Stage 2 MU in program year 2014.

As of April 30, 2014, 39 unique EHs are participating in the New Mexico Medicaid EHR Incentive Program: 33 that attested to AIU in their first year and six that attested to MU in their first year. All hospitals currently participating are enrolled in both the Medicare and Medicaid EHR Incentive Programs. The Medicaid program has received a total of 47 EH MU attestations, including those of the six EHs that attested to MU in their first year. Of the 47 MU attestations, 14 were for EHs in their third and last year (2013) of the Medicaid program and they attested to a 12-month EHR Reporting Period. Of the remaining 25 participating EHs, eight will be able to attest to Stage 2 MU in program year 2014 as they have attested to at least two years of Stage 1 MU between the Medicare and Medicaid EHR programs.

Through April 30, 2014, the program has paid $36,846,087 in EP incentives and $42,812,084 in EH incentives for a total of $79,658,171. This amount, however, does not reflect payment for all the attestations described above as the EHR program is still in the review and approval process for some attestations.

Unique Providers & Attestations by Provider Type
Through April 30, 2014

	AIU	MU	Totals
Unique Eligible Hospitals (EHs)			39
EH Attestations	33	47(1)	$42,812,084
Unique Eligible Professionals (EPs)			1679
EP Attestations	1665	752(2)	$36,846,087
Certified Nurse Midwives	93	77	
Dentists	223	28	
Nurse Practitioners	320	161	
Physicians	984	450	
Physicians Assistants	45	36	
Grand Total	**1698**	**799**	**$79,658,171***

* **Total paid through April 30, 2014, does not include all attestations.**
(1) Includes six EHs that attested to MU in their first participation year.
(2) Includes 14 EPs that attested to MU in their first participation year.

New Mexico has 16 Federally Qualified Health Centers (FQHCs). As of April 30, 2014, 420 unique EPs from all 16 FQHCs are currently participating in the NM Medicaid EHR Incentive Program: 416 attested to AIU their first year and four attested to MU in their first year. The program has received a total of 200 MU attestations from EPs practicing at FQHCs, including those of the four EPs who attested to MU in their first year. Through April 30, 2014, the program has paid $8,521,250 for AIU attestations and $1,130,500 for MU attestations for a total of $9,651,750 paid for EPs practicing at FQHCs.

EPs Practicing at FQHCs
Unique EPs, Attestations and Payment Totals
Through April 30, 2014

	AIU	MU	Totals
Total FQHCs in NM			16
Total FQHCs paid	16	12	
Unique EPs at FQHCs			420
Attestations	416	200(1)	616
Total Paid (AIU/MU)	**$8,521,250**	**$1,130,500**	**$9,651,750***
Counties Represented			28 out of 33
Urban*			4
Rural**			24

* **Total paid through April 30, 2014, does not include all attestations from EPs at FQHCs.**
** **New Mexico Urban counties are Bernalillo, Dona Ana, Sandoval and Santa Fe**
*** **New Mexico Rural Counties are the remaining 29 counties in New Mexico**
(1) **Includes four EPs that attested to MU in their first participation year.**

Indian Health Services (IHS) facilities operate in two IHS-designated areas in New Mexico: the Navajo Area in the northwest corner of the state which includes the counties of McKinley and San Juan, and the Albuquerque Area, which includes the counties of Bernalillo, Cibola, McKinley, Otero, Rio Arriba, Sandoval, Santa Fe, Socorro and Taos.

As of April 30, 2014, all seven IHS hospitals in New Mexico and 188 unique EPs from IHS New Mexico sites are currently participating in the New Mexico Medicaid EHR Incentive Program. Six hospitals attested to AIU in their first year and one attested to MU in its first year. The Medicaid program has

received a total of 12 IHS EH MU attestations, including that of the one hospital that attested to MU in its first year. All IHS hospitals have attested to a second year of MU, and for four of the IHS hospitals, 2013 was their third and last year in the Medicaid EHR Program. The remaining three hospitals will be able to attest to Stage 2 MU in Program Year 2014.

Of the 188 unique EPs participating from IHS New Mexico sites, 185 attested to AIU in their first year and three attested to MU in their first year. The program has received a total of 96 MU attestations from EPs practicing at IHS sites, including those of the three EPs who attested to MU in their first year.

Through April 30, 2014, the program has paid $3,383,000 in EP incentives and $8,017,802 in EH incentives for a total of $11,400,802 paid to IHS providers. This amount, however, does not reflect payment for all the attestations described above as the EHR program is still in the review and approval process for some attestations.

Indian Health Services (IHS) NM Sites
Unique Providers, Attestations and Payment Totals
Through April 30, 2014

	AIU	MU	Totals
Unique Hospitals			**7**
Hospital Attestations	6	12(1)	$8,017,802
Unique Professionals			**188**
EP Attestations	185	96(2)	$3,383,000
Grand Total			**$11,400,802***
Counties Represented			9 out 33
Urban*			3
Rural**			6

* Total paid through April 30, 2014, does not include all attestations from EPs at FQHCs.
** New Mexico Urban counties are Bernalillo, Dona Ana, Sandoval and Santa Fe
*** New Mexico Rural Counties are the remaining 29 counties in New Mexico
(1) Includes one EH that attested to MU in its first participation year.
(2) Includes three EPs that attested to MU in their first participation year.

3 Section B – The "To Be" HIT Landscape

This section presents a high-level vision of the HSD/MAD enterprise of the future (approximately 10 years) that inspires the transformation that the MITA framework helps realize.

3.1 HIT/E Goals and Objectives for New Mexico

The HSD/MAD enterprise of the future is one in which stakeholders (policy makers, all levels of government, advocates, consumers, providers, and others) participate in achieving improved population health outcomes by fostering individual and community health, safety, and wellness through a coordinated, effective, culturally responsive continuum of prevention, and treatment services. Stakeholders benefit from improved information access and exchange that allows providers, payers, and clients to view key clinical information in real time and use it to make care decisions. Providers and funders can then focus on providing excellent and effective health care, as the burden of information capture, processing, and reporting is largely replaced by direct exchange between data partners or direct access to a health exchange network.

To determine how the Department's specific goals will be actualized, HSD/MAD formed a multi-stakeholder discussion group to discuss and articulate the future state of healthcare delivery across the State. The group used "the ideal scenario" approach to explore both the Medicaid recipient and provider's experience in future years, and to discuss how various initiatives, supporting technologies and program improvements would bring about the necessary improvements.

In "the ideal scenario" (see Appendix 7.1 for full transcript), a Medicaid recipient can expect improvements in both the delivery of healthcare across the state and in health outcomes. Through the new technical services offered in a modernized MMIS, participation in the NM HIE and as a result of streamlined and automated business processes, HSD/MAD will provide significantly improved experience for its recipients, including:

- Improved health information sharing among providers, resulting in a comprehensive continuum of care over time.
- Improved access to one's Personal Health Record, enabling online review of medical history, doctor's instructions, laboratory results, upcoming appointments.
- Improved business processes, allowing recipients to apply once (online) for multiple programs and benefits, and to update personal information at conveniently located kiosks.

Similarly, in "the ideal scenario" envisioned in Medicaid's future, a Medicaid Provider can expect to provide improved continuity of care and better overall health outcomes through:

- Improved clinical data and supporting documentation that is available in a Coordination of Care Document.
- Improved access to relevant data through the HIE functionality, where a single sign-on and authentication process allows the provider seamless access to various data sources.
- Improved business processes, supporting automated provider credentialing, automated renewals, user-friendly claims payment and payment status queries and multiple opportunities for relevant information to be dispersed automatically.

And, in "the ideal scenario" the Medicaid agency can expect to improve cost effectiveness of its programs and drive better health outcomes through:

- Access to clinical data in the MMIS through HIE with the SDE.
- Analysis of clinical data to better define and track health outcomes
- The use of clinical data to support value-based health care purchasing and Medicaid-sponsored health homes.

Clearly, New Mexico is in the formative stages of HIT developments and HIE with many fledgling and developing initiatives. HSD/MAD will use its newly formed workgroups, discussed below, and its stakeholder relationships to continue to move toward the meaningful use of EHR technologies across New Mexico.

3.2 Encouraging Provider Adoption of EHR Technology

HSD/MAD recognizes that program communications are critical to the success of MIPP program implementation and the achievement of EHR adoption goals. Based on information received from focus group efforts, HSD/MAD believes that the New Mexico provider community has a relatively low awareness of the EHR Incentive Program, and where awareness is had, misconception and misinformation may be present.

HSD/MAD has identified the following areas necessary for address.

1. Program Awareness – increase general EHR Incentive Program awareness
2. Program Education – define and educate MIPP program requirements, enrollment processes, and available tools and resources
3. Program Support – identify and assist qualifying EPs, facilitate program enrollment and achievement of program requirements

3.2.1 Communicating to Develop Provider Awareness

HSD/MAD created MIPP program information pages and web pages (in July 2010) to provide general program awareness. These documents and pages will be actively updated with information to reflect program changes and links as developments occur.

New Mexico Medical Assistance Division (MAD) has developed a preliminary Outreach Plan as required to disseminate critical New Mexico EHR Incentive Program Information among program stakeholders, and to support the collection of data from stakeholders for purposes of improved Medicaid patients' benefit and, for compliance with EHR's future Meaningful Use data capture requirements.

The New Mexico EHR Incentive Program Outreach Plan details the approach for managing communications related to the program. Key objectives of this plan are to:

- Communicate MIPP objectives
- Communicate Plan components
- Ensure Stakeholder groups are targeted for communications
- Identify key vehicles to use with stakeholder groups
- Leverage strategic collaborative resources to penetrate existing EHR users (pre-Incentive Program users)

Anticipated outcomes are participation, compliance and stakeholder awareness of all aspects of the incentive program. In the spirit of environmental responsibility, New Mexico has embraced an inclusive and integrated approach to EHR communications via technology with which to engage its stakeholders.

3.2.2 Outreach Plan for MIPP Education

To ensure and maximize the success of New Mexico's EHR Incentive Program, HSD/MAD must engage the key stakeholders to help promote acceptance and participation. Active provider participation (FFS or Managed Care) in the program and compliance with the rules and procedures can only be attained through effective and timely communications. The goals of the Outreach Plan are to:

- Educate stakeholders to the benefits of the New Mexico EHR Incentive Program and the value of HIE to all healthcare stakeholders in New Mexico, including providers, members/consumers and payers
- Educate stakeholders on their role in making the New Mexico EHR Incentive Program successful
- Build commitment to the New Mexico EHR Incentive Program across all stakeholders
- Develop understanding and buy-in of the objectives, goals and timeline across all stakeholders

- Motivate staff to operate productively and effectively
- Contain risks of aversive reactions to the New Mexico EHR Incentive Program
- Use existing professional relationships to disseminate information wider and deeper into ubiquitous geographically remote state areas
- Effectively coordinate communications with all stakeholder organizations to achieve broad awareness and understanding, thus minimizing technologically fear-based reactionary/resistant behaviors, inaccuracies and/or conflicting messages/information.

Achievement of these goals will be evaluated periodically as New Mexico implements and operates its EHR Incentive Program. Adjustments and modifications are anticipated and will be undertaken as the need(s) for same dictates.

Section 4.2 (Educating Providers on MIPP Participation) also discusses a number of specific outreach efforts that will support early education of potentially eligible providers, and includes a discussion of coordination with HITREC to continually improve provider adoption of EHR technology.

3.2.3 Key Stakeholders in EHR Adoption

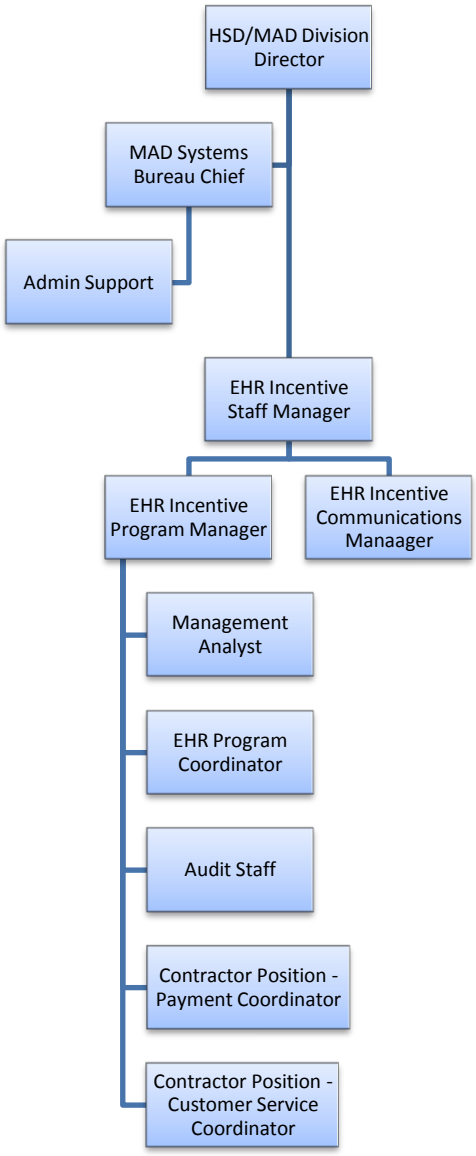
New Mexico's EHR Incentive Program stakeholders are those individuals and entities who will participate in or are affected by the initiative. Key stakeholders have been identified as:

- LCF Research
- New Mexico Medical Review Association
- New Mexico Department of Health
- New Mexico Hospital Association
- New Mexico Primary Care Association
- Medicaid-enrolled Indian Health Service facilities
- Various Medicaid providers serving New Mexico citizens
- 4 Centennial Care MCOs: Blue Cross Blue Shield, Molina, United, Presbyterian

3.2.4 Program Support – the HSD/MAD Organization

HSD/MAD estimated that 9 FTE positions would be necessary to effectively staff the program requirements. In light of State budget constraints and limitations to hiring, HSD/MAD is inquiring upon solutions to meeting these needs. An organizational chart of the expected resources necessary for MIPP program operations is shown below.

Figure 3a – MIPP Program Organizational Chart



3.3 Leveraging Existing Technologies to Support EHR

3.3.1 HITREC Provider Outreach

HSD/MAD will partner with the New Mexico Health Information Technology Regional Extension Center (NM HITREC) to reach out to the NM Medicaid provider community and assist in the adoption and deployment of EHR technology across the State. NM HITREC plans to assist 1,035 priority primary care providers working in small practices and underserved areas and provide technical assistance for adopting, implementing and upgrading EHRs to improve care. Annual Medicaid provider enrollment goals and distribution are displayed in Table 3a, below:

Table 3a – Estimated MIPP Enrollment for Eligible Professionals

Calendar Year	Estimated Annual EP Enrollment	EP Enrollment Distribution (% of Total EP)	Incentive Payment Year
2011	1087	18%	1st year
2012	1339	22%	2nd year
2013	1388	23%	3rd year
2014	1411	23%	4th year
2015	1431	24%	5th year
2016	1451	25%	6th year
Total EP	1451	100%	

* HSD/MAD is currently in the process of forecasting accurate participation in the MIPP. The above figures represent simple forecasting based on survey data and actual Medicaid provider populations.

Program Note: As of January 30, 2014, the New Mexico Health Information Technology Regional Extension Center (NM HITREC) had achieved 100 percent of its Milestone 1 goal by enrolling over 1,100 primary care providers, and its Milestone 2 goal of 1,035 providers live on a certified electronic health record with active quality reporting and e-prescribing. As of January 30, 2014, about 59% of providers working with NM HITREC had reached the Milestone 3 goal to achieve Stage 1 Meaningful Use of a certified electronic health record (EHR) system. The NM HITREC team assisted more than 235 practices in 32 of the 33 counties across New Mexico.

