

**STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY**



**STATE MEDICAID HIT PLAN
(SMHP)
VERSION 2.0**

CMS Letter - 9/3/2010

Enclosure A

October 13, 2010

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1 SMHP REVISION

This State Medicaid Health Information Technology (HIT) Plan (SMHP) Revision addresses the questions raised in the Centers for Medicare & Medicaid Services (CMS) letter dated September 3, 2010, and addenda. The CMS questions are noted below with relevant SMHP sections and revised text provided. All revisions are provided in the order of the question received from CMS and highlighted in ***bold italics*** to facilitate review. Future changes to this SMHP will be published in SMHP section order.

Global changes to the SMHP included:

1. "SoonerCare Electronic Health Record (EHR) Incentive Program" is changed to "Oklahoma EHR Provider Incentive Payment Program" throughout the SMHP.
2. Global search was conducted for "proposed rule" and revised to "Final Rule," where appropriate.



CMS Question 1: *Please describe whether and how tribal facilities were included in the environmental scan. Also, include other stakeholder groups, (e.g., family planning, clinics, mental health, long-term care, pharmacies, etc.).*

Response: See below in Section 2.5.4. Paragraphs 1, 3, and 6 are added as shown. In Section 2.5.5, a sentence is added to paragraph 1 to address ineligible provider types.

Section 2.5.4 Indian Health Service (IHS)/Tribal facilities/Urban Indian Clinic (I/T/U) Providers

Oklahoma Health Care Authority's (OHCA) Indian Health Unit serves as a liaison between OHCA and tribal governments with the goal of improving services to American Indian SoonerCare members and providers by increasing access to health care, advancing ongoing and meaningful communication, and maximizing partnerships.

Early on OHCA explored with I/T/U partners whether their providers would be eligible for participation in the federal Provider Incentive Program. Once it was clear that they could, the OHCA Indian Health Unit targeted these providers with the 10-question eligible professional (EP) follow-up scan. IHS and tribal hospitals were provided the eligible hospital (EH) scan.

To maximize outreach to this population, the OHCA Indian Health Unit personally contracted all I/T/U EPs and EHS to educate, obtain input and validate lists of potentially eligible providers, and later to survey the provider about their facility and their use of EHRs.

The Indian Health Unit worked directly with the OHCA planning and development committees to ensure consultation and inclusion of IHS, Tribal facilities and Urban Indian Clinics in Oklahoma. The Indian Health Unit each contracted Indian health facility by telephone or email, including Tribal facilities, Urban Indian facilities, IHS facilities, and the Oklahoma City Area IHS Administrative Office.

Each contracted site was personally contacted by one of the staff of OHCA Indian Health Unit to educate, get input, and obtain lists of their potentially eligible providers and later to survey the provider about their practice and their use of EHRs. OHCA Indian Health Unit worked with I/T/U facilities one-on-one to inform them of the initiative and how it might impact them. I/T/U staff was given the opportunity to ask questions, identify contacts within their tribe and arrange follow-up meetings or conference calls, etc., with OHCA if they had additional questions.

Of 677 surveys mailed, 475 were returned, most through the administrative offices of I/T/U facilities. This seemed to indicate that many I/T/U EPs and EHS were aware of this opportunity. Additional efforts included giving numerous presentations to the Oklahoma City Area IHS Administrative Office and Oklahoma City Area Inter-Tribal Health Board. The OHCA Indian Health Unit also produced a written summary of the Oklahoma EHR Provider Incentive Payment Program to all Tribal facilities, Urban Indian Health facilities, and IHS facilities. Future opportunities for outreach include the 4th Annual Tribal Consultation as well as SoonerCare provider training this fall. OHCA will also provide presentations to I/T/U providers upon request.



Section 2.5.5 Selection of Environmental Scan Participants

This section will describe how the environmental scan population was selected and demographics about the selected providers (statewide, eligible providers, hospitals, Health Information Exchange (HIE) networks) and provider specialties, etc.

OHCA elected to scan all currently contracted SoonerCare providers that were of the type considered eligible for the Oklahoma EHR Provider Incentive Payment Program under the proposed rule: Physician, Pediatrician, Nurse Practitioner, Certified Nurse Midwife, and Dentist, and all EHs in the State. **Ineligible provider types such as family planning, clinics, mental health, long-term care, and pharmacy providers were not scanned.** OHCA identified 6,199 individual and group providers and 130 hospitals, (which included 6 IHS hospital facilities). Ninety-three Federally Qualified Health Centers/Rural Health Centers (FQHCs/RHCs) were also identified. As Oklahoma is largely a rural State, extra efforts were made to ensure that scans reached and were responded to by small and rural providers. Focus of the scans remained on in-state providers.

CMS Question 2: *Since the majority of the State's Medicaid population is enrolled in a managed care program, please confirm that the State will be able to provide payments to all EPs affiliated with this program, including a description of the payment process that will used (i.e., all payments through Medicaid Management Information System (MMIS) and/or other means).*

Response: A new paragraph is added to Section 4.6 as shown below.

Section 4.6 Processing Payments to Providers

This section includes the plan for making payments to providers and a list of tasks that must be completed during the implementation phase to calculate and process provider payments. Appendix E contains the Table of Qualifying Patient Volume.

“SoonerCare” is Oklahoma’s Medicaid 1115(a) waiver program and is not entirely a managed care program. One of eight plans (SoonerCare Choice) is considered managed care. SoonerCare Choice operates under a Primary Care Case Management (PCCM) model in which the OHCA contracts directly with primary care providers throughout the State to provide basic health care services. Oklahoma’s Children’s Health Insurance Program (CHIP) members are seamlessly integrated into the SoonerCare Choice program. All the other eight medical program services in the demonstration, with the exception of emergency transportation which is paid through a capitated contract, are paid through the State’s Fee For Service (FFS) system. For the duration of the Oklahoma EHR Provider Incentive Payment Program, all incentive payments to EPs and EHs will be processed through the MMIS.

CMS Question 3A: *The State indicates on page 47 of the SMHP that it will not accept meaningful use (MU) data until 2012. Please clarify whether the State will be able to accept MU attestations in 2011.*

Response: See below in Section 3.2. The text in Third paragraph has been amended as shown.



