



IDAHO DEPARTMENT OF

HEALTH & WELFARE

Division of Medicaid



EHR Incentive Programs
A program of the Centers for Medicare & Medicaid Services

State Medicaid Health Information Technology
Plan

May 2016

Table of Contents

State Information	5
Acronyms and Definitions	6
Section 1 – Executive Summary	8
1.1 – Purpose.....	8
1.2 – Introduction.....	8
1.3 – Future Submissions of the Idaho SMHP.....	8
Section 2 – “As-Is” HIT Landscape Assessment	9
2.1 – HIT Landscape Assessment (Environmental Scan).....	9
2.2 – Broadband Internet Access	11
2.3 – FQHC Networks Receiving HIT/EHR Funding.....	13
2.4 – Veterans Administration and Indian Health Facilities Operating EHRs	13
2.5 – Existing HIT and HIE Relationships and Activities.....	14
2.6 – State Medicaid Agency Relationships	15
2.7 – Idaho’s Collaboration and Coordination with Statewide HIE.....	15
2.8 – Role of MMIS in HIT and HIE Environment.....	16
2.9 – Activities Currently Underway to Facilitate HIE/EHR Adoption.....	17
2.10 – Medicaid’s Relationship with the State HIT Coordinator	17
2.11 – Prospects for Participation in the Medicaid EHR Incentive Program	17
2.12 – Recent Relevant Changes to State Laws or Regulations	17
2.13 – Activities across State Borders	18
2.14 – Current Interoperability of State Immunization Registry and Public Health Reporting Databases	19
2.15 – CHIPRA Grants	20
Section 3 – “To-Be” HIT Landscape and Vision	22
3.1 – HIT and HIE Goals and Objectives	22
3.2 – Future IT System Architecture Relating to HIT and HIE.....	23
3.3 – Idaho Medicaid EHR Incentive Program Interface	24
3.4 – Vision for HIE Governance	25
3.5 – EHR Adoption Initiatives	25
3.6 – Health Resources Service Administration HIT/EHR Funding in Idaho.....	26
3.7 – Technical Assistance for Medicaid Providers	26
3.8 – Addressing Populations with Unique Needs	27
3.9 – Leveraging HIT-Related Grant Awards	27

3.10 – New State Legislation	28
Section 4 – Administration of the EHR Incentive Program Development Plan	29
4.1 – Professional and Hospital Eligibility	29
4.2 – Identifying Hospital-Based Professionals.....	30
4.3 – Verification of Provider Attestations.....	31
4.4 – Communication Approach.....	31
4.5 – Calculation of PV.....	32
4.6(a) – Verification of PV	33
4.6(b) – Verification of AIU	34
4.7(a) – “Practices Predominantly” Requirement.....	34
4.7(b) – MU in Second Participation Year	35
4.8 – Proposed Changes to Meaningful Use Definition	35
4.9 – Verification of Use of CEHRT	35
4.10 – Collection of MU Data	36
4.11 – Collection of Clinical Quality Measures Data.....	36
4.12 – IT, Fiscal, and Communication Systems	37
4.13 – IT System Changes	38
4.14 – IT Systems Modifications Timeframe	39
4.15 – Interface with CMS National Level Repository Timeframe	40
4.16 – Collection of Registration Data	40
4.17 – Program Website.....	40
4.18 – Anticipated MMIS Modifications.....	41
4.19 – Addressing Incentive Program Questions.....	41
4.20 – Provider Appeal Process.....	41
4.21 – Accounting for Federal Funding.....	42
4.22(a) – Frequency for Making EHR Incentive Payments.....	43
4.22(b) – Payments Made Directly to the Provider	43
4.23 – Assuring Payments Promote Adoption of CEHRT	44
4.24 – Managed Care Methodology	44
4.25 – Question Removed by CMS	44
4.26 – Role of Medicaid Contractors in Program Implementation.....	44
4.27 – EHR Incentive Program Assumptions and Dependencies.....	45