Grant funding for NM HITREC to assist eligible primary care practices concluded at the end of January 2014. However, LCF Research, lead organization for NM HITREC, will continue to offer services such as privacy and security risk assessments. LCF Research will continue to assist providers and hospitals with Health IT as the lead organization for the New Mexico Health Information Collaborative (NMHIC), the statewide health information exchange (HIE) network.

3.3.2 MMIS Enhancements

In 2011, HSD/MAD procured the services of a MMIS system takeover vendor that was required to enhance the current MMIS functionality to support a number of new federal and state initiatives.

Program Update: In March 2012, the contract was awarded to the incumbent vendor, Xerox State Healthcare. Xerox will continue to operate and maintain the MMIS and has already developed or is in the process of developing several system enhancements to support new federal and state initiatives, including:

- Implemented:
  - 5010 HIPAA Transaction Standards
  - *HIPAA Operating Rules*
  - *New Web Portal offering additional self-service capabilities for providers and recipients*
  - *New Fraud and Abuse Detection System*
  - *New Pharmacy Benefits Management System*
  - *Enhanced electronic document workflow capabilities*
- In Process:
  - ICD10 Diagnosis and Procedure Coding

3.3.3 Health Insurance Exchange

New Mexico is currently working toward a State Based Marketplace (SMB). The SMB will take the place of the Federally Facilitated Marketplace (FFM). HSD's eligibility system will provide eligibility services to the SMB beginning 11/15/14.

3.3.4 Health Center Controlled Networks Support Adoption

New Mexico has 15 FQHCs, 12 of which are involved in a Health Center Controlled Networks (HCCN) with HIT/EHR funding. The HCCN and the individual FQHCs have pledged to assist HSD/MAD in outreach efforts to encourage EHR adoption among private sector physicians. The HCCNs and their providers have volunteered to engage other eligible providers and share experiences, lessons learned, and best practices related to the acquisition and implementation of EHR systems. The HCCN and individual FQHCs will share tools developed to assess practice readiness, redesign patient flow, and assess vendor software and contracts. Provider champions from HCCN are willing to testify to the advantages of implementing EHRs and utilizing their capabilities to improve practice quality and efficiency.

3.4 Expanding HIT/E in New Mexico

3.4.1 E-Reporting Project (NM Department of Health)

The New Mexico Health Information Collaborative (NMHIC) has been designated by the New Mexico Department of Health as the primary agent for its e-Reporting project, which was launched in June of 2010. The project includes e-Reporting of laboratory and Emergency Room Discharge data to the NM Department of Health. The Electronic Reporting (e-Reporting) system was created by the New Mexico Health Information Collaborative (NMHIC) to provide the New Mexico Department of Health (NMDOH) with a reliable, secure and effective electronic data-collection system capable of receiving information from hospital emergency departments (ED) and results for notifiable conditions from laboratories via electronic laboratory reporting (ELR). The e-Reporting system consists of two forms of user access: 1) Online Reporting (reports viewed via a web browser), and 2) Flat File Extracts (pipe-delimited text files delivered to folders in a secured File Transfer Protocol (FTP) site).

When a particular provider/organization/lab/hospital is identified as a potential partner for data exchange, NMHIC is identified as the focal point of data collection. Once a data agreement has been signed, NMHIC is granted the authority to install 'Edge Server' technology at a facility with control set of parameters to compile datasets for the EMR system. This parameter is identified in conjunction with NMDOH and specification is created for data exchange. On a nightly basis, a process on the edge server extracts the potential data from the EMR system and stores it in a flat file format. These flat files are then extracted by NMHIC and transformed to HL7 2.3.1 for a secure transport to NMDOH. These flat files are also uploaded to e-Reporting database. The e-Reporting application can create individual extracts for different program areas that can be ingested into the program application for reporting purposes. The HL7 files provided to NMDOH are utilized in the New Mexico Electronic Disease Surveillance System via the Rhapsody Integration Engine. Messages are transformed from HL7 2.3.1 to XML for reporting purposes to CDC. Current data exchange system with NMHIC is not bi-directional as no updates are required to be transmitted back to the provider/labs.

Program Update: Two new additional feeds have been created for PRISM and LEAD application. Both of these feeds are generated from the initial e-Reporting extract.

3.4.2 Statewide Immunization Interoperability System (NMSIIS)

The New Mexico Statewide Immunization Information System (NMSIIS) is a computerized web-based database application developed to record and track immunization dates of New Mexico's children and adults, and to provide assistance for keeping NM citizens current for their recommended immunizations. Initial release took place several years ago, and a major upgrade was completed in 2009. New Mexico providers have access to the data at no cost, ensuring the State an integral tool for managing the proper immunizations for its citizens. NMSIIS can receive HL7 2.3.1 and 2.5.1 messages

directly for EHRs without the need for duplicate, manual data entry. NMDOH has implemented a bidirectional data exchange capability and is in the midst of testing that capacity. NMDOH expects to go live with bidirectional data exchange in October 2012.

3.4.3 Laboratory Information Management System (LIMS)

The University of New Mexico (UNM) Health Sciences Center (the largest academic health center in the state of New Mexico) promotes education and research while providing a high level of patient care. The Center partners with healthcare providers across the State, including HSD/MAD to provide state of the art healthcare to NM citizens. UNM recently designed and implemented a comprehensive Laboratory Information Management System (LIMS), a powerful system which can be leveraged to enhance the level of detail available in the NM HIE.

3.4.4 Death Registry Interface to MMIS

HSD/MAD is working with the Department of Health Vital Statistics to create an interface which will routinely push Death Registry data to the MMIS. The availability of registry data on a timely basis will support the Division's efforts to monitor program integrity, enroll providers to the MMIS and MIPP programs, and support ongoing oversight of potential fraud and abuse cases.

Program Update: Vital Records does transmit a file of death data to HSD on the 15th of every month, but no updates have been provided about the automation the process.

3.4.5 e-Prescribing (Medicaid Transformation Grant)

Through the e-Prescribing Medicaid Transformation Grant (ERx), HSD/MAD has made valuable inroads concerning adoption of HIT among Medicaid providers in New Mexico, working under the auspices of New Mexico Prescription Improvement Coalition (NMPIC). The project has successfully linked Medicaid data via HSD/MAD's contracted Prescription Drug Claims Processing System (PDCS), [4]with some 600 physicians using the ePrescribing functionality across the State.

3.4.6 CMS Center for Innovation Grants to Study Dually Eligible Recipients

HSD/MAD intends to apply for the recently announced CMS Center for Innovation grants to fund States' demonstration projects for beneficiaries with dual eligibility. Grant resources, if awarded, will be used to demonstrate those programs where significant health benefits and savings are derived from better coordination between Medicare and Medicaid for New Mexico's low-income seniors and recipients with disabilities.

[4] NM HSD Advance Planning Document for Health Information Technology Planning, 2009

4 Section C – Activities to Administer MIPP Program

4.1 MIPP Program Overview

With the implementation of the MIPP program in New Mexico, eligible Medicaid providers will be able to enroll to receive EHR incentive payments pursuant to the requirements described in the Department of Health and Human Services (HHS) Final Rule (Federal Register, July 28, 2010). Generally, HSD/MAD will administer the MIPP program, including identifying and approving eligible professionals (EP) and eligible hospitals (EH), determining and processing payments, reporting to the CMS Registration and Attestation System and verifying program compliance through pre- and post-payment audit actions. Specifically, the program components will be shared among those stakeholders listed in Table 1a, which provides a high level view of shared roles and responsibilities.

4.1.1 MIPP Program Roles and Responsibilities

Table 4a provides an overview of the roles and responsibilities that will comprise implementation of the MIPP in New Mexico, and includes participation by existing HSD/MAD bureau staff and contractors (ACS –now Xerox, and Meyers & Stauffer).

Table 4a – MIPP Implementation Roles and Responsibilities

Who	Role	Responsibility
Xerox	Fiscal Agent	Tracks FFS provider applications; updates MMIS provider file
Xerox	Fiscal Agent	Maintains provider portal/COTS enrollment software for MIPP enrollment, tracking and attestation
Benefits Bureau	Program Outreach	Communication and outreach to providers
Benefits Bureau	Program Eligibility and Enrollment	Monitors enrollment status
Benefits Bureau	Program Eligibility and Enrollment	Validates attestation details
Benefits Bureau	Program Eligibility and Enrollment	Approves providers and hospitals for MIPP participation
Benefits Bureau	Program Eligibility and Enrollment	Sends file of approved EPs and EHs to Program Administration Bureau for payment
Benefits Bureau	Audit	Supports post-payment audit by providing guidelines and clarifications on eligibility requirements
Program Administration Bureau	Financial Management	Generates ATRs authorizing all gross level payouts, including MIPP. ATRs identify provider, payment amount, appropriation code and authorized signature
Quality Bureau	Quality Assurance	Performs post-payment audit/notify Medicaid Provider Fraud Control Unit of suspect fraud
Myers & Stauffer	Hospital Audit Agent	Reviews EHR Units prepayment validation processes
Myers & Stauffer	Hospital Audit Agent	Performs EP and EH desk audit or onsite audit for MU

4.1.2 Impact of MIPP Implementation on HSD/MAD Operations

Implementation of the MIPP program elements necessary to support EHR incentive payments to providers will create a number of new areas of responsibility within HSD/MAD. While the distribution of associated workload will likely be refined in the coming months, the impact to current operations is summarized in the following table:

Table 4b – Impact of MIPP on Current HSD/MAD Operations

HSD/MAD Business Area	Impact to Operations / Responsibilities
MIPP Program/Operations	• Oversee the activities for the administration and oversight of the MIPP Program including work planning, resource management, and performance management • Provide status reports to the Medicaid Director as necessary • Recommend operational changes to improve efficiency and effectiveness of program • Gather operational lessons learned and best practices from other states and CMS • Resolve provider issues, questions and complaints • Oversee the revision of operational procedures for staff responsible for the administration and oversight of the MIPP Program • Oversee system test for new system changes • Oversee the training of operations staff for the initial implementation of the EHR incentive program • Coordinate with CMS and EHR registration system on operational activities and resolve interface issues • Coordinate with the State HIT Coordinator and NMHIC to understand current HIT/HIE initiatives and environment to assist in the development of a transition plan to tie into State-wide HIE
Eligibility/Enrollment	• Review and resolve registration errors between the CMS Registration System and EHR registration system (MMIS) • Validate pre-payment attestation information • Monitor status of provider eligibility through the EHR registration system dashboard • Follow up with providers to collect additional information as necessary to complete registration and attestation • Notify providers of eligibility status into the New Mexico EHR program • Notify PAB, and fiscal agent of approved eligibility to facilitate the start of the payment process
Finance	• Establish necessary project codes and funding codes so expenditures for program administration and oversight can be tracked and reported appropriately • Establish fund codes in MMIS so incentive payments to providers are tracked and reported appropriately • Generate an indication to CMS Registration and Attestation System of

HSD/MAD Business Area	Impact to Operations / Responsibilities
	MIPP Program qualification and intent to pay. • Validate accuracy of ATR process • Validate that a provider who is receiving the payment meets State-approved program guidelines • Approve the ATR prior to finalizing EHR incentive payments • Generate incentive payment and Remittance Advice (RA) to providers • Generate federal reports as required per CMS (e.g., CMS-64)
Audit	• Develop checklist tool to aid in auditing of attested information • Identify necessary documentation to validate attestation proclamations • Perform audits on EPs and EHs to validate information submitted to HSD/MAD is true and accurate
Appeals	• Hold informal review of contested decisions prior to formal appeals process • Research and prepare summary of evidence for appealed decisions related to the EHR incentive program • Review and recommend decisions on formal appeals submitted by providers
Call Center/Provider Relations	• Respond to questions regarding the MIPP Program • Forward complaints/unresolved questions to MIPP Program Manager for resolution
Communications, Training, and Outreach	• Develop a detailed communications and training plan for the MIPP Program implementation • Monitor and update the communication and outreach plan based on new HIT/HIE initiatives • Develop communication, training, and outreach materials related to the operations of the MIPP Program • Develop program information content for New Mexico web site and call center staff, including compiling of frequently asked questions • Conduct training sessions as needed • Provide assistance to providers who are participating in the MIPP Program to explain policies, tools, process and procedures • Coordinate and communicate with the NM HITREC, NMHIC, and professional associations
IT	• Oversee system changes that are needed to support the program (State) • Document the testing process for validating EPs' and EHs' capabilities to exchange information electronically (Stage 1) • Review and approve system design documents and test cases (State) • Develop user acceptance test cases and conduct user acceptance tests (State) • Perform design, development, testing, and implementation activities for required system changes (State and MMIS Vendor) • Provide ad hoc data analysis and generate reports to support the

HSD/MAD Business Area	Impact to Operations / Responsibilities
	administration and oversight of the MIPP Program (MMIS Vendor)
Medicaid HIT Planning	• Work with the HSD Secretary, Medicaid Director, State HIT Coordinator, and other key stakeholders to represent Medicaid's interests in the NM HIE • Manage the development of the next iteration of the SMHP • Perform project management activities including resource and work planning, status reporting, issue resolution, risk management, deliverable reviews and approvals, and budget management and reporting • Recommend program and policy changes to enable HSD/MAD to achieve their program goals and objectives • Manage stakeholder relationships (e.g., providers, professional associations etc.) • Coordinate and communicate with CMS regarding the MIPP Program efforts and other future projects that promote HIE • Coordinate and communicate with NMHIC and NM HITREC specifically as it relates to the SMHP • Coordinate and communicate with other states • Review future rules and regulations (e.g., Meaningful Use Stages 2 and 3) and assess impacts to the program • Work with the EHR Program Manager to develop transition plans as needed • Work with staff to identify opportunities for using clinical data to meet program goals and objectives • Document a plan for how the HSD/MAD will use clinical data to manage and improve the health of Medicaid members • Coordinate the process for reviewing and providing feedback on the definitions of stages 2 and 3 of Meaningful Use as they are being defined • Document the plan for how HSD/MAD can use HIE to improve quality of care, fiscal management and streamline operations • Work with HSD/MAD staff to determine how HIT/E can be used to support delivery of care and payment reform • Work with HSD/MAD staff to determine the feasibility of modifying policies, NMAC, and stakeholder contracts to better support and promote HIT/E efforts • Document business requirements and facilitate requirement sessions for future HIT projects (e.g., stages 2 and 3 Meaningful Use) • Summarize future rules and regulations (e.g., Meaningful User Stages 2 and 3) and document potential impacts to the program
HIT/E Adoption/NM HITREC Coordination	• Coordinate with NM HITREC in the development of a recruitment plan to encourage providers to participate in the MIPP Program and become Meaningful Users of EHR technologies • Work with NM HITREC to identify providers needing technical assistance

HSD/MAD Business Area	Impact to Operations / Responsibilities
	with EHR adoption and Meaningful Use • Coordinate with NM HITREC to provide technical assistance to providers including the assistance in the selection, implementation and Meaningful Use of certified EHR technology • Determine location and players for clinical data repository. Work with NMHIC and other stakeholders to design the best approach for clinical data, for both Medicaid and the State.

4.1.3 Impact of MIPP to MITA Business Capability

In a companion deliverable, the impact of the MIPP implementation to HSD/MAD current business processes is discussed more fully, and also addresses those areas where MITA business capability might be improved as a result of the new MIPP program features. For example, improved and automated enrollment processes for MIPP might eventually be expanded to support general Medicaid provider enrollment, and the resulting improvement in MITA business capability would be significant.