Section 3.2 Vision for HIT Environment

This section will include a description of OHCA assumptions and where the path and timing of their plans have dependencies based upon State-specific readiness factors.

Oklahoma will ~~not~~ **accept from dual Medicare/Medicaid providers attestations of meeting MU through our attestation system but will not be able to accept the meaningful use measurement results through that system. Upon approval of the MU chapter of the Implementation Advance Planning Document (IAPD), OHCA will devise a method to accept the actual results of the MU measures for analysis and reporting in other formats. OHCA will accept MU data and integrate this information into the new system when it becomes available from providers who wish to submit it.**

CMS Question 3B: *Additionally, starting on page 14, “OHCA will use the meaningful use measures identified in the Final Rule for the first year of the program.” This statement does not agree with statements above. Please correct this issue and clarify when the State will use the MU measures defined in the final rule.*

Response: See below in Section 1.1.3. The text in the paragraph 13 has been amended as shown.

Section 1.1.3 Provider Incentive Program Implementation

OHCA will use the MU measures identified in the Final Rule for the first year of the program **upon implementation of the MU chapter of our IAPD.**

CMS Question 4: *Starting on page 56, electronic verification of eligibility is not a final rule MU objective. Public health reporting is limited to testing for Stage one, not submission of reports. Therefore, OHCA's target exceeds MU. Please be clear about what are OHCA targets versus expectations for providers.*

Response: See below in Section 3.2. The last two rows of Table 6 have been deleted as shown.

Table 1 Performance Measures for SoonerCare Provider HIE Participation

Performance measure	Metric	Method and Data sources	Initial target
Percent of providers participating in HIE services enabled by statewide directories or shared services	Percent of providers using shared services	Number of providers with logins to shared services each month divided by the total number eligible to use shared services	40% participation in OKHIE at year 2
Percent of pharmacies serving people within the State that are actively supporting electronic prescribing and refill requests	Percent of new scripts that are electronic Percent of refill requests that are electronic	Number of scripts written electronically divided by the total number of scripts filled Number of refill requests submitted electronically to providers by	40% of scripts should be electronic by end of year 2 participation in OKHIE. 40% of refill requests should be electronic by the end of year 2



Performance measure	Metric	Method and Data sources	Initial target
		pharmacies divided by the total number of refills completed	participation in OKHIE
Percent of clinical laboratories serving people within the State that are actively supporting electronic ordering and results reporting	Percent of lab tests ordered electronically Percent of lab results delivered electronically	Number of lab tests ordered electronically divided by the total number of lab tests ordered Number of lab test results delivered electronically divided by total number of lab tests	Once OKHIE is established the target for SoonerCare providers is: 40% ordered electronically 95% of test results delivered electronically in Year 2
Provider participation in HIE by MU requirement met	Identity of providers who demonstrate MU Percent of providers demonstrating MU by requirement	Given finalized list of requirements, the HIE will be used to assess the number and identity of providers who meet relevant MU criteria	Once OKHIE is established, the target for SoonerCare providers is: 40% of providers meet MU criteria in Year 2
Electronic exchange of clinical summaries	Percent of clinical summaries available electronically	Number of clinical summaries in HIE divided by the total number of encounters documented	25% available electronically by the end of year 2 participation in OKHIE
Immunizations available via HIE	Percent of childhood and adult immunizations documented electronically and available in HIE Percent of providers documenting immunization administration electronically	Number of immunization administrations available electronically divided by the total need for vaccines. Number of providers entering immunization administrations each month divided by the total number of providers in the State	Once OKHIE is established, the target is 99% of immunization records available electronically by the end of year 2 and 80% of providers documenting immunizations electronically by the end of year 2
Eligibility checking	Percent of providers using electronic eligibility checking	Number of electronic eligibility checks divided by the total number of eligibility checks	60% of eligibility checks electronic by end of year 2 participation in OKHIE
Public health reporting	Percent of reports to State and local public health agencies	Number of electronic reports to public health agencies of vital statistics, reportable	50% of reports via electronic means by the end of year 2 participation in OKHIE



Performance measure	Metric	Method and Data sources	Initial target
	occurring electronically	conditions, etc. divided by total number of reports	

CMS Question 5: Starting at page 48, please include additional detail concerning how the State will interface and verify this information

Response: Section 3.2 **Registration and Attestation** is revised in its entirety as shown.

Registration and Attestation

OHCA has as part of its MMIS, a web-based electronic provider enrollment (EPE). The EPE system will be modified to accommodate registration and attestation data related to the ~~SoonerCare~~ **Oklahoma EHR Provider Incentive Payment Program**.

When OHCA receives a transaction from the National Level Repository (NLR) indicating that a provider has registered for the Oklahoma ~~SoonerCare~~ EHR Provider Incentive Payment Program, a transaction will be stored in a database in the MMIS for record tracking. Two basic validations will be made: 1.) validate the National Provider Identifier (NPI) in the transaction is on file in our MMIS Provider database, 2.) validate the provider is currently contracted with OHCA. If either of these conditions is not met, a “provider not eligible” status will be automatically sent back to the CMS NLR.

OHCA will publish on its public website and on our provider secure site, information regarding how to use the EPE system to submit an attestation for the Oklahoma EHR Provider Incentive Payment Program and advise what information and documentations the provider will need in order to: 1.) participate in the Oklahoma EHR Provider Incentive Payment Program, and 2.) meet attestation requirements to qualify for the incentive payment. ~~send the provider information regarding how to log into the EPE system and advise what information and documentation the provider will need in order to (1) register in the SoonerCare EHR Incentive Program and (2) meet attestation requirements to qualify for their incentive payment.~~

During the registration and attestation process, basic eligibility criteria, such as verification of provider NPI and taxpayer identification number (TIN), provider type, NLR status and both federal and local sanctions will be verified using EPE. **Only currently contracted providers can login to the EPE Provider Portal. The link for the EHR attestation function will only be displayed to professional provider and hospital types as designated by CMS. The Oklahoma EHR attestation process will first request the provider to enter their CMS Registration number, and this number will be compared to the NLR transactions on file locally in our MMIS. If the number is found, the NPI in the NLR Registration transaction will be compared to the provider’s NPI number associated with their login. The NLR payee TIN will also be compared to the TIN numbers associated with the provider and his/her group TINs. Any sanctions/exclusions provided in the NLR transaction will be addressed manually.**



Providers that do not meet the requirements for the program will be informed of the specific issues that affect their eligibility and the process for redress.

The MMIS/EPE system will be updated manually after eligibility verification, to reflect the provider's positive or negative eligibility. This will trigger a registration eligibility response transaction (B-7) update to the CMS NLR. In addition, when eligibility and all supporting documentation has been received and verified, a duplicate payment inquiry will be sent to the CMS NLR.

CMS Question 6: Starting at page 75, please confirm that "Acute Care hospital means any provider with a provider specialty of 010 – Acute Care Hospital or 016 – IHS Hospital" will include/match up with all of the hospitals CMS designated. (Note the only registrations the State will receive from the NLR include hospitals with the correct CCNs, so the State will be responsible for ensuring that the Average Length of Stay is 25 days or fewer),

Response: Section 4.5.1.3 second paragraph and bullet #7 are amended as shown. A sentence is added to Section 4.5.1.5 paragraph 1 to indicate how OHCA plans to monitor Critical Access Hospitals (ACHs) to ensure only admissions with an average length of stay of 25 days or less. Attestation statement is added to Table 10 in Section 4.6.1 (shown in Question # 11 below) to ensure only admissions with average length of stay 25 days or fewer are included when determining patient volume.

Section 4.5.1.3 Eligible Provider Types

Specifically, the ~~SoonerCare~~ **Oklahoma EHR Provider Incentive Payment Program** Registration component of the EPE web site will be limited to the following MMIS provider types, **which will include all of the hospital and professional provider types designated by CMS:**

- Acute Care hospital = Any provider with a provider specialty of 010 – Acute Care Hospital; ~~or~~ 016 – IHS Hospital, **or 014 – Critical Access Hospital**

Section 4.5.1.5 Verifying EP Patient Volume

Claims data from OHCAs DW will be used to verify the reasonableness of patient volume attested to by EPs **and to ensure CAHs average length of stay is 25 days or fewer.** EPs will be asked to provide separate patient volume numbers from each of the different locations associated with their NPI. This will help in two ways: 1) Practice owners/managers at one location will not be able to complete the EPs attestation for all practices and therefore, will not be able to complete the attestation and assign payment to their location without the EPs knowledge and 2) The patient volume numbers will be easier to validate at the location level than in the aggregate.

CMS Question 7: Starting at page 75, with the term "meets a SoonerCare patient volume." The Medicaid patient volume requirements are not specific to just a portion of the State's program. Please clarify in your definition of patient volume that all Medicaid clients (SoonerCare, FFS, other) will be included in the calculation.

Response: Section 4.5.1.4 paragraph 2 has been added as shown below.



CMS Question 8: Starting at page 78, with patient volume (Medicaid and NPI). Please clarify which option the State is using. It appears that to be the FFS option (non-consideration of patient panels), but also refers to SoonerCare. CMS recommends that the State consider combining the two options in order to maximize participation.

Response: Section 4.5.1.4 shown in entirety adds paragraphs 1, 2, 3, and bullet #1.

Section 4.5.1.4 Methodology for EP Patient Volume

SoonerCare Choice is a Partially Capitated Case Management managed care model. This population is enrolled in a Patient Centered Medical Home. Patient panel methodology will not be utilized. SoonerCare encounters are identified below:

For SoonerCare patient volume calculations, all populations, except CHIP members enrolled in the SoonerCare Choice Program, are considered to be Medicaid recipients, are SoonerCare members, and may be used in the numerator to the SoonerCare Patient formula ratio. Additionally, SoonerCare providers may count non-SoonerCare out-of-state Medicaid recipients, if properly documented, in the numerator of the patient volume ratio. The OHCA will participate in a CMS Region VI multi-state collaborative meeting October 19 – 22, 2010, to lay the framework for state to state data sharing.

Identification of CHIP members is a significant issue. SoonerCare members who receive services paid by Title XXI are seamlessly integrated through the Medicaid 1115 (a) waiver, as a demonstration population in the SoonerCare Choice program (see response to CMS Question 2). Due to this integration, it is impossible for EPs and EHS to distinguish between patients receiving medical assistance under Title XIX versus Title XXI. The SoonerCare membership card does not distinguish between SoonerCare programs nor does the remittance advice report distinguish which funding sources paid for members' claims. Additionally, the State does not habitually generate reports down to that level of fidelity necessary to show the fund code/program code used to pay a claim to a SoonerCare provider.

OHCA has adopted the Final Rule CMS patient volume definition for the Oklahoma EHR Provider Incentive Payment Program. The following statements encapsulate the CMS Final Rule definition regarding patient volume:

- **...The regulation at 495.306(e) states that a Medicaid encounter will exist where Medicaid (or Medicaid demonstration project approved under section 1115) paid for part or all the service; or where Medicaid (or a Medicaid demonstration project approved under section 1115) paid all or part of the individual's premiums, co-payments and/or cost-sharing. Because the methodology is based upon Medicaid payment for an encounter, and because it will be difficult or impossible for EPs and EHS to distinguish between payment that is due to expansion populations (who are not receiving title XIX medical assistance), Providers will be allowed to include in the patient volume calculation individuals who are part of expansion populations under section 1115 (a) (2) of the Act. (Source: Final Rule page 540.)**
- **"... all EPs and the vast majority of hospitals will need to meet certain patient volume thresholds in order to be eligible for incentive payments. (The only exception to this rule is for children's hospitals, which have no patient volume threshold requirement)..."**



- ...for the SoonerCare member volume, these thresholds are calculated using as the numerator the individual hospital's or EPs total number of SoonerCare member encounters in any representative continuous 90-day period in the preceding calendar year and the denominator is all patient encounters for the same individual professional or hospital over the same 90-day period.”
- EPs practicing predominantly in an FQHC or RHC **must have a minimum of 30% patient volume attributable to needy individuals as defined as §495.302** and will be evaluated according to their “needy individual” patient volume. To be identified as a “needy individual,” patients must meet one of following criteria: (1) received medical assistance from SoonerCare or the CHIP; (2) Were furnished uncompensated care by the provider; or (3) Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