The following table displays the MITA business processes that were assessed and updated in the context of the MIPP implementation.

Table 4c – MITA Business Processes Impacted by MIPP Implementation

ID #	MITA Business Process Name	New Mexico Business Process Name
Business Relationship Management		
BR01	Establish Business Relationship	Memorandum of Understanding Execution
Operations Management		
OM07	Audit Claim/Encounter	Adjudication/ Claim Resolution
OM09	Prepare Remittance Advice/Encounter Report	Remittance Advice
OM10	Prepare Provider EFT/Check	Prepare Provider EFT/Check
OM18	Inquire Payment Status	Claim Status Inquiry
OM19	Manage Payment Information	Accounting and Financial
OM24	Manage Recoupment	Mass Adjustment Process
Program Management		
PG05	Develop and Maintain Program Policy	Program Benefit Changes
PG15	Perform Accounting Functions	Accounting and Financial Subsystem
PG16	Develop and Manage Performance Measures and Reporting	Monitor Service Level Agreement (SLAs)
PG18	Draw and Report FFP	
PG19	Manage FFP for Services	Manage FFP for Services
Program Integrity Management		
PI01	Identify Candidate Case	Health Spotlight and EFADS

PI02	Manage Case	Manage Case
Provider Management		
PM01	Enroll Provider	Provider Enrollment
PM02	Disenroll Provider	Provider Enrollment
PM04	Manage Provider Communication	Provider Relations Call Center
PM05	Manage Provider Grievance and Appeal	Fair Hearings Process
PM06	Manage Provider Information	Provider File Updates
PM07	Perform Provider Outreach	Provider Outreach

4.2 Educating Providers on MIPP Participation

Although MIPP-related communication processes and staffing plans are currently being refined, HSD/MAD anticipates using its existing program staff and structures to support the MIPP implementation (i.e., provider call center).

HSD/MAD will provide MIPP program information to EPs and EHs through provider communication and outreach activities, including dissemination of key resource points such as CMS, ONC, and the State REC. EPs and EHs will be instructed to determine if they meet MIPP guidelines, and then to register with the CMS Registration and Attestation System and submit the attestation statement through the EHR registration system enrollment application at the Fiscal Agent's web portal. Provider communication will outline essential requirements the provider must meet to enroll in the MIPP program and receive incentive payments, including:

- Holds status as a Medicaid Fee-For-Service (FFS) or a Managed Care Organization provider, either through Medicaid Provider Enrollment or the EHR Unit's EHR Incentive Provider Participation Agreement (enrollment "lite").
- Completed registration with the CMS Registration and Attestation System
- Meets participation requirements by provider type
- Registered as an authorized user of the State EHR registration system
- Prepared to submit attestation detail for the MIPP program
- Retains proper documentation to support AIU or Meaningful Use attestation

4.2.1 Provider Communication Vehicles

HSD/MAD will collaborate with a variety of providers and provider organizations to communicate with the wider provider stakeholders in the EHR Incentive Program. Provider organizations may use different combinations of vehicles.

Table 4d – Provider Communication Vehicles

Dialogue/Interact	Provider Association Meetings	Association meetings dedicated to providing information on industry trends/hot topics	Varies	Varies	Aligns with Directors of impacted policy areas – Div of Medical Management, Div of Healthcare, Div of Provider Operations, Div of Community Alternatives
	Collaboration	Leverage networks for accessing providers	Varies	Varies	Project Team
	One-on-one Meetings	Provide one-on-one sessions to provide updates on important issues or topics	Varies	Varies	
	Health Fairs	Showcase activities and receive feedback from stakeholders	Varies	Varies	
Inform	Email	Use email lists to provide project updates to stakeholders	Varies	N/A	
	Press Releases	Provide project information or updates to various state-wide newspapers	Varies		Project Team

	Newsletters	Provide program information and updates	Varies		Project Team, HITREC, Xerox
	Webinars	Provide program information & SLR demonstrations: AIU, MU, and using Group Administrator	Varies		Project Team; HITREC; Xerox
	Follow-Up	Provide web link on State's HSD website and SLR Provider Outreach Page for stakeholders to email questions	N/A	www.state.nm.us.gov, www.nm.arraincentive.com	

HSD/MAD EHR incentive program information is currently accessible via the State of New Mexico's Human Services Department web site, the fiscal agent provider portal, and the Provider Outreach Page. In collaboration with Medical Assistance Division of the Human Services Department the EHR project staff is currently working to cull out areas for collaboration and efficiencies. Such information will be reflected in future iterations of the Communication Plan with the understanding that education and information are the two key critical areas to ensure the program's success. As such, education and information will be provided on an ongoing basis through a concerted, inclusive approach using multiple methods and vehicles so as to sustain interest, communicate value and avail avenues for obtaining additional information and/or support when appropriate.

The provider web portal extends the business capabilities of Medicaid program providers by offering user-friendly tools and resources electronically. The provider portal will support the MIPP program, with links to EHR incentive program information, announcements, and a link to the state EHR registration system and the Provider Outreach Pages (http://nm.arraincentive.com). This information can be accessed by providers regardless of whether or not they have enrolled in the EHR registration system, including managed care organization providers.

4.2.2 Provider Outreach

In collaboration with the Regional Extension Center, outreach will be conducted with potentially eligible providers (EPs) and potentially eligible hospitals (EHs). Specific activities to support adoption of EHR technologies will include:

- HSD/MAD will deliver EHR presentations to EPs during Health Information Technology Regional Extension Center (HITREC) training and outreach events.
- Disseminate EHR materials to potential participants in geographic regions
- Collaborate with HITREC on establishment of training sessions for EPs and EHs and their staff members to assist in EHR adoption and achievement of meaningful use. Provide information regarding specific EHR software options and vendors' responsibilities.
- Conduct individual provider visits and webinars when necessary to ensure adequate support is available for EHR Incentive Program participation.

Program Note: Outreach is being targeted to providers in the areas of Adopt, Implement and Upgrade (AIU) certified EHR technology and Meaningful Use. Through August 2012, 747 Eligible Professionals and 29 Eligible Hospitals had been paid for AIU. The EHR project team, in collaboration with HITREC, is reaching out to providers who have completed AIU through webinars, emails and newsletters with information on Stage 1 Meaningful Use and attestation requirements for meaningful use.

Outreach to Eligible Professionals who have not yet attested to AIU in the New Mexico EHR Incentive Program is being approached in two ways:

- *Providers who are in the CMS Registration and Attestation System or in the New Mexico State Level Registry (SLR) for an extended period of time are being contacted by Project Team staff to identify reason attestation has not been completed and to provide assistance.*
- *The Project Team is using MMIS and SLR data to prioritize outreach to Eligible Professionals who have not yet registered in the EHR Incentive Program. The team is reviewing data in terms of eligible provider type, geographical location, and those with 30% or greater Medicaid claims data.*

4.3 Determining MIPP Eligibility and Enrollment

As the single state agency administering Title XIX programs, HSD/MAD approves or denies medical or social service providers requesting status as Medicaid providers. Provider enrollment activities are presently under the direction of the Benefits Bureau and are supported by mostly manual processes. Prospective providers visit the fiscal agent's (FA) provider portal, download and complete a provider application and submit it via mail to the FA, who images the document and keys the information into the MMIS for tracking.

Several barriers currently limit the Division's ability to automate the Medicaid provider enrollment application process. First, the MMIS is unable to accept and process an electronic application. Secondly, the current New Mexico legal practice requires a "wet" signature on all legal documents and has been interpreted to apply to the Medicaid provider agreements.

Provider enrollment staff in the Benefits Bureau performs the basic credentialing process for fee-for-service medical providers, through paper requests to licensing and certification agencies. Once this process is complete, the provider enrollment staff notify the FA of the Bureau's decision and directs the FA to notify the provider of his/her Medicaid program participation status and, if eligible, provides billing instructions for the appropriate provider type and specialty. Servicing providers with managed care organizations (MCOs) are credentialed by the managed care organizations themselves per contract agreements between HSD/MAD and MCOs.

The MIPP provider registration and attestation process will provide an automated process through the installation of a "commercial off the shelf" (COTS) product developed by Affiliated Computer Systems (ACS) –now Xerox. The COTS product will support the enrollment and attestation process, including receipt of provider registration data from the CMS Registration and Attestation System via interface and allow for provider submission of documentation. This application will become the EHR incentive program registration and attestation system and will be accessed through http://nm.arraincentive.com for registration and attestation in August 2011. Xerox, on behalf of the State of NM, will accept registration data for NM's Medicaid providers from the CMS Registration and Attestation System through the following process: 1) The NLR hosts the B6 on their FTPS (with X509 cert) site. This site is also known as GenTran. 2) ACS uses MoveIt Central to download the file from NLR to the ACS servers. 3) Microsoft SQL Server components (MS SQL Agent (scheduler), SSIS (integration service)) import the B6 file into SQL Server. EHR registration system interface testing with the CMS Registration and Attestation System on behalf of the New Mexico client has been successfully completed. The CMS Registration data was moved to the test environment the week of 6/6/11. We are on track to promote the CMS Registration data to the UAT environment the week of 6/20/11 and to the production environment the week of 6/27/11.HSD/MAD expects to have its EHR registration and attestation system implemented and able to accept enrollment in August 2011.

Medicaid provider enrollment information is pre-loaded into the EHR registration system from the MMIS and serves as an initial validation of provider registration and eligibility information.

It should be noted that while EPs and EHs can submit attestation electronically through the enrollment system, they will be required to print, sign and mail the attestation document to HSD/MAD to be compliant with state policy requiring a "wet" signature. Incentive payments cannot be released until HSD/MAD has received the signed attestation document.

4.4 Registration with CMS Registration and Attestation System

The CMS Registration and Attestation System provides much of the EP's or EH's enrollment information for first year participation in the MIPP program. When providers first register with the CMS Registration and Attestation System, they must provide:[5]

a. Name
b. NPI – National Provider Identifier
c. Business address and telephone number
d. PTAN/CCN – Provider number (for hospitals)
e. TIN – Taxpayer Identification Number that is to be used for payment
f. Provider's intent to participate as a Medicaid or Medicare provider and the State in which the provider will participate.

The CMS Registration and Attestation System will issue a registration/tracking number to the provider for future correspondence and tracking enrollment progress, meanwhile sending a daily batch file to the EHR Registration system enrollment module with provider enrollment updates. The EHR registration system will also accept routine updates from the CMS Registration and Attestation system containing CMS attestation detail relating to Medicare eligible hospitals.

[5] Federal Register/v.75, No. 144, July 28, 2010, p. 44571-44572, 495.10, Participation Requirements for EPs, EHs and CAHs

4.5 MIPP Program Participation Requirements

Table 4.e below summarizes program requirements by provider type, and discusses at a high level the method by which HSD/MAD will verify Medicaid patient volume.

Table 4e – MIPP Participation Requirements and Calculation of Medicaid Patient Volume

Entity -- Eligible Professional (EP) or Eligible Hospital (EH)		Definition	Qualifying Patient Volume Threshold[6]	Patient Volume Verification Method
Physicians (M.D, D.O)	Physician, including Pediatrician and Psychiatrist Can practice in any setting, other than hospital based, including public health office.	Non-hospital based – *cannot* have 90% or more of the EP's services performed in a hospital inpatient or emergency room setting.	30% Medicaid, 20% Medicaid for Pediatricians, with reduced incentive or	**Medicaid patient encounters** in any 90-day reporting period in the preceding calendar year **divided by total patient encounters** in same 90-day period[7] Or [Total Medicaid patients assigned to the provider in any representative continuous 90-day period in the preceding calendar year with at least one encounter in the year preceding the start of the 90-day period] + [Unduplicated Medicaid encounters in that same 90-day period] *100 [Total patients assigned to the provider in the same 90-day with at least one encounter in the year preceding the start of the 90-day period] + [All unduplicated encounters in that same 90-day period]
	predominately practicing in FQHC/RHC	• Over 50% of total patient encounters over 6 mos. occur at FQHC or RHC. • Not subject to hospital-based exclusion.	30% patient volume attributed to needy individuals • Medicaid or CHIP • Uncompensated care or • Services at no cost or sliding scale	Can use either option above but with needy individuals used in numerator and denominator
Dentist	May practice in any setting, including predominately practicing in FQHC/RHC	Non-hospital based – *cannot* have 90% or more of the EP's services performed in a hospital inpatient or emergency room setting.	30% Medicaid or 30% Needy Individuals For EPs practicing predominantly in FQHC/RHC	Can use either option above

[6] Federal Register/v.75, No. 144, July 28, 2010, p. 44578-44579, 495.306 Establishing Patient Volume
[7] Federal Register/v.75, No. 144, July 28, 2010,p. 44578, 495.304 Medicaid Provider Scope and Eligibility

Certified Nurse Midwives	May practice in any setting including predominately practicing in FQHC/RHC	Non-hospital based – *cannot* have 90% or more of the EP's services performed in a hospital inpatient or emergency room setting.	30% Medicaid or 30% Needy Individuals For EPs practicing predominantly in FQHC/RHC	Can use either option above
PA @ FQHC/RHC led by PA	Practice limited to FQHC or RHC	Not subject to hospital-based exclusion	30% Needy Individual	Can use either option above
Nurse Practitioner	May practice in any setting including predominately practicing in FQHC/RHC	Non-hospital based – *cannot* have 90% or more of the EP's services performed in a hospital inpatient or emergency room setting.	30% Medicaid or 30% Needy Individuals For EPs practicing predominantly in FQHC/RHC	Can use either option above
Eligible Hospitals	Acute Care Hospitals and Critical Access Hospitals	• CCN range • Avg. patient stay <25 days.	10% Medicaid	Must use patient encounters, but encounters for hospitals are inpatient discharges and ER visits
	Children's Hospital	CCN range	No requirement	N/A
IHS & 638 Hospitals	All IHS acute care hospitals	• CCN range • Avg. patient stay <25 days.	10% Medicaid	Must use patient encounters, but encounters for hospitals are inpatient discharges and ER visits. Verification from RPMS data runs.

4.5.1 Eligible Professionals (EP)

HSD/MAD defines MIPP-eligible professionals according to CMS' Final Rule, which includes the following provider categories:

- Physicians = Any provider who has a provider type of 301 (Doctor of Medicine) or 302 (Doctor of Osteopathy)
- Physician Assistant (practicing in an FQHC or RHC that is "so led" by a Physician Assistant) = Any provider affiliated with FQHC or RHC with a Provider Type of 305*
- Pediatrician = Provider Type 301, with specialty Type 037.
- Nurse Practitioner = Any provider with a provider type of 316
- Certified Nurse Midwife = Any provider with a provider type of 322
- Dentist = Any provider with a provider type of 421

* "So led" is defined per page 44483 of the Final Rule as: (1) the PA is the primary provider in a clinic (2) the PA is a clinical or medical director at the practice (3) the PA is an owner of the FQHC or RHC.

HSD/MAD will identify EPs by their associated provider type and specialty in the MMIS provider master file. Since identification of qualifying PAs is not possible solely through the MMIS, HSD/MAD will work with the New Mexico Primary Care Association to effectively identify this provider group. HSD/MAD will require EPs to be enrolled as a provider with Medicaid FFS or with a Medicaid Managed Care Organization.

HSD/MAD will receive updates from the Vital Records in the Department of Health to capture Death Registry detail. Additional interfaces to the EHR registration system will eventually be introduced with the fiscal agent contracts with Lexis Nexis for provider credentialing after January 1, 2013. (i.e., to Vital Records in the Department of Health to capture Death Registry detail).