Table 2 SoonerCare Patient Volumes

EH Type	Patient Volume over 90-day Period
Acute Care Hospital	10%
Children's Hospital	No percentage requirement
EP Type	Patient Volume over 90-day Period
Physicians (M.D., D.O.)	<ul style="list-style-type: none"> 30% SoonerCare For Medicaid EPs in FQHC/RHC - 30% Needy Individuals
Dentists	
Certified Nurse Midwives	
Nurse Practitioners	
PAs in FQHC/RHC led by a Physician Assistant (PA)	
Pediatricians	<ul style="list-style-type: none"> 30% SoonerCare If Pediatrician patient volume = 20-29%, the provider may qualify for 2/3 of incentive payment

CMS Question 9: Starting at page 77, Hospital-Based EPs, please clarify whether the State plans to utilize any encounter data to make this determination.

Response: OHCA replaces the second sentence of Section 4.5.1.6 as shown.

Section 4.5.1.6 Assuring Providers Are Not Hospital-Based

OHCA will ask providers to attest that they are not hospital-based. In addition, **EP paid claims data** for the reporting period will be analyzed with the provider's NPI in the rendering provider field to **determine** the place of service for their claims. Since the definition of “hospital based” now includes inpatient or ER setting, OHCA plans to use only Place of Service Codes 21-



Inpatient Hospital and 23-ER as a basis for “hospital-based” services. Analysis will be made of professional and institutional claims (and dental claims, for dental providers) to verify where their SoonerCare member time is spent. If the predominant place of service is at the inpatient hospital or ER, OHCA will consider the provider to be hospital-based.

CMS Question 10: *Starting at page 79, “EPs and EHs enrolling in Oklahoma EHR Provider Incentive Payment Program must have a practice physically located within Oklahoma.” Technically, the State may not make requirements like this, but you can say that they must have a valid payment relationship established. For example, if a provider had a practice just over the border, but still served 30 percent Oklahoma Medicaid – they may participate (and with 30 percent Medicaid, you are assured that you already have a payment relationship with the provider). Another example is that providers practicing predominantly just have to meet the program requirements, but do not have to have a practice anywhere in particular.*

Response: Section 4.5.2 has been amended as shown.

Section 4.5.2 Eligible Providers

This section will identify hospitals and providers eligible to enroll in the Oklahoma PIP.

OHCA will qualify providers as defined in the ***Final Rule Medicare and Medicaid Programs; EHR Incentive Program***. As specified under section 1903(t)(2)(A) of the Act, SoonerCare participating providers who wish to receive a Medicaid incentive payment must meet the definition of a “Medicaid EP”, “Medicaid EH” **or** “***Critical Access Hospital***.” The EP definition (1903(t)(3)(B) of the Act) lists five types of Medicaid professionals: Physicians, dentists, certified nurse-midwives, nurse practitioners, and physician assistants practicing in an FQHC or RHC that is so led by a physician assistant. OHCA also engaged I/T/U and determined that I/T/U providers that meet the eligibility criteria could also participate in the program.

All EPs and EHs enrolling in ~~SoonerCare~~ Oklahoma EHR Provider Incentive Payment Program must have a contract to provide services to SoonerCare members.

A condition of eligibility for the Oklahoma EHR Provider Incentive Payment Program is a valid SoonerCare provider contract. This establishes the payment relationship for providers who would bill directly for services rendered. SoonerCare contracts are generated using an online web application which will electronically enroll providers once necessary documentation has been faxed to OHCA. For purposes of attestation to the requirements of the incentive program, we have developed a SoonerCare contract amendment which will be electronically submitted and approved upon receipt of faxed support documentation.

For purposes of verifying patient volume prior to payment, OHCA will perform business queries to our MMIS and using paid claims data associated with the specific provider, determine the reasonableness of the provider patient volume. In the case of providers who are not physically located in the State but have a SoonerCare contract or in-state providers who are using Medicaid patients from another state to achieve their patient volume requirements, OHCA will suspend the incentive payment until verification of Medicaid encounters is made through collaboration with the provider’s home state



Medicaid agency and the appropriate documentation is manually analyzed to ensure patient volume requirements have been achieved.

Out of state providers without a valid SoonerCare contract who register on the NLR and elect to participate in Oklahoma’s EHR Provider Incentive Payment Program will be considered ineligible until the out of state provider has a valid SoonerCare provider contract. Multi-state collaboration and data sharing will be used to verify non-SoonerCare out of state Medicaid recipient encounters. The OHCA will participate in a CMS Region VI multi-state collaborative meeting October 19 – 22, 2010, to lay the framework for state to state data sharing.

CMS Question 11: Starting at page 82-84, attestations. Please add clarifying language that describes which attestations are required when a hospital is dually-eligible for Medicare and Medicaid incentives.

Response: Section 4.6.1 is shown in its entirety. Paragraph 3 has been added under Table 9 in SMHP and Table 10 has been updated to clarify which attestations are required for dually eligible EHs.

Section 4.6.1 Provider Registration and Payment Request

Providers (EPs, EHs, and CAHs) contacting OHCA regarding the ~~SoonerCare Oklahoma EHR Provider Incentive Payment Program~~ payment process will be directed to the OCHA secure provider web site for detailed information on participation in the ~~SoonerCare~~-EHR Incentive Program in Oklahoma. Providers will be instructed to register in the NLR before requesting payment from OHCA.

OHCA is leveraging capability to have providers electronically engage with OHCA. OHCA is modifying the design and requirements to match NLR and Office of National Coordinator certification web service and screen designs are available upon request.