An EP will identify his/her total patient volume and the Medicaid patient volume from practice management software or with hard copy files. Patient volume data will be entered by an EP through the EHR registration system. Pre-payment determinations of the validity of the Medicaid data entered into the EHR registration system during the initial stages of the program will be handled through query reporting of aggregate claims and encounter data in MMIS. NM employs a Payment Coordinator who will contact the provider and request practice management reports that verify the Total Encounters entered if Medicaid encounter/claims data deviates from MMIS by a defined threshold.

In the near future, additional functionality will be applied to the EHR registration system that will allow for the proactive gathering of the practice management reports that supports the Total Encounters entered. Providers will be requested to attach their practice management reports that support the encounter data entered to demonstrate Medicaid eligibility. Introducing this functionality further streamlines the process for the Payment Coordinator and allows him or her to have the supporting data from the beginning of the pre-payment verification process.
Program Note: The SLR has the capacity to allow for providers to attach practice management reports when requested by HSD/MAD during the prepayment validation process.

For the longer term solution, the EHR registration system will introduce functionality that will conduct automated verification of encounter data via the evaluation of claims. This future functionality will compare the Medicaid eligibility percentage that resulted from the data entered in the EHR registration system by the provider to the results of the same formula applied to the aggregate claims data in NM's MMIS system. A State-identified variance will be applied to the automated validation and the provider will pass or fail. For example, if the State selects a 10%+/- variance and the SLR calculated Medicaid eligibility is 41% and the Omnicaid calculation returns 31%, the provider would pass**.** Validation of non hospital-based providers will be determined by place of service codes in claims data. See Table 4e for a list of participation requirements.

HSD/MAD will verify qualifying EP information and attestations as part of the approval process to the extent that documentation is available. The body of information available to HSD/MAD will contribute to the level of risk assigned to an EP for audit purposes.

4.5.2 -Eligible Professionals (EP) in Group Practice

EPs practicing in a group setting may be eligible to receive MIPP payments if they are an enrolled Medicaid FFS or MCO provider. The patient volume percentage may be calculated on the individual EP's practice volume or the group practice volume, but each provider must follow the same methodology for calculating patient volume. A servicing provider operating in a group practice who wishes to receive MIPP payments in his/her own name may do so. A detailed listing of EP program requirements is identified in Table 4e.

EPs contracting with several groups will be required to identify the group or practice where s/he is using certified EHR software for at least 50% of his/her patient volume, attest to AIU or meaningful use, and has 30% Medicaid patient volume.

HSD/MAD will verify group affiliations, total Medicaid patient volume for the group, non-hospital based status, and proof of AIU or meaningful use data for the EP prior to approving EPs for the first participation year. HSD/MAD will ask group EPs to submit a document to the EHR registration system during the attestation process that list all EPs participating in that group and their patient volumes. Each EP in a group will also submit documents that evidence AIU, such as a purchasing or service contract, or meaningful use data as output from the provider certified EHR technology. MMIS maintains the affiliations between groups/clinics and individual providers in those groups. Affiliations are documented. This affiliation is evaluated before information is initially placed in MMIS and periodic verifications of affiliations occur. We will verify that this connection, indeed, exists. Periodically, the individuals affiliated with a group are reported to the group in order for the group to update their records. Individuals are likewise provided their affiliated group information for the individual to update.

Program Update: HSD/MAD has implemented program and policy changes pursuant to the requirements described in the Department of Health and Human Services (HHS) Stage 2 Final Rule.

Stage 2 Eligibility Changes Effective Program Year 2013 and Forward—HSD/MAD implemented the following program changes and screens/forms in the SLR were updated as appropriate:

- *The option to permit providers to calculate total Medicaid encounters or total needy individual patient encounters in any representative, continuous 90-day period in the 12 months preceding the EP's date of attestation. This option is in addition to the regulatory language that bases patient volume on the prior calendar year.*
- *The option to permit providers to calculate the Medicaid patients assigned to the EP's panel in any representative, continuous 90-day period in either the preceding calendar year or in the 12 months preceding the EP's date of attestation, when at least one Medicaid encounter took place with the Medicaid patient in the 24 months prior to the beginning of the 90-day period.*

- *Permit providers to include CHIP recipients in their patient volume calculation under the expanded definition of patient encounters to include patients who are Title XIX eligible and who meet the definition of "optional targeted low income children" under section 1905(u)(2) of the Act.*
- *The revised definition of "practicing predominantly" to allow EPs to use either: (1) the most recent calendar year; or (2) the most recent 12 months prior to attestation. Changes to the State Level Registry or MMIS system were not required to accommodate the revised "practicing predominantly" definition.*

4.5.3 Public Health Professionals

New Mexico has 53 public heath offices, including at least one office in every county in the state. The offices are organized into 5 Regions and staffed by State employees. Each Region is identified as a Medicaid billing provider, while the professionals in the field offices are identified as the servicing providers.

Physicians, nurse practitioners, certified nurse midwives and dentists employed by the public health offices can participate as EPs in the MIPP program if they meet all program enrollment criteria. NMDOH is working with HSD/MAD to confirm patient volume and Medicaid percentages across the public health Regions and for individual practitioners. NMDOH anticipates some of their physicians will meet either the 20% Medicaid patient threshold for pediatricians or the 30% Medicaid patient threshold for other professionals.

DOH currently uses more than one billing system for Medicaid and will be identifying all Medicaid members from all sources to present a consolidated picture for MIPP program eligibility. In addition to meeting the Medicaid patient volume requirement, these providers must meet the other participation requirements identified in Table ee above.

4.5.4 Eligible Hospitals (EH)

Eligible hospitals must be an active Medicaid FFS provider or Medicaid Managed Care Organization provider and meet the requirements as specified in the Final Rule, e.g., classified by Medicare as an acute care hospital or Children's hospital with a length of stay under 25 days. The HSD/MAD provider types include:

- Acute Care hospital = Any provider with a provider type of 201 – Acute Care Hospital or 221 – IHS Hospital; and*
- Children's Hospital (N/A)**

* An acute care hospital is defined as a health care facility where the average length of patient stay is 25 days or fewer and a Medicare CCN number (i.e. provider number) whose last four digits in the series run from 0001 through 0879 and 1300 through 1399.

** NM does not currently have any separately certified children's hospitals.

The IHS is currently developing reports that will document EH patient volume. IHS is also in the process of creating a report that captures the data required for states' calculation of hospital incentive payments. Data for each report will come from the Clinical Information System, (the Resource and Patient Management System), at each IHS facility and are considered to be auditable data sources. These reports will provide the data used by IHS providers for attestation. Reports can be generated for an individual Eligible Provider, a group, or a hospital/ER and output can be provided as total values or as a detailed listing. HSD/MAD will validate Medicaid patient volume reported by IHS against MMIS claims data for EPs and EHs.

Program Note: HSD/MAD did not pre-determine the Medicaid patient volume or the one-time payment calculation for any EH in order to expedite the EH participation. The data was only used to estimate initial enrollment and for budgeting.

Program Update: HSD/MAD has implemented program and policy changes pursuant to the requirements described in the Department of Health and Human Services (HHS) Stage 2 Final Rule.

Stage 2 Eligibility Changes Effective Program Year 2013 and Forward—HSD/MAD implemented the following program changes and screens/forms in the SLR were updated as appropriate:

- *The option to permit providers to calculate total Medicaid encounters in any representative, continuous 90-day period in the 12 months preceding the eligible hospital's date of attestation. This option is in addition to the current regulatory language that bases patient volume on the prior federal fiscal year.*
- *Permit providers to include CHIP recipients in their patient volume calculation under the expanded definition of patient encounters to include patients who are Title XIX eligible and who meet the definition of "optional targeted low income children" under section 1905(u)(2) of the Act.*

4.5.5 IHS and Tribal 638 Practitioners

Medical practitioners who are employees of the IHS (or the 638 tribal entities) are not required to be licensed in NM, as long as they are licensed in at least one other state. In order for IHS and Tribal 638 EPs to participate in the New Mexico MIPP program they must be enrolled with Medicaid FFS or Medicaid Managed Care Organization, meet Medicaid patient volume requirement, and meet other participation requirements identified in Table 2a above. HSD/MAD is coordinating with IHS to receive detailed supplemental information for these EPs. As with IHS hospitals, IHS is developing reports that will document patient volume for individual EPs, and for group practices. Data for each report will come from the Clinical Information System, (the Resource and Patient Management System), at each IHS facility. HSD/MAD will validate IHS patient volume data against MMIS claims and encounter data.

4.6 Attestation of Adoption, Implementation, Upgrade

4.6.1 Attestation Process for AIU

The EHR registration system includes screens/forms to accommodate the AIU and program eligibility attestation requirements and thus becomes the repository for MIPP data. Once registered as an authorized user of the EHR registration system, a provider ~~will~~ submits attestation details and provides documentation as evidence of AIU, such as a sales or service contract. All providers participating in the MIPP must be enrolled Medicaid FFS or Medicaid Managed Care Organization providers. A provider who only participates as a Managed Care Organization provider must supply sufficient financial information to MAD to allow the MMIS to make payment, including a tax identification number or social security number.

EHs also submit attestation details of meeting program requirements through the EHR registration system. Those EHs that have been deemed eligible under Medicare will not be required to resubmit duplicative attestation details, since those details will be available to the State through interface with the CMS Registration and Attestation System.

Program Note: HSD/MAD allows providers to include claims/encounter data from border states, if needed, in order to meet the patient volume threshold. However out of state data requires HSD/MAD to contact the relevant state to confirm that data and may sometimes delay the validation process.
The EHR registration system includes a dashboard-type tool that allows MIPP Program Operations staff to validate attestations, some of which are automated through interfaces with the MMIS and other databases.

The EHR staff, located in the Systems Bureau, leverage existing resources (e.g., MMIS provider file, death registry) to complete the validation process, verifying data manually where necessary, and notifying the provider via email of conflicting or missing information. For a full discussion of program oversight and auditing, see Section 5.

In the meantime, the EHR registration system will successfully automate key functions in the enrollment process, including:

a. Verifying an enrollee's active Medicaid provider status in either the FFS Medicaid program or as a Medicaid Managed Care Organization provider
b. Verifying enrollee's Medicaid patient volume
c. Notifying providers of eligibility determination
d. Producing a file of EPs and EHs, and forwarding to the FA for updating the provider master file
e. Producing a file for the Program Administration Bureau to support and authorize the creation of Accounting Transaction Requests (ATR)

f. Notifying providers of MIPP eligibility and anticipated payment schedule
g. Notifying CMS Registration and Attestation System of authorized MIPP payments via file exchange

4.6.2 Verification of Adopt, Implement or Upgrade Attestation

HSD/MAD plans to verify the professional's status as a fee-for-service provider prior to payment, e.g., validating the provider is currently enrolled as an active provider for the Medicaid program (the FFS or Medicaid Managed Care program); currently is classified as a billing provider as a payee to receive financial MIPP payments only, or has assigned payment to his affiliated employer and is not found on a sanction list by the HHS Office of Inspector General (OIG) or State Medicaid Provider Fraud Control Unit prior to payment. The Federal OIG provides HSD/MAD a periodic list of providers under sanction, and HSD/MAD is required to cancel the Medicaid program participation for any provider found on the list. A similar process applies to those providers sanctioned by the Medicaid Provider Fraud Control Unit.

Other elements of MIPP eligibility, including Medicaid (or needy individual) patient volume, not hospital based and AIU of certified EHR technology will be verified pre-payment, where data is readily available.

Through the audit staff and contractors with the EHR Unit, the Division will validate all MIPP program requirements in its formal post-payment audit process. The process includes auditing of initial AIU attestations and, after the first participation year, meaningful use measures. For a full discussion of processes supporting MIPP program oversight, see Section D – The MIPP Program Audit Strategy.

4.7 Attestation of Meaningful Use (MU)

During year 1 of the program, the EHR registration system was modified to include Meaningful Use (MU) attestation functionality. Design of the MU attestation screens and forms was approved by CMS. The NM State Level Registry (SLR) began accepting MU attestations in April 2012. Beginning with Program Year 2012, providers in the NM Medicaid EHR Program have the option to attest to AIU or MU for their first participation year, and must attest to MU for all subsequent program participation years. Each year, providers must meet all program eligibility criteria in the SLR.

All Eligible Hospitals (EHs) currently participating in the New Medicaid EHR Incentive Program are participating in the Medicare EHR Incentive Program. An EH that is a Meaningful EHR User under the Medicare EHR Incentive Program is deemed a Meaningful User for Medicaid. EHs will attest to MU in the CMS EHR Program first, and then attest to eligibility requirements in the New Mexico SLR.

EHR Reporting Period

The first time attesting to MU, providers must demonstrate meaningful use for a 90-day EHR reporting period; in subsequent years, providers will demonstrate meaningful use for a full year EHR reporting period (an entire federal fiscal year for hospitals or an entire calendar year for EPs) except in 2014, which is described below under *Stage 2 EHR Program Final Rule—Meaningful Use* , Program Year 2014 changes.

Stage 1 and Stage 2 Meaningful Use

To receive a Meaningful Use payment, an EP must demonstrate the Meaningful Use (MU) of the certified EHR technology. Three components of MU are:

1. Use of certified EHR in a meaningful manner;
2. Use of certified EHR technology for electronic exchange of health information to improve the quality of health care; and
3. Use of certified EHR technology to submit Clinical Quality Measures (CQMs) and other measures selected by CMS.

Requirements for demonstrating MU will be completed in three separate stages. Stage 1 and Stage 2 of MU require providers to meet the following objectives:

- Report on required core objectives
- Report on selected menu set objectives
- Report on certain clinical quality measures

The exact number of core and menu set requirements and clinical quality measures (CQMs) vary depending upon:

- whether the provider is an eligible professional or eligible hospital;
- whether the provider is attesting to Stage 1 or Stage 2 of Meaningful Use; and
- for Stage 1, in what program year the provider is attesting to Stage 1.

For Stage 1 MU, Eligible Professionals must report on:

Program Years 2011 - 2012	Program Year 2013	Program Year 2014
15 core set measures	14 core set measures	13 core set measures
5 of 10 menu objectives	5 of 10 menu objectives	5 of 9 menu objectives w/o exclusions or all 9 menu objectives
3 core or alternate core CQMs	3 core or alternate core CQMs	9 out of 64 CQMs, cover at least 3 of the 6 NQS domains
3 additional CQMs	3 additional CQMs	

For Stage 1 MU, Eligible Hospitals must report on:

Program Years 2011 - 2012	Program Year 2013	Program Year 2014
14 core set measures	12 core set measures	11 core set measures
5 of 10 menu objectives	5 of 10 menu objectives	5 of 10 menu objectives w/o exclusions or all 10 menu objectives
15 CQMs	15 CQMs	16 out of 29 CQMs, cover at least 3 of the 6 NQS domains

Stage 1 MU—2013

- Computer Point of Entry (CPOE) entered by CMAs to include licensed health care professionals when appropriately credentialed
- CPOE Alternate Measure to require more than 30% of the medication orders created by the provider during the EHR reporting period are recorded using CPOE
- New exclusion for generating and transmitting eRx when there is no pharmacy within the organization and there is not a pharmacy that accepts eRx within 10 miles at the start of the reporting period
- Vital Signs Alternate Measure (Optional in 2013, Required 2014 and forward) when more than 50 percent of all unique patients seen by the provider during the EHR Reporting Period have blood pressure (ages 3 and over only) and height and weight (all ages) recorded as structured data
- New exclusions for Vital Signs (Optional in 2013, Required 2014 and forward) for any EP who sees no patient 3 years or older; believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice; when they believe that height and weight

are relevant to their scope of practice, but blood pressure is not they can exclude blood pressure; or when they believe that blood pressure is relevant to their scope of practice, but height and weight are not they can exclude height and weight;

- Incorporate CQMs in the definition of Meaningful Use and remove separate core objective for hospitals
- Remove requirement for the exchange of key clinical information electronically; and
- Add the wording "according to applicable law and practice" to measures related to
    - Immunizations
    - Reportable Labs
    - Syndromic Surveillance

Program Year 2014 and Forward:

Current Federal Rule v. Proposed Federal Rule

Note: In light of the proposed new federal rule governing EHR Incentive Programs, the State may postpone opening the NM SLR for 2014 attestations under the currently approved federal regulation for EHR Incentive Programs— Federal Register/Vol. 77, No. 171/Tuesday, September 4, 2012/Rules and Regulations.

On May 20, 2014, the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) released a proposed rule that would allow eligible professionals, eligible hospitals, and critical access hospitals to continue to use 2011 Edition certified electronic health record technology (CEHRT) for the reporting period in 2014 for the Medicare and Medicaid EHR Incentive Programs.

The state will work with the Xerox SLR development team to develop or change any SLR screens necessary for providers to attest under the proposed new rule, and implement these changes in the SLR should the new rule become effective. The state would update its SMHP as necessary for the new rule and seek CMS approval of any SMHP updates and any related SLR screens prior to implementation.

The state has concerns with administering the EHR Program under two different Final Rules governing the same Program Year, especially with the tracking and verifying of attestations. During the 60-day comment period (began 5/23/2014), many questions remain unanswered as to how attestations submitted under the current rule may be impacted if the new rule becomes effective. Additionally, having two federal regulations governing the EHR program will be challenging for providers as they seek to comply with program regulations.

HSD/MAD will implement the following program changes beginning in Program Year 2014.

- Under the currently approved final rule, the following changes apply to all providers attesting to Stage 1 or Stage 2 MU in Program Year 2014.
- Should the proposed rule become effective, the following changes would apply ***only*** for providers opting to attest to 2014 Stage 1 or Stage 2 MU as defined in the Federal Register/Vol. 77, No. 171/Tuesday, September 4, 2012/Rules and Regulations. Under the new rule, providers will have the option of attesting to 2013 Stage 1 Objective and Measures using 2011 Edition certification or using the combination 2011 & 2014 Edition certification. Providers will make their decisions based on their CEHRT certification Edition at the time of attestation.
- Should the proposed rule not become effective, the following changes would continue to apply to all providers attesting to Stage 1 or Stage 2 MU in Program Year 2014.
- To attest to AIU in Program Year 2014, providers must have CEHRT upgraded to the 2014 Edition standard under the current rule and the proposed rule.

The State's SLR vendor, Xerox, updated the appropriate SLR screens/forms necessary to implement Stage 2 Final Rule changes for 2014, and these have been approved by CMS. Xerox is currently testing SLR system changes prior to implementation. Subsequent to CMS approval of New Mexico's SMHP-U, the target dates for the New Mexico EHR Incentive Program to begin accepting 2014 attestations may change from those listed below. In the event of a change, new dates will be announced at a later time.

- EPs— June/July 2014
- EHs: AIU and 1st Year Stage 1 MU—June /July 2014
- EHs—2nd Year Stage 1 MU and Stage 2 MU—October 2014

CEHRT 2014–All providers, regardless of their stage of MU (Stage 1 or Stage 2), must have their certified EHR technology upgraded to the 2014 Edition EHR Certification Criteria as adopted in the *Health Information Technology: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition; Revisions to the Permanent Certification Program for Health Information Technology, Final Rule* published on September 4, 2012 (45 CFR §170).

EHR Reporting Period—2014 Only: All providers, regardless of their stage of MU (Stage 1 or Stage 2), are only required to demonstrate MU for 3-month EHR Reporting Period (42 CFR §495.4).

- EPs may choose any continuous 90-day period in calendar year 2014. EPs may, but are not required to, use a calendar quarter for the 2014 EHR Reporting Period.
- EHs and CAHs must use a federal fiscal year quarter as the 2014 EHR Reporting Period:
    - October 1, 2013 to December 31, 2013
    - January 1, 2014 to March 31, 2014
    - April 1, 2014 to June 30, 2014
    - July 1, 2014 to September 30, 2014

Batch Reporting—New Mexico is not opting to allow batch reporting of MU data.

Stage 1 MU—2014

Core

- Vital Signs: Alternate measure from 2013 replaces the original measure
- Patient Electronic Access: Addition of new core objective to provide patients with ability to view online, download and transmit health information for all providers
- Removal of clinical quality measures as a separate core objective for EPs
- Removal of electronic copy of health information core objective
- Removal of electronic access to health information menu objective

Menu

- Exclusions no longer count toward minimum number of menu objectives. Providers will attest to 5 menu objectives without an exclusion, ***or***:
    - EPs will attest to all 9 menu objectives
    - EHs will attest to all 10 menu objectives

Stage 2 MU—2014

Core and Menu

EPs and EHs must attest to Stage 2 MU Objectives and Measures and defined in the Federal Register/ Vol. 77, No. 171/Tuesday, September 4, 2012/Rules and Regulations.

- Exclusions will not count toward minimum number of menu objectives.

Eligible Professionals must report on:

Program Year 2014
17 core set measures
3 of 6 menu objectives w/o exclusions or all 6 menu objectives
9 CQMs, cover at least 3 of the 6 NQS domains

Eligible Hospitals must report on:

Program Year 2014
16 core set measures
3 of 6 menu objectives w/o exclusions or all 6 menu objectives
16 out of 29 CQMs, cover at least 3 of the 6 NQS domains

Clinical Quality Measures (CQMs)—MU Stages 1 and 2

Beginning in Program Year 2014, all providers attesting to Stage 1 or Stage 2 must select CQMs from at least 3 of the 6 key health care policy domains recommended by the Department of Health and Human Services' National Quality Strategy (NQS):

1. Patient and Family Engagement (4 measures)
2. Patient Safety (6 measures)
3. Care Coordination (1 measure)
4. Population and Public Health (9 measures)
5. Efficient Use of Healthcare Resources (4 measures)
6. Clinical Processes/Effectiveness (40 measures)

EPs will report on 9 out 64 CQMs. In the NM SLR, providers will have the option of choosing nine Pediatric Measures, nine Adult Measures, or choosing nine measures from a total of 64 CQMS.

Electronic Reporting of CQMs—EPs will not be required to submit CQMs electronically.

EHs will choose 16 CQMs from a total of 29 measures. All EHs currently participating in the New Medicaid EHR Incentive Program are participating in the Medicare EHR Incentive Program. EHs will attest to MU in the CMS EHR Program first, and then attest to eligibility requirements in the New Mexico SLR. EHs will attest to CQMs in accordance with the Medicare EHR requirements.

4.7.1 Attestation Process

In addition to meeting participation requirements in Table 4e, a provider who participates their second payment year will attest to meeting meaningful use measures as outlined by CMS for Stage 1. All providers participating in the MIPP must be enrolled Medicaid FFS or Medicaid Managed Care Organization providers. A provider who only participates as a Managed Care Organization provider must submit a EHR Provider Participation Agreement Form to MAD to allow the MMIS to make payment, including a tax identification number or social security number.

The EHR registration system includes screens to accommodate meaningful use and program eligibility attestation requirements and thus becomes the repository for MIPP data. Once registered as an authorized user of the EHR registration system, a provider will submit attestation details such as patient volume and reporting the results of meaningful use measures.

The meaningful use screens in the EHR State registration system will identify each objective, provide exclusion criteria, and allow providers to exclude themselves from a measure if appropriate. When an objective requires data from a patient record, the provider must attest to as to whether the data was

extracted from all patient records or only from patient records maintained using certified EHR technology. Attestations are in the form of answering yes or no to certain measures, or entering a numerator and denominator from the certified EHR for certain measures. Where a provider fails to meet a measure, the EHR registration system will allow a provider to continue to another measure, but it will not allow them to successfully submit an attestation until all measures have been met.

EHs will also submit attestation details of meeting program requirements through the EHR registration system. Those EHs that have been deemed eligible under Medicare will not be required to resubmit duplicative attestation details, since those details will be available to the State through the C5 interface with the CMS Registration and Attestation System.

4.7.2 Verification of Meaningful Use Attestation

The EHR registration system will include a dashboard-type tool to allow MIPP Program Operations staff to validate attestations, some of which will be automated through interfaces with the MMIS and other databases. HSD/MAD will use aspects of the CMS Meaningful Use Audit Strategy for prepayment validation of some meaningful use measures – such as denominator validations as outlined by CMS, and validating applicable exclusions against HSD/MAD MMIS data. Prepayment validation may also include the request of a provider's EHR meaningful use report(s). Additionally, HSD/MAD will validate testing/reporting of public health measures with the New Mexico Department of Health.

HSD/MAD plans to verify the professional's status as a fee-for-service provider prior to payment, e.g., validating the provider is currently enrolled as an active provider for the Medicaid program (the FFS Medicaid program or Medicaid Managed Care program); currently is classified as a billing provider, as a payee to receive financial MIPP payments only, or has assigned payment to his employer and is not found on a sanction list by the HHS Office of Inspector General (OIG) or State Medicaid Provider Fraud Control Unit prior to payment. The Federal OIG provides HSD/MAD a periodic list of providers under sanction, and HSD/MAD is required to cancel the Medicaid program participation for any provider found on the list. A similar process applies to those providers sanctioned by the Medicaid Provider Fraud Control Unit.

Other elements of MIPP eligibility, including Medicaid (or needy individual) patient volume, not hospital based and AIU of certified EHR technology will be verified pre-payment, where data is readily available.

Through the audit staff and contractors with the EHR Unit, the Division will validate all MIPP program requirements in its formal post-payment audit process. The process includes auditing of initial AIU attestations and, after the first participation year, meaningful use measures. For a full discussion of processes supporting MIPP program oversight, see Section 5 – The MIPP Program Audit Strategy.

4.8 Attestation Elements Required

Table 4.f below organizes attestation elements which must be collected to support MIPP implementation.

Table 4f – MIPP Attestation Elements

Provider Type	EHR Year 1 Reporting Period	EHR Years 2 through 6 Reporting Period	Yes No Attestation	Data Provided Attestation
All	The EP/EH must define the 90 day period used for meeting patient volume requirements	The EP/EH must define the 90 day period used for meeting patient volume requirements		Start date of the 90 day representative period is entered in the Medicaid eligibility section of the SLR by the EP or EH. The SLR system automatically calculates the end date of the 90 day representative period.
EPs	The EP must identify the method by which they meet patient volume (panel vs. encounter)	The EP must identify the method by which they meet patient volume (panel vs. encounter)		EPs can enter Total Encounters and Total Medicaid Encounters and Panel Members and Medicaid Panel Members in the Medicaid eligibility section of the EHR registration system
All	The EP/EH must provide the number of Medicaid patients, by payment source. Medicaid payers include: NM FFS, MCO payers and out-of-state Medicaid.	The EP/EH must provide the number of Medicaid patients, by payment source. Medicaid payers include NM FFS, MCO payers and out-of-state Medicaid.		EPs can enter Total Medicaid Encounters, Total Medicaid Panel Members and Needy Individuals if the provider claims to predominantly practice in an FQCH and RHC in the Medicaid eligibility section of the EHR registration system EHs can enter Total Medicaid Discharges in the Medicaid eligibility section of the EHR registration system.
EPs and EHs	The EP/EH must provide the total number of patients	The EP/EH must provide the total number of patients		EPs can enter Total Encounters, Total Panel Members and Needy Individuals if the provider claims to predominantly practice in an FQCH and RHC in the Medicaid eligibility section of the EHR registration system EHs can enter Total Discharges in the Medicaid eligibility section of the EHR registration system
Select EPs	EPs predominantly practicing in an FQHC or RHC who choose to use needy individuals patient volume must provide the	EPs predominantly practicing in an FQHC or RHC who choose to use needy individuals patient volume must provide the total		An EP can identify him/herself as serving predominately in an FQHC or RHC in the Medicaid eligibility section of the EHR registration system. When FQHC or RHC is

Provider Type	EHR Year 1 Reporting Period	EHR Years 2 through 6 Reporting Period	Yes No Attestation	Data Provided Attestation
	total number of needy individuals as defined by the rule.	number of needy individuals as defined by the rule.		selected, an additional required field appears where the provider must enter his/her total number of needy individuals as defined by the rule. An EP who chooses to use only Medicaid encounters for Patient Volume, can enter zero in the needy individuals box.
Select EPs	EPs predominantly practicing in an FQHC or RHC must provide the total number of patients	EPs predominantly practicing in an FQHC or RHC must provide the total number of patients		EPs can enter Total Encounters in the Medicaid eligibility section of the EHR registration system
Physician Assistant	The Physician Assistant (PA) must attest that he/she is working in an FQHC or RHC so led by a PA.	The Physician Assistant (PA) must attest that he/she is working in an FQHC or RHC so led by a PA.	X	Upon saving his/her Medicaid eligibility, if the provider type = Physician Assistant, the EHR registration system will validate that the FQHC or RHC option is selected.
EPs	The EP attests that he/she practices predominantly in an FQHC or RHC, if applicable	The EP attests that he/she practices predominantly in an FQHC or RHC, if applicable	X	An EP can identify him/herself as serving predominately in an FQHC or RHC in the Medicaid eligibility section of the EHR registration system.
EPs	The EP is a non-hospital based professional as defined by the rule, except those EPs practicing predominantly in FQHC or RHC	The EP is a non-hospital based professional as defined by the rule, except those EPs practicing predominantly in FQHC or RHC		An EP must attest in the initial workflow step in the EHR registration system that they do not perform 90% of his/her services in an inpatient hospital or emergency room setting. Place of Service Code query reported will be generated from MMIS claims and encounter data to validate attestation.
EPs	The EP is not concurrently receiving an incentive payment from another State, Medicare or under another New Mexico TIN	The EP is not concurrently receiving an incentive payment under another State, Medicare or another New Mexico TIN	X	Once approved for payment by the State, the EHR registration will generate a D-16 transaction for each approved EP to CMS to ensure that the provider has not received a payment or is not currently pending for a payment from another State. The EHR system will then receive a D-16 response to approve the EP for payment or show a payment paid or pending.
EHs	The EH is not concurrently receiving an	The EH is not concurrently receiving an incentive	X	Once approved for payment by the State, the EHR registration

Provider Type	EHR Year 1 Reporting Period	EHR Years 2 through 6 Reporting Period	Yes No Attestation	Data Provided Attestation
	incentive payment from another State, or under another New Mexico TIN	payment from another State, or under another New Mexico TIN		will generate a D-16 transaction for each approved EP to CMS to ensure that the provider has not received a payment or is not currently pending for a payment from another State. The EHR system will then receive a D-16 response to approve the EP for payment or show a payment paid or pending.
All	Provider has adopted, implemented or upgraded (A/I/U) certified EHR	The provider has used certified EHR technology	X	The provider must select their attestation type (A/I/U), include a brief narrative on how they qualify for the attestation type and attach documentation illustrating their agreement/contract with the EHR vendor.
All	The EHR product used is certified and provide the product certification number	The EHR product used is certified and provide the product certification number		In the EHR registration system, the provider must provide their CMS EHR certification ID number; the EHR registration system validates the number entered against the ONC certified EHR product list. Providers also have an area where they can attach a letter with the product's certification number, if applicable.
EPs	The EP has confirmed assignment of payment to TIN	The EP has confirmed assignment of payment to TIN	X	The EP confirms the assignment of payee TIN by their signature on the Attestation Agreement. The Attestation Agreement lists the Payee TIN.
All		The provider has specified the meaningful use reporting period (90 days for first year of MU reporting, then full year thereafter) and provided the result of each applicable measure for all patients seen during the EHR reporting period for which a selected meaningful use measure is applicable	x	The EHR registration system includes this functionality in the section of the application designed to capture MU attestations.
All		The provider has satisfied the required objectives and associated measures as defined under §495.6 and as applicable to the stage per	X	The EHR registration system includes this functionality in the section of the application designed to capture MU attestations.