Providers (EPs, EHs, and CAHs) are directed to the EPE site to begin ~~SoonerCare Oklahoma EHR Provider Incentive Payment~~ Program registration. OHCA will validate the SoonerCare provider enrollment and the NLR record, affirming that the provider has selected Oklahoma SoonerCare participation. The provider is then directed to the Oklahoma secure EPE Attestation page where he/she will enter his/her NLR Registration number. The Attestation process will search for the NLR Registration number in the NLR table. The Attestation process will automatically compare the provider type, NPI, and payee TIN to the information from the NLR. If these do not match, the user will receive an error message on the screen with an OHCA phone number to call for assistance. The Attestation process will compute the current participation year based on the most recent NLR Registration record participation year and the number of participation/payment years recorded in the Oklahoma MMIS.

Table 9 EP Attestations

During EHR Year 1 reporting period, the EP attests:	During EHR Years 2 through 6 reporting period, the EP attests:
The EP is a board certified Pediatrician, if applicable	The EP is a board certified Pediatrician, if applicable



During EHR Year 1 reporting period, the EP attests:	During EHR Years 2 through 6 reporting period, the EP attests:
The Physician Assistant attest that he/she is working in an FQHC or RHC so led by: a) a PA as the primary provider in the clinic, b) a PA as the clinical or medical director at a site of practice, or c) a PA as an owner of an Rural Health Clinic	The Physician Assistant attest that he/she is working in an FQHC or RHC so led by: a) a PA as the primary provider in the clinic, b) a PA as the clinical or medical director at a site of practice, or c) a PA as an owner of an RHC
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
The EP is not Hospital based professional who furnishes 90% or more of his/her professional services in an inpatient hospital or emergency room setting, if he/she does not practice predominantly in an FQHC or RHC	The EP is not Hospital based professional who furnishes 90% or more of his/her professional services in an inpatient hospital or emergency room setting, if he/she does not practice predominantly in an FQHC or RHC
The EP is not concurrently receiving an incentive payment from another state, or under another SoonerCare ID number or Medicare program	The EP is not concurrently receiving an incentive payment from another state, or under another SoonerCare ID number or Medicare program.
The EP has adopted, implemented or upgraded (A/I/U) a certified EHR	The EP used certified EHR technology
The EHR product used is certified and EP entered a product certification number	The EHR product used is certified and EP entered a product certification number
The EP has reported the number of Full Time Equivalent (FTE) jobs created by implementing this certified EHR product	The EP has reported the number of FTE jobs created by implementing this certified EHR product
The EP has reported the amount of cash payments made directly attributable to him/her for the certified EHR (not including payments from state or local governments, in-kind contributions, etc.)	The EP has reported the amount of cash payments made directly attributable to him/her for the certified EHR (not including payments from state or local governments, in-kind contributions, etc.)
The EP has confirmed That at least \$3,750 of the EHR technology is the responsibility of him/her or his/her employer, group, clinic, hospital affiliation, or in-kind contributions or grants	The EP has confirmed That at least \$1,500 of the EHR technology is the responsibility of him/her or his/her employer, group, clinic, hospital affiliation, or in-kind contributions or grants
The EP has confirmed assignment of his/her payment to another TIN and agrees to this assignment, if applicable	The EP has confirmed assignment of his/her payment to another TIN and agrees to this assignment, if applicable
The EP's percentage of SoonerCare encounters or Needy Individual (for EPs practicing predominantly in an FQHC/RHC) patient volume is equal to or greater than the allowed percentage of their specialty (See Appendix E)	The EP's percentage of SoonerCare encounters or Needy Individual (for EPs practicing predominantly in an FQHC/RHC) patient volume is equal to or greater than the allowed percentage of their specialty (See Appendix E)
The EP has specified the patient volume date range of at least 90 days	The EP has specified the patient volume date range of at least 90 days
	The EP has specified the EHR reporting period and provided the result of each applicable measure for all patients seen during the EHR reporting period for which a selected measure is applicable



During EHR Year 1 reporting period, the EP attests:	During EHR Years 2 through 6 reporting period, the EP attests:
	The EP has satisfied the required objectives and associated measures under §495.6(d) and §495.6(e), except §495.6(d)(10) "Report ambulatory clinical quality measures to the State"
	The EP attests to meeting the MU criteria associated with his/her year of participation and applicable stage per the rule
	If applicable, the EP attests that the clinical quality measures not reported do not apply to any patients treated by the EP
The EP attests that all information is true and accurate per wording in the rule	The EP attests that all information is true and accurate per wording in the rule
The EPs electronic signature on the attestation is valid for the SoonerCare EHR Incentive Program payment request	The EPs electronic signature on the attestation is valid for the SoonerCare EHR Incentive Program payment request

For all calendar years, an EP who practices in multiple physical locations, not all of which have certified EHR technology available, the EP will demonstrate MU using only the locations where the EP has certified EHR technology available.

In order to qualify for payment, the EP must meet the definition of §495.4 meaningful EHR user.

Hospitals enrolled in Medicare Incentive Payment Programs will be deemed eligible for Medicaid – Oklahoma EHR Provider Incentive Payment Program. Payment will be made if they have met all the eligibility criteria for Medicaid, and have met the Medicare definition for MU.

Table 10 EHs and CAHs Attestations

Attestations apply to all hospitals unless otherwise noted.

EHs or CAHs eligible only for the Oklahoma EHR Incentive Payment Program, attesting to Adopt, Implement, or Upgrade in their first participation year attests that:	During 2011 reporting period, the EHs or CAHs attesting to MU attests that:	During 2012 and subsequent reporting periods, the EHs or CAHs attesting to MU attests that:
The EH or CAH adopted, implemented or upgraded (A/I/U) certified EHR technology	The EH or CAH used certified EHR technology	The EH or CAH used certified EHR technology
The EH or CAH has attested using the most recent year admissions with average length of stay 25 days or less to determine Medicaid patient volume	The EH or CAH has attested using the most recent year admissions with average length of stay 25 days or less to determine Medicaid patient volume	The EH or CAH has attested using the most recent year admissions with average length of stay 25 days or less to determine Medicaid patient volume
	The EHR product used is certified and EH or CAH	The EHR product used is certified and EH or CAH entered