Provider Type	EHR Year 1 Reporting Period	EHR Years 2 through 6 Reporting Period	Yes No Attestation	Data Provided Attestation
		the rule		
All		The provider has satisfied the State required Public Health objectives and associated measures	X	The EHR registration system includes this functionality in the section of the application designed to capture MU attestations.
All		The provider attests that the clinical quality measures not reported do not apply to any patients treated by the provider	X	The EHR registration system includes this functionality in the section of the application designed to capture MU attestations.
All	The provider attests that all information is true and accurate per wording in the rule	The provider attests that all information is true and accurate per wording in the rule	X	The provider attests that all information is true and accurate by their signature on the Attestation Agreement which includes specific wording as required in the rule.
EHs and CAHs	The official submitting on behalf of an EH or CAH, to the best of their knowledge attests to the accuracy of the information being submitted as being accurate and true	The official submitting on behalf of an EH or CAH, to the best of their knowledge attests to the accuracy of the information being submitted is accurate and true	X	The official submitting on behalf of an EH or CAH attests that the information is true and accurate to the best of their knowledge by their signature on the Attestation Agreement which includes specific wording as required in the rule.

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

HSD/MAD allows a 60-day attestation grace period for all eligible professionals and a 90-day attestation grace period for hospitals. The grace period will give providers an extra 60 or 90 days, respectively, following their reporting period to submit an attestation. For Program Year 2013 only, and with prior approval from CMS, a 90-day grace period was allowed for EPs to complete attestations.

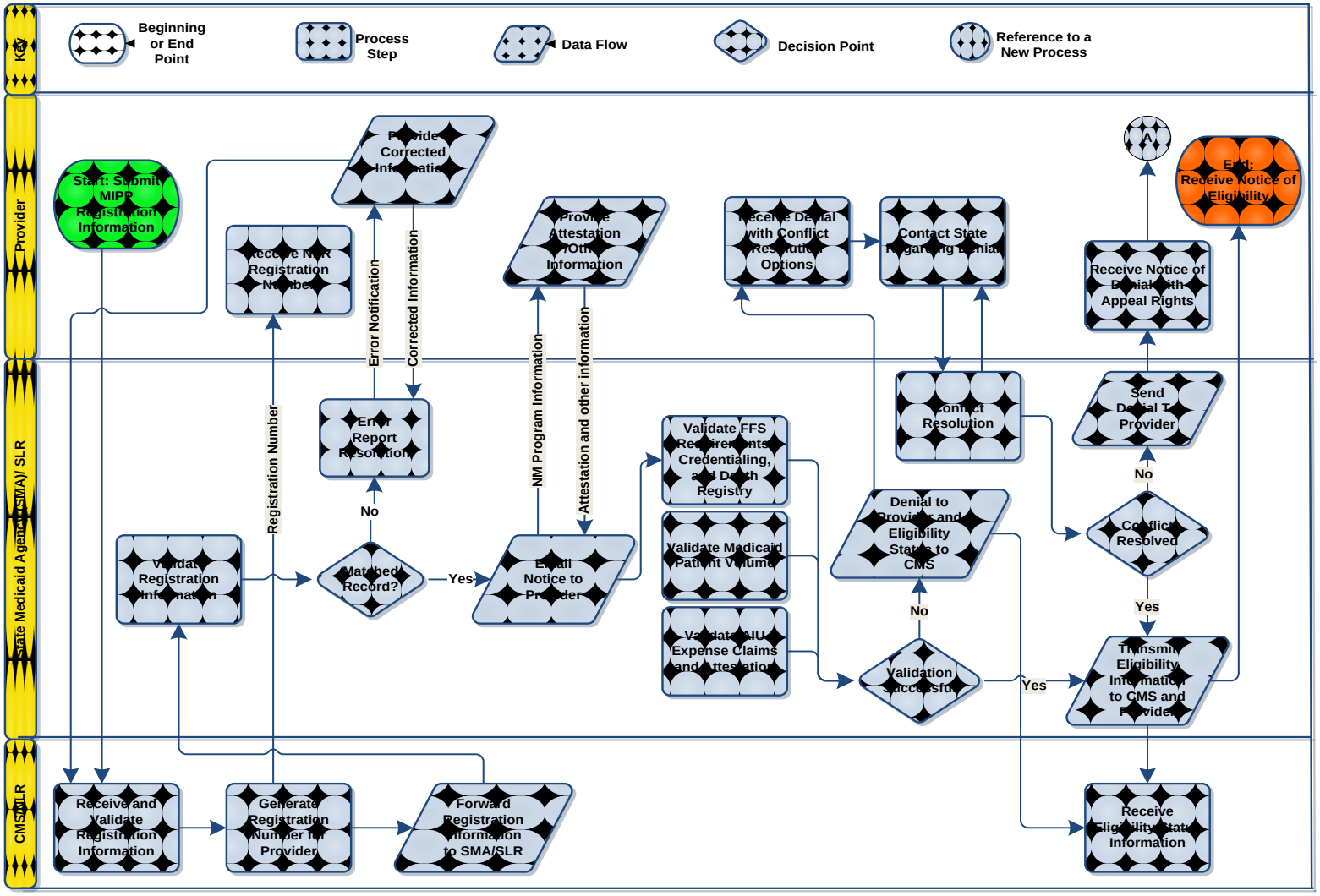
Reporting Period and Grace Periods		
	Reporting Period	Grace Period
Eligible Professionals	Calendar Year (January 1 – December 31)	60 Days (January 1 - March 1)
Eligible Hospitals	Federal Fiscal Year (October 1 – September 30)	90 Days (October 1 - December 29)

4.9 MIPP Rules and Medicaid Program Manual Regulations

HSD/MAD has implemented policy for the purposes of regulating and administering the New Mexico EHR Provider Incentive Payment Program. This policy is located at 8.300.22 NMAC, *Electronic Health Records Incentive Program,* of the Medical Assistance Program Policy Manual.

Changes to the MIPP policy during year 1 of the program include acceptance of an out-of-state Medicaid recipient to be counted in the recipient volume requirement. The original rule was based on the premise that it would be difficult to include out-of-state Medicaid recipients in the EHR incentive payment calculations. However, states have resolved verification issues. With this change, more New Mexico Medicaid providers will qualify for federal EHR incentive payments.

4.10 Enrollment Process Flow



4.11 EHR Payment Processing and Tracking

4.11.1 Processing MIPP Payments

HSD/MAD will pay EPs and EHs for Adoption, Implementation or Upgrade (AIU) of EHR technology and subsequent meaningful use of the technology. To receive payment, EPs and EHs must be enrolled as a Medicaid FFS or Managed Care Organization provider; and be registered to receive payment directly from HSD/MAD (i.e. registered as a billing or unrestricted provider, or as a payee established to receive only MIPP payments). The MMIS has the ability to make MIPP payments to providers without that provider needing to be a FFS provider in the Medicaid program. Some components of the process listed here are discussed more fully in other sections. The MIPP Program payment process includes the following key steps which are discussed in further detail in previous and subsequent sections:

- Provider completes enrollment and attestation, detail is verified per previous discussion
- Provider receives notice of program eligibility and payment calculations
- EHR registration system passes file of eligible providers to FA to update provider master file
- EHR registration system passes file to Program Administration Bureau to prepare ATR

4.11.2 Assigning MIPP Payments

EPs are permitted to reassign their incentive payments to their employer or to an entity with which they have a contractual arrangement allowing the employer or entity to bill and receive payment for the EP's covered professional services. In addition, EPs may assign payment to an organization recognized by HSD/MAD as a qualified organization promoting the use of EHR technology. Currently HSD/MAD recognizes both New Mexico Health Information Collaborative and New Mexico HIT Regional Extension Center as entities promoting the use of EHR technology. The organization may not retain more than 5% of the annual EHR incentive payment for those costs unrelated to the certified EHR, which will include salaries and benefits, rent, maintenance, utilities, insurance and travel. EPs and EHs who plan to assign incentive payments are required to identify a TIN for the assignee. The assigned entity must also register with the CMS Registration and Attestation System. New Mexico will establish an application process for Entities Promoting the Use of certified EHR technology and require the entity become registered with the State of New Mexico as an entity capable of receiving reassigned payments from eligible participants or eligible entities in the Medicaid EHR Incentive Program. This process is currently being developed, but as of now, will require the Entities to provide information on the activities they will be performing to promote certified EHR adoption, with an explanation and attestation that they will not retain more than five (5) percent of the reassigned payments for activities unrelated to the promotion of certified EHR technology, and New Mexico will guarantee that information, pursuant to the Federal Register stated requirements. New Mexico's EHR Incentive Program audit procedures of these entities are also still in development and will be included in the annual update to the SMHP. Currently, the only two entities

identified as potentially eligible to receive payments are the State Designated Entity for the New Mexico Health Information Technology Regional Extension Center (HITREC) and New Mexico Health Information Collaborative, both of whom are under separate Cooperative Agreements with the Office of National Coordinator.

Program Note: As of writing the SMHP update, no provider has assigned their incentive payment to a State Designated Entity.

4.11.3 Calculating Payments to EPs

HSD/MAD will use the formula and guidelines described in the Final Rule to calculate MIPP payments for both EPs and EHs. The following descriptions provide the basic guidelines from the Final Rule.

For the initial program year, all payments for EPs are subject to the Net Average Allowable Cost (NAAC) ceiling of $25,000 per EP.[8] EPs deemed to have met all MIPP program requirements will receive a payment amounting to 85% of NAAC or $21,250. For subsequent participation years, payments to EPs are subject to a $10,000 ceiling for maintenance of the EHR technology. EPs deemed to have met all MIPP program requirements in each subsequent payment year will receive a payment amounting to 85% of NAAC or $8,500 per qualifying year.

EPs may receive payments on an annual, non-consecutive basis for up to six years between 2011 and 2021. In order to receive an incentive payment, EPs must participate in the program by 2016. In order to receive the maximum payment, EPs who delay participation until 2016 must participate in consecutive years from 2016 to 2021. Hospitals must also participate by 2016 in order to receive an incentive, but the nature of their participation will be determined by the State's disbursement schedule..

4.11.4 Calculating Payments to EHs

The EH aggregate incentive payment is a separate calculation for each hospital, as described below.

1. EH aggregate incentive amount calculation will be a one-time, up front calculation using the equation outlined in the Final Rule.
2. EHs have a base amount of $2,000,000 for each of four years, plus a discharge-related amount, times the Medicaid share of the total.
3. HSD/MAD submitted a hospital incentive payment calculation to CMS that showed what fields from the cost report are used to complete the calculation. CMS approved the HSD/MAD method of calculating a hospital incentive payment in April 2011.

[8] Federal Register/v.75, No. 144, July 28, 2010, p. 44579, 495.308 Net Average Allowable Costs, the Basis for Determining the Incentive Payment

4. HSD/MAD will issue incentive payments over three years with payments distributed at 50 percent of the total payment in the first participation year of program enrollment, 40 percent of the total payment in the second participation year of program enrollment, and 10 percent of the total payment in the third participation year of program enrollment.

   Program Update: In some instances, an aggregate incentive payment for eligible hospitals may not be able to be calculated if an eligible hospitals does not have a four years of prior cost report data. This may occur for hospitals in several distinct situations, such as newly constructed hospitals, changes of ownership, and reorganization of a single multi-campus hospital into multiple separate providers. In those instances where a hospital is operating under a new CCN, the hospital must have at least two years of cost report discharge data under the new CCN to attest in the NM State Level Registry. Subsequent to Year 1, the incentive payment calculation must be adjusted each year, based on new cost report data that is submitted to the state in future incentive payment participation years. This approach assures that the new hospital has four years of total discharges by its final year of attestation.

5. HSD/MAD will accept the most recently submitted Medicare Cost Reports as the basis for the calculation of EHR Incentive Program payment at the time of enrollment.

6. Base Year: Beginning with Program Year 2013, HSD/MAD implemented the option for hospitals to use the most recent continuous 12-month period for which data are available prior to the payment year.

7. HSD/MAD has identified those fields from the cost reports that will be used to perform MIPP calculations. In lieu of cost reports for IHS, HSD/MAD will also accept IHS-generated reports that capture the data required for states' calculation of hospital incentive payments. Data for each report will come from the Clinical Information System (the Resource and Patient Management System), at each IHS facility. HSD/MAD will also accept hospital financial statements and MMIS claims/encounter data if cost reports are not available, although HSD/MAD anticipates participating EHs will submit cost reports.

8. HSD/MAD will use Medicaid Management Information System (MMIS) data as the basis for validating hospital Medicaid patient volume.

9. HSD/MAD will designate the hospital Fiscal Year as the basis for calculation of all measures as related to hospitals to include:

    i. Length of stay
    ii. Payment calculation

4.11.5 Executing MIPP Payments to Providers

HSD/MAD will use its Accounting Transaction Request (ATR) process to make all MIPP incentive payments. The EHR enrollment module is anticipated to automate the interface of approved providers and hospitals to both the Fiscal Agent (FA) (to update the provider file) and to the Program Administration Bureau (to initiate the ATRs). The ATR is designed to authorize non-client based payments, such as cost settlements, but can be used for any non-client transaction. Presently a manual process, the ATR request is approved by Program Administration Bureau (PAB) staff and forwarded to the FA for data entry and processing. The EHR unit will process the MIPP payments within 60 days following the approval and receipt of signed attestation and issue the payments as part of the weekly payment cycle. Payments may be issued as often as weekly, depending on the turnaround time of validations and volume of enrollment each week. Delays in the 60-day processing cycle can occur when providers delay supplying supporting documentation to the state, such as practice management reports. Once a provider has been approved for payment, the providers can expect to be paid within two payment cycles.

HSD/MAD assures CMS that the MIPP payments will be made to EPs and EHs pursuant to the requirements in the Final Rule. HSD/MAD will use the prepayment verification process expected to be incorporated into the EHR registration system to assure payments are authorized through the formula described in the Final Rule. The ATR authorization process, with two levels of approval, provides additional assurance that the MIPP payments represent the amount authorized by the payment calculation process pursuant to the Final Rule.

4.11.6 Monitoring Provider Payments

The FA (Xerox) has enhanced the MMIS to support the MIPP payments. The State is able to identify and track the MIPP payments and revenue through the MMIS to the State accounting system (SHARE). The system changes approved and implemented were the addition of two new financial reason codes to the financial subsystem to identify MIPP payments and recoupments.

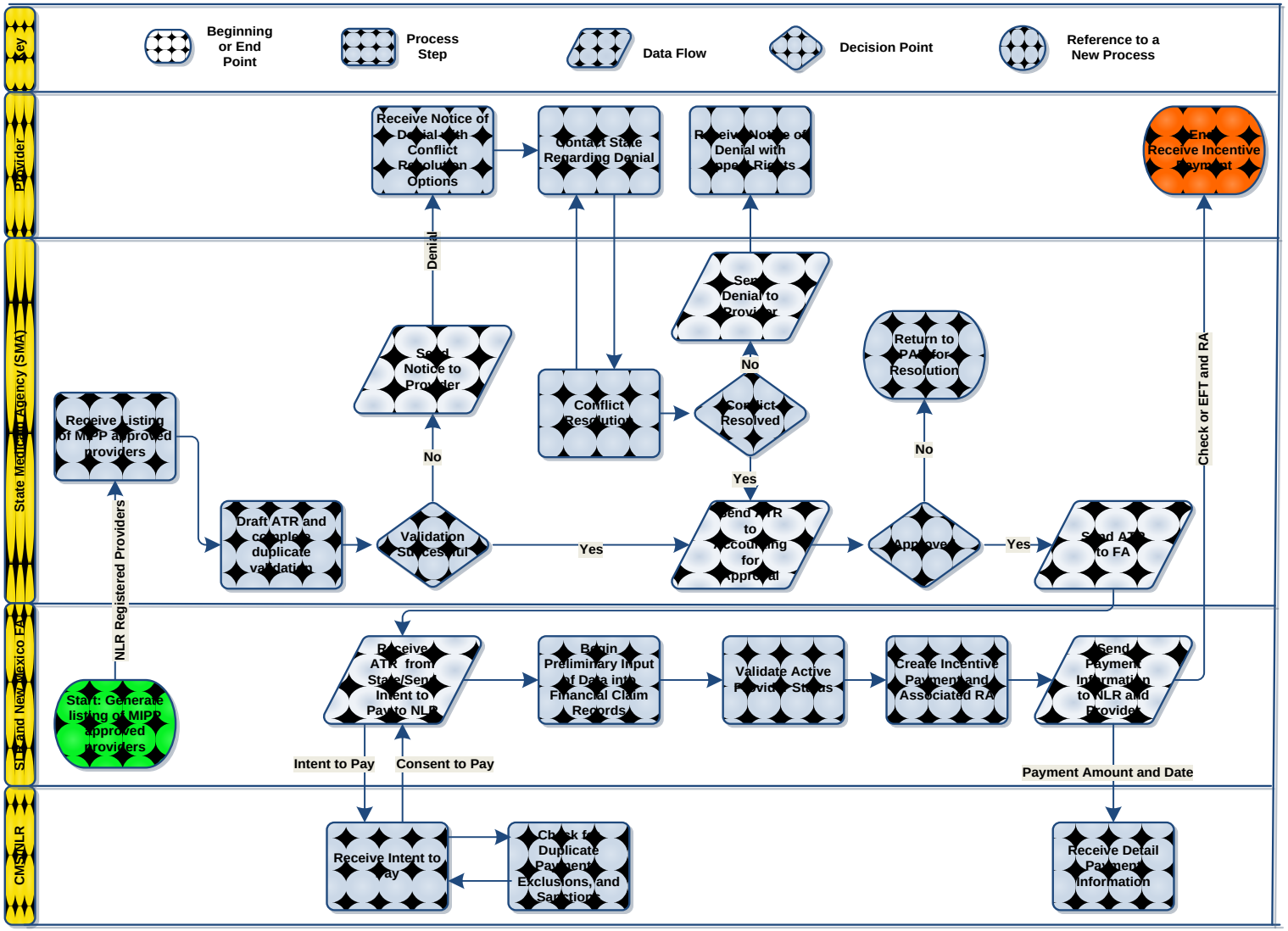
In addition to the MMIS enhancement, the CMS-64 Quarterly Report of Expenditures were revised to report and identify incentive payments via the 64.10 BASE Summary Report which was programmed to report eligible professionals and hospitals utilizing the new financial reason codes. Each individual

payment is recorded in the MMIS, is viewable in the Omnicaid Interface and can be queried from the data warehouse.

ATRs are subject to some editing (such as provider verification) in the processing of a financial claim, but not a duplicate payment check. The ATR payment is identified on the provider's Remittance Advice (RA) and can be researched through an inquiry through the provider call center. The electronic funds transfer (EFT) is also available for any ATR payment.

The administrative responsibility for the MIPP program rests primarily with HSD/MAD and includes oversight for the enrollment process, payment and reporting and program oversight. HSD/MAD assures CMS that the Federal financial participation (FFP) earned by affected HSD/MAD staff will be reconciled and reported separately from other Title XIX administrative costs. HSD/MAD uses time allocation studies to determine breakdown of administrative costs and will allocate the MIPP program administration pursuant to the time allocation results. In effect, HSD/MAD will use the same allocation process for the MIPP program costs as is used for all Title XIX administrative costs. The various program allocation costs are incorporated into the HSD cost allocation plan approved by HHS.

4.12 Payment Process Flow



5 Section D – The MIPP Program Audit Strategy

5.1 Conducting MIPP Program Oversight

Performing program oversight for MIPP will require a different approach than HSD/MAD has used historically in its oversight of the Medicaid program. The MIPP payments are based on assurances from the EPs of patient volumes from one or several practices and adoption, implementation, upgrade and use of EHR technology to support efficiency, improved service and enhanced quality of care. Moreover, the MIPP payments do not represent payments for any specific services performed. This section describes the HSD/MAD approach and execution of program oversight for MIPP.

New Mexico agrees to have processes in place to verify those elements of the SMHP related to assurances for program integrity, e.g., no amounts greater than 100% of FFP will be claimed by the State for MIPP payments, payments will be made to the EP or EH or to an employer or facility to which the EP has assigned payment. These processes include a system test environment to verify the accuracy of the logic supporting the new reason code value for MIPP payments. The test environment can simulate the production environment and verify the reason code value is collecting only the MIPP payouts. The logic directing the MIPP payments to be claimed at 100% federal revenue in the CMS-64 report will also be validated in a test environment to verify accuracy of the report module. Verification of the accuracy of the payment TIN, whether the EP's or an assigned entity, is performed with a manual check of the CMS Registration and Attestation System data when HSD/MAD Program Administration staff prepare the ATR. As the ATR process is automated, the verification of the payment TIN will be part of the cross check between the payment field on the CMS Registration and Attestation System record and the payment field on the ATR.

HSD/MAD also recognizes the opportunity to use the data sources at the State Designated Entity (NMHIC), any data repositories at the NMDOH (e.g., immunization registry, public health surveillance data) and other EHR databases to verify meaningful use. At the submission of this SMHP, the State does not have such connections in place, but plans to use these resources as the EHR process matures.

5.2 Audit Approach and Resources

HSD/MAD will use a combination of pre-payment verification and post-payment validation (audit) to ensure integrity of the MIPP.

The Division initially planned to use MIPP Program management staff to conduct pre-payment verifications, but a general hiring freeze in State government has delayed hiring five additional staff for

provider enrollment support. Assuming that management of the MIPP operation will eventually require two (2) full time equivalents (FTEs), the Division will contract with the FA for MIPP program support.

Program Note: The EHR Unit employs a full-time auditor to conduct pre-payment reviews and post-payment audits for EP AIU attestations. HSD/MAD also has contracted with Myers and Stauffer, LC, to perform post-payment AIU audits of hospitals—calculation and eligibility, and in some cases, audit of MU. Myers and Stauffer will also perform post-payment MU audits for EPs.

The HSD/MAD Quality Assurance Bureau is responsible for Medicaid program oversight, including review of potential overutilization and identification of possible provider fraud and abuse cases. The EHR Unit auditor will undertake EP AIU post-payment audits of MIPP as part of its ongoing responsibility. The HSD/MAD audit agent will perform post-payment audits for EH AIU, MU and EP MU.

HSD/MAD submitted a separate and confidential audit strategy to CMS in April 2012 and was approved by CMS. The audit strategy will remain as a separate document from the SMHP and details of HSD/MAD's audit strategy have been removed from the section of the SMHP update.

5.3 Fraud and Abuse Prevention

The criteria and payment for MIPP participation is well defined and should provide clear decisions for identifying outright program fraud. The required activities for participation in MIPP are definable and should be verifiable from provider practice review, for patient volume, and audit trail for AIU of EHR or meaningful use of certified EHR technology. The combination of CMS and state registration systems reporting, claims submission records and practice records all support compliance with MIPP.

If the QA Bureau identifies a situation that appears to be fraudulent, based on available records, or lack thereof, the QA Bureau will forward the case to the Medicaid Provider Fraud Control Unit in the Attorney General's office.

5.4 Incentive Payment Recoupment

In addition to MIPP oversight and auditing processes, a recoupment process for overpayments under the MIPP will be included as part of the existing accounting module for the MMIS. When HSD/MAD is made aware of an overpayment, either through the MIPP program audit function, or provider notification, HSD/MAD will direct the FA to set up an accounts receivable (AR) under the EP's or EH's Medicaid provider number. This AR is set up through manual intervention in the system by the FA. Since the EP or EH has a Medicaid provider number, the recoupment will go against all claims.

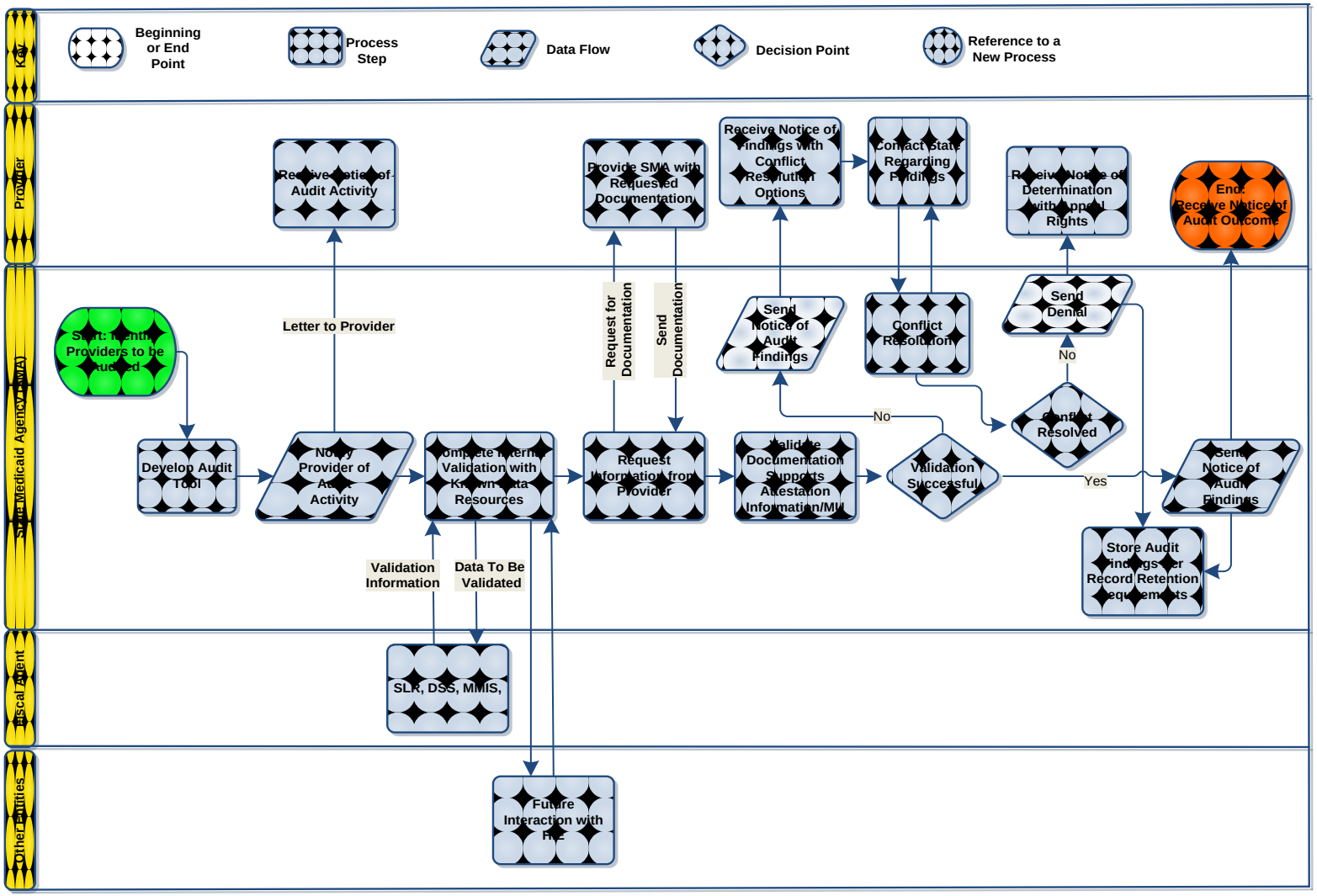
The accounting logic in the MMIS will direct the recouped amounts against revenue codes, assigning the appropriate FMAP on the voided claims to the AR. Because the MIPP payments are 100% FFP, it could take several comparable claim amounts, at the State FMAP to satisfy the AR. The QA Bureau has the option of requesting a manual payment from the provider if they determine the provider's claim volume is not sufficient to satisfy the overpayment in a reasonable period of time, usually six (6) months.

5.5 Provider Grievance and Appeal Processes

New Mexico Administrative Code, Chapter 353 provides for appeals to Medicaid rules through a Fair Hearing Process under prescribed circumstances. HSD/MAD will amend these rules, if necessary, to include provider incentive payments, provider eligibility determination, and efforts to adopt meaningful use in the MIPP Program as appealable decisions. In addition, the code provides for an informal resolution process.

HSD/MAD will provide the appeals process pursuant to its administrative rules, noted above. In addition, an EP or EH can appeal a denial decision through the EHR registration and attestation system. This informal appeals process will include informal discussion with the provider, a re-review and re-submission of new data If necessary, an EP/EH will attest to new data provided, and re-submit a signed attestation before an appeals decision is overturned. HSD/MAD will include these amendments to the Fair Hearings process as part of the HSD/MAD Program Regulation update incorporating the MIPP rules.