EHs or CAHs eligible only for the Oklahoma EHR Incentive Payment Program, attesting to Adopt, Implement, or Upgrade in their first participation year attests that:	During 2011 reporting period, the EHs or CAHs attesting to MU attests that:	During 2012 and subsequent reporting periods, the EHs or CAHs attesting to MU attests that:
	entered product certification number, vendor, product, and version	product certification number, vendor, product, and version
The EH or CAH has reported the number of FTE jobs created by implementing this certified EHR product	The EH or CAH has reported the number of FTE jobs created by implementing this certified EHR product	The EH or CAH has reported the number of FTE jobs created by implementing this certified EHR product
	The EH or CAH satisfied the required objectives and associated measures under §495.6(f) and §495.6(g).	The EH or CAH has satisfied the required objectives and associated measures under §495.6(f) and §495.6(g), except §495.6(f)(9) "Report hospital clinical quality measures to the State"
		The EH or CAH attests that the information submitted with respect to clinical quality measures was generated as output from an identified certified EHR technology
		The EH or CAH attests that the information was submitted to the knowledge and belief of the official submitting on behalf of the EH or CAH
		The EH or CAH attests that the information submitted includes information on all patients to whom the measure applies (not applicable to dually EHs)
		For EHs or CAHs that do not report one or more measures, the EH or CAH attests that the clinical quality measures not reported do not apply to any patients treated by the EH or CAH during the reporting period (not applicable to dually EHs)
		The EH or CAH attests numerators, denominators, and exclusions for each clinical quality measure result reported, providing separate information for each clinical quality measure including the numerators,



EHs or CAHs eligible only for the Oklahoma EHR Incentive Payment Program, attesting to Adopt, Implement, or Upgrade in their first participation year attests that:	During 2011 reporting period, the EHs or CAHs attesting to MU attests that:	During 2012 and subsequent reporting periods, the EHs or CAHs attesting to MU attests that:
		denominators, and exclusions for all patients irrespective of third-party payer or lack thereof; for Medicaid patients. (not applicable to dually EHs)
		The EH or CAH attests the beginning and end dates for which the numerators, denominators, and exclusions apply (not applicable to dually EHs)
	The EH or CAH specified the EHR reporting period and provided the result of each applicable measure for all patients admitted to the inpatient or emergency department (Place Of Service (POS) 21 or 23) of the hospital during the EHR reporting period for which a selected measure is applicable	The EH or CAH specified the EHR reporting period and provided the result of each applicable measure for all patients admitted to the inpatient or emergency department (POS 21 or 23) of the hospital during the EHR reporting period for which a selected measure is applicable (not applicable to dually EHs)
The EH or CAH attests that all information is true and accurate per wording in the rule	The EH or CAH attests that all information is true and accurate per wording in the rule	The EH or CAH attests that all information is true and accurate per wording in the rule
The EH or CAH electronic signature on the attestation is valid for the Oklahoma EHR Provider Incentive Payment Program payment request	The EH or CAH electronic signature on the attestation is valid for the Oklahoma EHR Provider Incentive Payment Program payment request	The EH or CAH electronic signature on the attestation is valid for the Oklahoma EHR Provider Incentive Payment Program payment request

Provider attestation information will be reviewed by OHCA to determine provider eligibility. The EHR system certification number entered on the attestation has been verified prior to payment being made. (OHCA is working with CMS and Office of National Coordinator (ONC) to automate this process.) Providers determined to be eligible will receive incentive payment for that year. Providers will have to re-attest each year to MU for each year's participation in Oklahoma EHR Provider Incentive Payment Program prior to receipt of an incentive payment.

OHCA will confirm the provider's eligibility for the current year's payment via the MMIS Provider subsystem. OHCA will approve the provider incentive payment via the MMIS Financial subsystem.



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

CMS Question 12: *References to “when the CMS final rule is out” should be updated to reflect that the final rule is now published and any associated policies should be adjusted to reflect the final rule requirements.*

Response: A search of the document was conducted to identify any references to “when the CMS final rule is out.” One instance was found in Section 4.3.1.1 Recent Changes in State Laws or Regulation. The sentence 2 in first paragraph was removed from the SMHP as shown.

Section 4.3.1.1 Recent Changes in State Laws or Regulation

MITA Reference: Develop and Maintain Program Policy (PG05)

A statewide regulatory review is underway; at this point, only minimal changes and no new State laws are expected at this time. ~~Once the Final Rule is released, it will be reviewed for any changes to determine if the initial review is still relevant or if it needs revision.~~

CMS Question 13: *Starting at page 85, please clarify how the State will calculate and/or ensure this.*

Response: Section 4.6.2.1 paragraph 1 has been amended as shown.

Section 4.6.2.1 EP Payment Calculations

OHCA will validate Provider “net” average allowable costs. ***EPs will attest to 1.) The amount of cash payments directly attributable to only the EHR technology; and 2.) At least \$3,750 (first year)/\$1,500 (2nd – 6th years) have been paid by the EP or on their behalf by their employer, in kind, grant, etc. OHCA will request supporting documentation on audit. The amount of cash payments directly attributable to only EHR technology will be subtracted from the Health and Human Services-defined Net Average Allowable Cost (NAAC) of \$54,000 (first year) or \$20,610 (subsequent years), to arrive at the NAAC. If the NAAC exceeds the maximum NAAC of \$25,000 (first year) or \$10,000 (subsequent years), the NAAC will be reduced to the maximum NAAC allowed for that provider’s participation year. The EHR incentive payment will be 85% of the maximum allowed NAAC, not to exceed \$21,250 in the first year and \$8,500 in years 2-6. Pediatricians attesting to a patient volume between 20% - 29% will receive 2/3 of the incentive payment amount.*** Allowable costs for each provider must be adjusted in order to subtract any cash payment that is made to SoonerCare EPs and is directly attributable to payment for certified EHR technology or support services of such technology. Payments from State or local governments, in-kind contributions and grants do not reduce the average allowable costs. The resulting figure is the “net” average allowable cost, that is, average allowable cost minus payments from other sources (other than State or local governments).

OHCA will calculate 85 percent of a “net” allowable cost not to exceed a maximum in the first year of \$21,250. Per §495.310, an EP may not begin receiving payments later than calendar year 2016. For subsequent years, OHCA will calculate 85 percent of a NAAC, not to exceed a maximum of \$8,500. Payment after the first year may continue for a maximum of five years.