5.6 Auditing Process Flow



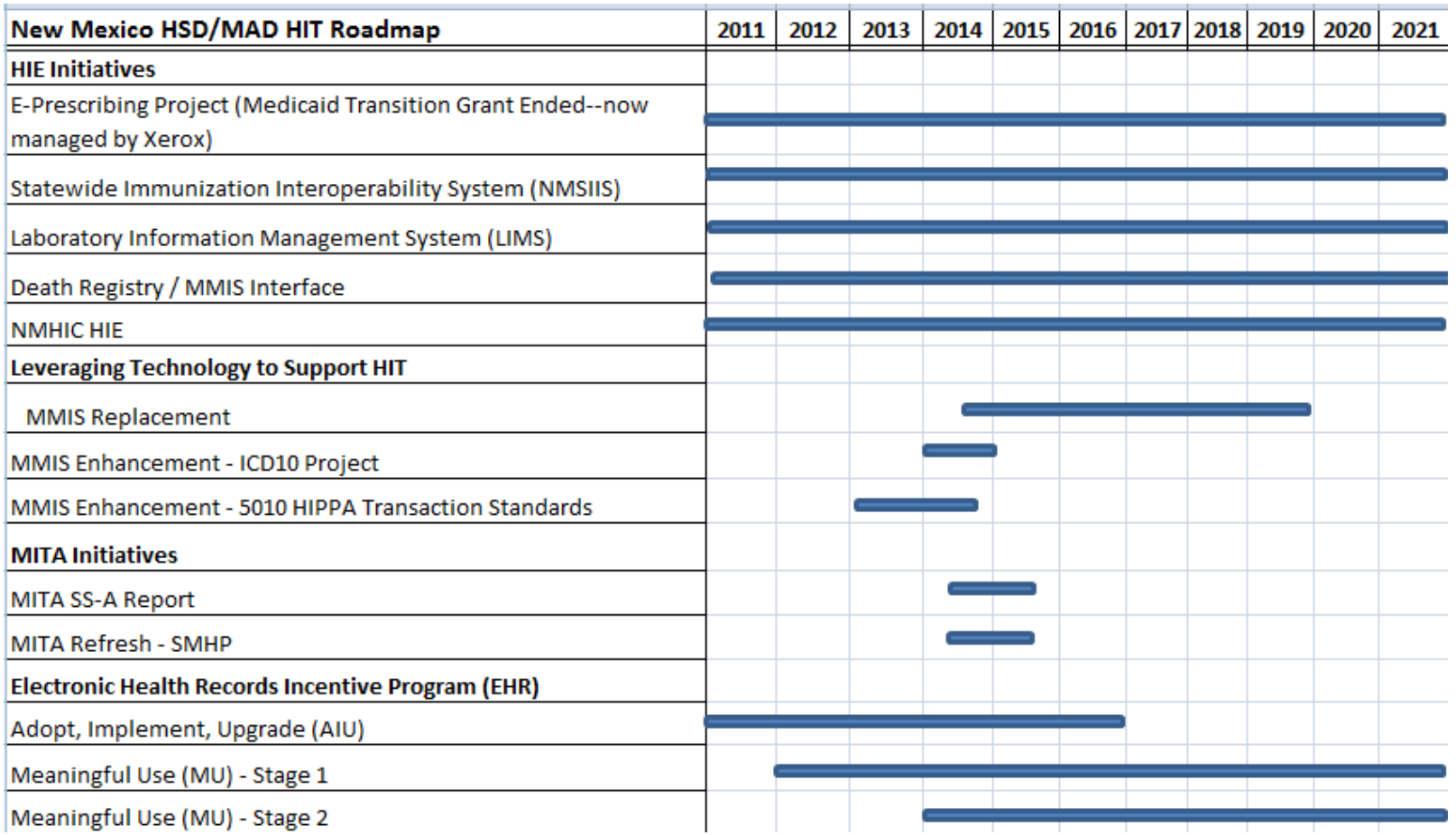
6 Section E – The HSD/MAD HIT Roadmap

The HSD/MAD HIT Roadmap includes the variety of initiatives discussed in Section 3 – The "To Be" HIT Landscape. HSD/MAD partners with an increasingly sophisticated community of healthcare advocates, technology vendors, medical providers, clinicians and associations whose focus is on using integrated technologies to improve healthcare for New Mexicans. Figure 6a (following page) indicates a representation of general timelines for key components of the HSD/MAD HIT Roadmap over a period of 10 years.

The ultimate vision for HSD's future HIT landscape is the widespread meaningful use of health information technology by its Medicaid providers to support the Department's more specific goals of improved cost effectiveness, improved health outcomes, improved disease management and ultimately, the development of a fully patient-centric health care delivery system. The implementation of the EHR Incentive Program is an important step in HSD/MAD's commitment to its HIT Roadmap.

As providers and hospitals mature in the EHR participation, the requirement to submit clinical data increases, and the agency must determine the means by which it will continue to manage and evaluate the clinical data submitted. HSD/MAD's ability to utilize clinical data in combination with its current administrative data will surely evolve over subsequent years in the EHR Incentive Program, and is heavily dependent on decision points yet to be made within HSD/MAD. The recommendations of Clinical Data and Technical Workgroups will be instrumental in developing activities and plans that allow EHRs to submit data to the HIE, Statewide Immunization Information System, or Laboratory Information Management System.

Figure 6a HSD/MAD HIT Roadmap



7 Appendices and Attachments

7.1 The Idea Scenario – Case Study

The "ideal scenario" gives practical detail to the HSD/MAD vision for its future state of business operations, healthcare delivery and supporting technical services, and describes ways in which the agency can best provide high quality and effective healthcare using new technologies, interactive systems, accessible data and streamlined business processes. In subsequent sections, HSD/MAD explains the projects, initiatives and technologies it will leverage to eventually create this future state of business operations.

A physician (Dr. Frederick) relocates to Santa Fe, NM from San Diego, CA and is hired by St. Michaels Family Practice Clinic.

Dr. Frederick completes her Medicaid provider enrollment process online through the NM State Provider portal providing information specific to her provider type/specialty and any or all levels of participation (e.g., billing, servicing). The provider portal tracks and indicates the status of Dr. Frederick's application and automatically verifies information, sanction status, and credentials through standardized interfaces with appropriate entities (e.g., licensing boards, NPDB, HIPDB, NPPES, SSA, PECOS). The application is automatically processed within 24 hours and Dr. Frederick's information is loaded into a state-wide registry where all provider information is accessible to all NM agencies and other states. The state-wide registry performs periodic re-verification of credentials and sends alerts to HSD/MAD staff and sends provider notifications when follow-up is needed.

St. Michaels Family Practice Clinic is an active member of the NM HIE, and once Dr. Frederick begins submitting Medicaid claims, the HSD/MAD clinical data repository will search HIE records for clinical details relevant to a planned study of Medicaid recipient populations currently receiving services and medications relating to certain diagnoses. The outcome of the population studies will form the basis of a contract change for HSD/MAD's Managed Care Organizations relative to treatment protocols for the diagnoses in question.

A 26-year old Hispanic woman (Ms. Sanchez) presents to an Urgent Care Center (UCC) with her 6-year old child. The mother appears to have limited ability to speak English, so the Urgent Care registration team calls for the assistance of an interpreter as the screening process gets under way. Because the young mother and her child recently relocated from Las Cruces, NM, and because the UCC is a

participant in the NM HIE, the staff is able to retrieve a comprehensive EHR for both the mother and child.

Both are complaining of general flu-like symptoms and the child has a low grade fever. Neither has received any medical attention, nor have they selected a Medicaid PCP since relocating to the Santa Fe area, according to the current EHR. The intake process confirms that the patient has not sought care in an out-of-state clinic, nor from an entity not participating in the HIE. The file is noted as in need of a Medical Home, and a list of eligible providers and clinics is created (in Spanish) and reviewed with Ms. Sanchez.

UCC staff may assist Ms. Sanchez by enrolling her with a new Medicaid PCP of her choice electronically. Under this scenario, Ms. Sanchez is automatically scheduled for her initial follow-up appointment with the newly selected PCP prior to her discharge from the Urgent Care Center. Alternately, Ms. Sanchez may receive a printed listing of eligible providers (in Spanish) and be directed to a kiosk located in the lobby (or any other community kiosk) where she can enroll with a new Medicaid PCP. Ms. Sanchez is able access her culturally and linguistically appropriate Public Health Record (PHR) online or through a community kiosk where one can perform a variety of tasks (elect a PCP, schedule an appointment, update demographic information, access care protocols etc.).

Updated information collected through the intake process is automatically pushed to Medicaid to update the recipient files with new address and other demographic information. In addition, data is pushed to PCPs and associated clinics regarding the new patient information.

The Urgent Care physician reviews the medical detail, lab tests and results and protocols followed in Las Cruces (utilizing predictive modeling functionality). The patient's persistent cough leads to a discussion about possible TB infection, and a test is ordered. The test and results are reported to the State Department of Health and to the recipient. The attending physician also notes a deficiency in the child's immunization record, confirms the missing vaccination with the mother, and administers the vaccine per state protocol. Information regarding vaccination is automatically pushed to the State immunization registry.

As Ms. Sanchez and her child leave the Urgent Care Center, they have received instructions for managing their flu-like symptoms, have enrolled with a new Medicaid PCP, and have been scheduled for an initial follow-up appointment. In addition to any hardcopy instructions the recipient may receive, Ms. Sanchez' PHR provides a summary of treatment, follow-up protocols, and list of scheduled follow-up visits.

The clinical data resulting from the Urgent Care visit is available and routinely mined by HSD and DOH for program support and predictive modeling activities.

Having selected Dr. Frederick and St. Michaels Clinic as her medical home, Ms. Sanchez' CCD becomes available online to assist in the new patient evaluation process. Dr. Frederick easily accesses the CCD to review all new actions, diagnoses, and the lab results from Sanchez' recent TB tests. Upon confirming TB test results on the CCD and with Ms. Sanchez, a review of EHR shows tests revealing high sugar content and toxicity in the liver. Dr. Frederick interviews patient to identify other possible risks/chronic conditions and determines patient should be examined for HEP-C.

Dr. Frederick orders the HEP-C work-up and follow-up tests. As Ms. Sanchez leaves the clinic, her tests are scheduled through the office practice management software, and she has a printed account of her visit with follow-up instructions based on standard state protocols. The clinic's integrated practice management software automatically generates claims to be submitted electronically based on patient information and clinical diagnoses and data input to the medical record during the office visit and examination.

HSD/MAD envisions a future that robustly employs technology (e.g. EHR/HIE) to better serve the State's Medicaid recipients.

7.2 Table of Suggested Reports

Report Type	Report Description
Registration Report	provider registration information assisting the verification of EP's registered in the program
Eligibility Report	provider eligibility information assisting the verification and validation of an EP's status
Validation Report	shows the data that has been tracked to determine the validity of an EP's Registration, Eligibility, and Attestation information
Payment Reporting	who has been paid, when they were paid, how much they were paid, the Check of electronic transaction number of the payment, a distinct timeframe for viewing i.e. a month, quarter, or year. Who has completed their submission for payment, whether or not they have received that payment
CMS Registration and Attestation System Report	showing all providers that have enrolled in the CMS Registration and Attestation System, whether or not the providers that have enrolled in the CMS Registration and Attestation System are currently enrolled in the MIPP

Report Type	Report Description
AIU and MU report	showing if the provider has completed their AIU or MU attestation respectively, when it was completed (Date of completion), and provider's AIU or MU attestation data.
Provider Report	showing providers that have entered information into the MIPP application and have completed data entry, have not completed data entry, where they are in the process, this report can also be time sensitive i.e. a provider began their data entry but did not finish and have not returned to complete for longer than 60 days. This report can also be used as an outreach and education tool allowing outreach coordinators to reach out to those providers and assist them with completion.
Attestation Report	showing if a provider has completed their attestation, why or why not. It can also show whether or not the attestation was completed successfully why or why not.
Eligibility Report	showing if the provider has met the eligibility requirements set forth in the application. Report also has a mechanism that allows states to create a threshold range for providers i.e. if a provider is above 29% Medicaid volume yet below 29.9% Medicaid volume it can generate a letter which again can be used as an outreach tool to assist providers that may have missed some information that could get them to eligibility for the EHR incentive.
Forecasting Report	showing possible payments to providers and hospitals, the report allows states to forecast needs to provide incentive payments to those eligible to receive payments. The report can also determine average payment size. This is for Eligible Hospitals and Eligible Professionals.
Ineligibility Report	shows which providers have been deemed ineligible for incentive payments why they were deemed ineligible. This report can also generate a letter to the providers informing them of their status and the reason why

7.3 List of Terms and Acronyms

Acronym	Definition
ACS	Affiliated Computer Services, Inc.
AHRQ	Agency for Healthcare Research and Quality
AIU	Adopt/Implement/Upgrade
AR	Accounts Receivable

Acronym	Definition
ARRA	American Recovery and Reinvestment Act of 2009
ATR	Accounting Transaction Request
BSB	Benefits Bureau
CAB	Contract Administration Bureau
CAH	Critical Access Hospital
CCD	Continuity of Care Document
CCN	CMS Certification Number
CEO	Chief Executive Officer
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CIO	Chief Information Officer
CMS	Centers for Medicare & Medicaid Services
CNO	Chief Nursing Officer
COO	Chief Operating Officer
COTS	commercial off the shelf
CPSI	Computer Programs and Systems, Inc
DHHS	Department of Health and Human Services
NMDOH	New Mexico Department of Health
DW	Data Warehouse
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
EH	Eligible Hospital
EHR	Electronic Health Record
EMR	Electronic Medical Record
EP	Eligible Professional
ePHI	electronic Protected Health Information
ER	Emergency Room
ERx	e-Prescribing
FA	Fiscal Agent
FADS	Fraud and Abuse Detection System
FCC	Federal Communications Commission
FFP	Federal Financial Participation
FFS	Fee-For-Service
FFY	Federal Fiscal Year
FMAP	Federal Medical Assistance Percentage
FQHC	Federally Qualified Health Center
FTE	Full Time Equivalent
FTP	File transfer protocol
FY	Fiscal Year
HCCN	Health Center Controlled Networks
HHS	United States Department of Health and Human Services

Acronym	Definition
HIE	Health Information Exchange
HIMSS	Health Information and Management Systems Society
HIPAA	Health Insurance Portability and Accountability Act
HISPC	Health Information Security and Privacy Collaboration
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HITREC	Health Information Technology Regional Extension Center
HL7	Health Level Seven
HRSA	United States Health Resources and Services Administration
HSD	New Mexico Human Services Department
IAPD	Implementation Advance Planning Document
ICD	International Classification of Diseases
ID	Identification
IHS	Indian Health Services
IT	Information Technology
LCF	Lovelace Clinic Foundation
LOINC	Logical Observation Identifiers Names and Codes
MAD	Medical Assistance Division
MCO	Managed Care Organization
MD	Medical Doctor
MIPP	Medicaid Incentive Provider Payment (Program)
MITA	Medicaid Information Technology Architecture
MMIS	Medicaid Management Information System
MTG	Medicaid Transformation Grant
MU	Meaningful Use
NAAC	Net Average Allowable Cost
NASMD	National Association of State Medicaid Directors
NM	New Mexico
N-M	Certified Nurse Midwife
NMAC	New Mexico Administrative Code
NMHA	New Mexico Hospital Association
NMHIC	New Mexico Health Information Collaborative
NMHITREC	New Mexico Health Information Technology Regional Extension Center
NMMRA	New Mexico Medical Review Association
NMPCA	New Mexico Primary Care Association
NMPIC	New Mexico Prescription Improvement Coalition
NP	Nurse Practitioner
NPHIN	National Public Health Information Network
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPRM	Notice of Proposed Rulemaking

Acronym	Definition
OGC	Office of General Counsel
OIG	United States Department of Health and Human Services Office of the Inspector General
ONC	Office of the National Coordinator for Health Information Technology
P4P	Pay For Performance
PA	Physician Assistant
PAB	Program Administration Bureau
PAPD	Planning Advance Planning Document
PCP	Primary Care Physician
PDCS	Prescription Drug Claims Processing System
PHI	Protected Health Information
PHIN	Public Health Information Network
PHR	Personal Health Record
PIP	Provider Incentive Program
PTAN	Provider Transaction Access Number
QA	Quality Assurance
QIO	Quality Improvement Organization
RA	Remittance Advice
REC	Regional Extension Center
RFP	Request for Proposal
RHC	Rural Health Clinic
RHIO	Regional Health Information Organization
RPI	Research and Polling, Inc.
RPMS	Resource and Patient Management System
SDE	State Designated Entity
SMHP	State Medicaid Health Information Technology (HIT) Plan
SNOMED	Systemized Nomenclature of Medicine
SOA	Service Oriented Architecture
SSA	Social Security Administration
SS-A	State Self-Assessment
SUR	Surveillance and Utilization Review
SWTAG	Southwest Telehealth Access Grid
TIN	Taxpayer Identification Number
US	United States
VA	Veterans Affairs
VP	Vice President