SoonerCare EPs may receive payments on a non-consecutive, annual basis. No payments may be made after calendar year 2021. In no case shall a SoonerCare EP participate for longer than six years or receive payment in excess of the maximum \$63,750.

EPs that meet the State definition of Pediatrician and carry between 20 and 29 percent Medicaid patient volume will have their payment reduced by one-third. The Pediatrician will not receive more than \$14,167 in the first year and not more than \$5,667 for subsequent years. The total allowable for six years will not exceed \$42,500. All other requirements noted above for an EP remain the same.

CMS Question 14: *It appears that "SoonerCare" refers to both Medicaid and CHIP. Please add clarifying language that the State understands that CHIP encounters do not count in the calculation of Medicaid patient volume.*

Response: Please see Section 4.5.1.4 above (see CMS Question 8); shown in entirety adds paragraphs 1, 2, 3 and bullet #1.

CMS Question 15: *Please clarify in the SMHP when discussing incentive payments or amounts that these payments are not based upon a percentage of cost, and that they are incentives not reimbursements.*

Response: Section 4.3.1 text in sentence two has been amended as shown. Section 4.6.2.1 revisions are shown above in Question 13.

Section 4.3.1 Policy Changes

OHCA policy staff will conduct a comprehensive review of new policy required to implement the ~~SoonerCare~~ **Oklahoma EHR Provider Incentive Payment Program**. At this time, OHCA expects to create a new section of policy dedicated solely to the governance of these programs. Within this new section, the agency will address administrative processes, provider eligibility rules, and ~~reimbursement incentive payment~~ criteria and procedures. Specifically, OHCA will address policy on issues related to SoonerCare patient volume standards, the definition of pediatrician, MU criteria and payment to EPs. Where there is no specific written policy, *OHCA will defer to the Final Rule.* ~~issued by CMS.~~ OHCA will also revise relevant sections of OHCA Administrative Code (title 317), Chapter 2 Grievance rules to incorporate provider appeals processes related to EHR incentive payments.

CMS Question 16: *Starting on page 76, the SMHP indicates that the State may need to conduct State rulemaking. Please clarify what rule-making will be needed, if rulemaking presents any challenges to your January implementation, and provide any timelines for this activity.*

Response: Section 4.3.1.1 is shown in entirety. A new paragraph 2 is added in SMHP.



Section 4.3.1.1 Recent Changes to State Laws and Regulations

A statewide regulatory review is underway; at this point, only minimal changes and no new State laws are expected at this time. ~~Once the Final Rule is released, it will be reviewed for any changes to determine if the initial review is still relevant or if it needs revision.~~

Rules have been developed and are going through the Oklahoma rule making process. Areas addressed are: program description, eligible providers (under revision), SoonerCare patient volume description by provider type (under revision), the requirement of providers to maintain proof of encounters for out of state Medicaid patients, A/I/U and MU definitions, the payment process and administrative appeals. The timeline for implementation is contained within the simultaneously submitted IAPD and are currently scheduled to be complete on or about December 1, 2010.

CMS Question 17: *The SMHP indicates that “During the period of eligibility, be a SoonerCare Contracted provider (exceptions may be providers who do not contract directly with OHCA but are based in SoonerCare contracted FQHC, RHC, IHS, or Tribal facilities.” Please describe how the State will pay EPs who want to use their own TIN as opposed to the clinic TIN.*

Response: See Section 4.4. A new paragraph 2 is added to the SMHP as shown.

Section 4.4 OHCA Contract Changes

For purposes of the Oklahoma EHR Provider Incentive Payment Program, providers who are based in contracted FQHC, RHC, IHS, or Tribal facilities will be required to complete a rendering provider agreement. This agreement will require the provider to provide all necessary information to receive an EHR Incentive payment and subsequent Internal Revenue Service (IRS) Form 1099.

CMS Question 18: *Starting on page 12, “A comprehensive review of new policy required to implement the Oklahoma EHR Provider Incentive Payment Program will occur after the Final Rule is released. OHCA anticipates a new section of policy dedicated solely to the governance of the program. Based on the assessment, areas that must be addressed include policy related to SoonerCare patient volume standards, the definition of pediatrician, MU criteria, and payments to EPs. Where no specific written policy exists, OHCA will defer to the Final Rule issued by CMS.” Please include specific information in the SMHP concerning all planned or anticipated OHCA policy to implement the incentive program.*

Response: See Section 1.1.3, paragraphs 4 and 5 have been amended as shown.

Section 1.1.3 Provider Incentive Program Implementation

Another important ongoing activity is the review of regulatory requirements, identification of policy and regulatory changes. OHCA policy staff will conduct a comprehensive review of new policy required to implement the ~~SoonerCare~~ **Oklahoma EHR Provider Incentive Payment Program. At this time, OHCA expects to create a new section of policy dedicated solely to the governance of the program. Within this new section, the agency will address administrative processes, provider eligibility rules, and reimbursement-incentive payment criteria and procedures. Specifically, OHCA will address policy on issues**



related to SoonerCare patient volume standards, the definition of pediatrician, MU criteria, and payment to EPs. Where no specific written policy exists, OHCA will defer to the Final Rule. OHCA will also revise relevant sections of OHCA Administrative Code (title 317) Chapter 2 Grievance rules to incorporate provider appeals processes related to EHR incentive payments.

The Oklahoma rules have yet to be finalized; however OHCA anticipates a final version by late-October. Many of the areas are contingent upon CMS final acceptance of answers in this update to the SMHP. However, areas identified in the rules are: program description, eligible providers (under revision), SoonerCare patient volume description by provider type (under revision), the requirement of providers to maintain proof of encounters for out of state Medicaid patients, A/I/U and MU definitions, the payment process and administrative appeals. Based on the timeline submitted with Oklahoma's IAPD, administrative rules for the program to include provider appeals are currently scheduled to be complete on or about December 1, 2010.

CMS Question 19: *The SMHP does not appear to discuss critical access hospitals in Oklahoma. Please clarify if there are CAHs and how the State will address these providers in the program, including OHCA outreach.*

Response: See Section 2.5.2. A new paragraph 2 is added as shown.

2.5.2 Hospital and CAH Scan

The CAHs were included in the hospital survey. OHCA collaborated with the Oklahoma Hospital Association to ensure CAHs were informed and aware of the Oklahoma EHR Provider Incentive Payment Program opportunity. Information was made available to CAHs on OHCA web site, numerous Oklahoma associations, upon request from associations and through semi-annual provider training workshops.

CMS Question 20: *Starting on page 74, Provider Eligibility. The State did not include discussions of physician assistants practicing in FQHCs and RHCs. Please refer to the final rule, and add this information to the SMHP.*

Response: Section 4.4, a new paragraph 2 has been added to the SMHP. Section 4.5, paragraphs 4 was amended and a new paragraph 5 added to the SMHP as shown.

Section 4.4 OHCA Contract Changes

For purposes of the Oklahoma EHR Provider Incentive Payment Program, providers who are based in contracted FQHC, RHC, IHS, or Tribal facilities will be required to complete a rendering provider agreement. This agreement will require the provider to provide all necessary information to receive an EHR Incentive payment and subsequent IRS Form 1099.

Section 4.5 Provider Eligibility for Incentive Payments

At this time, providers and hospitals eligible for the SoonerCare Oklahoma-EHR Provider Incentive Payment Program are as follows:



- Physicians
- Pediatrician
- Nurse Practitioner
- Certified Nurse Midwife
- **Physician Assistants practicing in FQHCs and RHCs led by a Physician Assistant**
- Dentist
- Acute Care hospital
- Children's Hospital

A FQHC or RHC is considered to be PA led when: 1.) the PA is the primary provider in a clinic (e.g., part time physician and full time PA in the clinic); 2.) the PA is the clinical or medical director at a clinical site of the practice; or 3.) the PA is the owner of the RHC.

CMS Question 21: Starting on page 75, (§4.5.1.8), ensure providers are licensed, not sanctioned. CMS would like additional detail about how the State enrolls providers into their SoonerCare program and how OHCA will ensure that they are protecting the Oklahoma EHR Provider Incentive Payment Program from excluded, sanctioned or debarred providers.

Response: See Section 4.5.1.8. A new paragraph 2 is added and a new second sentence is added to paragraph 3 as shown.

Section 4.5.1.8 Ensure Providers are Licensed; Not Sanctioned

MITA Reference: Enroll Provider (PM 01) and Disenroll Provider (PM 02)

OHCA's existing process for checking provider licensure and sanctioning will be employed for the Oklahoma EHR Provider Incentive Payment Program as well.

SoonerCare contracts are generated using an online web application called EPE. The application is filled out by a provider, electronically signed and electronically enrolls provider once necessary licensure and credentialing documentation has been faxed to OHCA and proper verification has been performed.

All providers are manually checked for sanctions before being enrolled in SoonerCare. Once a month, CMS sends a file that is run against the provider file to check for any new sanctions. **The monthly sanction listing is continuously used to verify eligibility of currently contracted providers as well as providers seeking to enroll as a SoonerCare provider.** CMS also sends letters when new providers to the State are sanctioned. OHCA staff use multiple local resources to identify new sanctions. All these sources will be reviewed prior to completing any provider's enrollment in the Oklahoma EHR Provider Incentive Payment Program.

While I/T/U providers are required to be licensed, they are not required to have a valid Oklahoma license. As part of the EPE contracting process, OHCA verifies with the appropriate State licensing entity that the I/T/U provider has a valid license.

CMS Question 22: Starting on page 91 (§4.9.2), Fraud and Abuse Prevention. "OHCA plans additional annual audit activities to support the validation of provider attestations and provider data submissions to ensure compliance with the federal program. "Please clarify how the State



will conduct these audits, and whether the State plans to utilize contractors for this purpose". Please describe any scope of work that is anticipated for contractors.

Response: See Section 4.9.2, paragraphs 4 through 8 are added as shown.

Section 4.9.2 Fraud and Abuse Prevention

OHCA's Program Integrity and Accountability Unit will conduct annual audits of provider incentive payments. There is no plan to use contractors to perform any audits of this program. Audits will be conducted via statistical sampling. Volume, scope, methods, and procedures will be based on risk assessments and materiality consistent with the OHCA Program Integrity and Planning Division Audit Review Process. Guidance in the Audit Review Process handbook outlines the steps below to define Audit Scope.

Assessment and Analysis

The audit assessment and analysis phase includes steps necessary to assemble information that will enable the audit team to make decisions concerning the nature, timing, and extent of detailed audit work. The review includes a timely gathering and analysis of information so that potential audit areas can be identified and plans made to review and test management controls over these areas.

Focus Objectives

Focusing on objectives is a function of the internal control assessment and risk analysis, which can be done systematically through the process of a survey.

Risk Analysis and Internal Control Assessment

The purpose of the audit survey is to identify areas of potential audit risk and design audit work to minimize the risk. The audit team should target its resources in areas with the most risk. This requires that the audit team gain an understanding of the internal control structure. With this understanding, the team should identify the controls that are relevant to the objectives of the audit. The team should then assess the relative control risk for each control. There are several approaches to making a risk analysis and internal control assessment. Regardless of the method followed, the team must consider all factors relevant to the audit objective. These factors include materiality, significance of legal and regulatory requirements, and the visibility and nature of the government programs.

Refine Objectives

Through a careful process of analyzing risk and assessing internal controls, the team must ensure that the audit objectives cover the areas of highest risk consistent with resource limitations. The team should refine the overall objective(s) established in the preliminary planning phase when necessary.

CMS Question 23: Starting on page 91 (§4.9.3). Provider Appeals. Please clarify when the State anticipates having administrative rules in place that allow for provider appeals, and any obstacles to implementation, such as rules processing time, provider notice, etc.



Response: See Section 4.9.3, paragraph 1 is amended as shown.

Section 4.9.3 Provider Appeals

OHCA will have a process in place for a provider to appeal incentive payments, provider eligibility determination, and efforts to adopt MU in the Oklahoma EHR Provider Incentive Payment Program. ***Based on the timeline submitted with Oklahoma's IAPD, administrative rules for the program to include provider appeals are currently scheduled to be complete on or about December 1, 2010.***