Section 5 – Audit Strategy	46
Section 6 – HIT Roadmap	47
6.1 – HIT/HIE Pathway	47
6.2 – Annual Benchmarks and EHR Adoption Expectations	49
6.3 – Annual Benchmarks for Medicaid Goals.....	49
6.4 – Annual Benchmarks for Audit and Oversight Activities.....	50
Appendix A – Activity Schedules	51
A.1 – Previous Activity Schedule.....	51
A.2 – Proposed Activity Schedule.....	52
Appendix B – Broadband Grants in Idaho	53
Appendix C – Provider Attestation Portal Application Steps	57
Appendix D – Incentive Program Process Flows.....	58
D.1 – Program Process Flows Glossary.....	58
D.2 – EH Preliminary Eligibility Verification.....	59
D.3 – EP Preliminary Eligibility Verification	60
D.4 – Final Eligibility Verification.....	61
D.5 – EP PV Check.....	62
D.6 – EH Patient Volume Check.....	63
D.7 – Navision Provider Payment	64
D.8 – Payment Recoupment	65
D.9 – Provider Appeals.....	66
Appendix E – Hospital Calculation Worksheet	67
E.1 – Eligibility Details	67
E.2 – Calculation.....	68

State Information

Name of State:	State of Idaho
Name of State Medicaid Agency:	Idaho Department of Health and Welfare Division of Medicaid
Name of Contact(s) at State Medicaid Agency:	Cale Coyle, Principal Financial Specialist KayLee Leavitt, Senior Financial Specialist Alan Brewington, Senior Financial Specialist
E-mail Address(es) of Contact(s) at State Medicaid Agency:	Cale: coylec@dhw.idaho.gov KayLee: leavittk@dhw.idaho.gov Alan: brewinga@dhw.idaho.gov
Telephone Number(s) of Contact(s) at State Medicaid Agency:	Cale: (208) 364-1817 KayLee: (208) 287-1175 Alan: (208) 364-1994
Date of Submission to CMS Regional HITECH Point of Contact:	June 01, 2016
Version #	5.0

Acronyms and Definitions

AIU	–	Adopt, Implement, Upgrade
ALOS	–	Average Length of Stay
APD	–	Advance Planning Document
ARRA	–	American Recovery and Reinvestment Act of 2009
ATCB	–	Authorized Testing and Certification Body
CAH	–	Critical Access Hospital
CCHIT	–	Certification Commission for Health Information Technology
CCN	–	CMS Certification Number
CEHRT	–	Certified EHR Technology
CFR	–	Code of Federal Regulations
CHIP	–	Children’s Health Insurance Plan
CHIPRA	–	Children’s Health Insurance Plan Reauthorization Act of 2009
CHPL	–	Certified HIT Product List
CMS	–	Center for Medicare and Medicaid Services
CPOE	–	Computer Process Order Entry
CQM	–	Clinical Quality Measure
CY	–	Calendar Year
DHHS	–	Department of Health and Human Services
DSS	–	Decision Support System
ED	–	Emergency Department
EDI	–	Electronic Data Interchange
EH	–	Eligible Hospital
EHR	–	Electronic Health Record
EIN	–	Employer Identification Number
EMR	–	Electronic Medical Record
EP	–	Eligible Professional
FEIN	–	Federal Employer Identification Number
FFY	–	Federal Fiscal Year
FQHC	–	Federally Qualified Health Center
HHS	–	Department of Health and Human Services
HIE	–	Health Information Exchange
HIO	–	Health Information Organization
HIPAA	–	Health Insurance Portability and Accountability Act of 1996

- HIT – Health Information Technology
- HITECH – Health Information Technology for Economic and Clinical Health
- IAPD – Implementation Advanced Planning Document
- IDHW – Idaho Department of Health and Welfare
- IIMS – Idaho Incentive Management System
- IHC – Indian Health Clinic
- IHDE – Idaho Health Data Exchange
- IHS – Indian Health Services
- IT – Information Technology
- MITA – Medicaid Information Technology Architecture
- MMIS – Medicaid Management Information System
- MU – Meaningful Use
- NHIN – National Health Information Network
- NLR – National Level Repository
- NP – Nurse Practitioner
- NPI – National Provider Identifier
- OIG – Office of the Inspector General
- ONC – Office of the National Coordinator
- PAPD – Planning Advanced Planning Document
- PCA – Program Cost Account
- PHR – Personal Health Record
- PV – Patient Volume
- RHC – Rural Health Center
- RHIO – Regional Health Information Organization
- SFY – State Fiscal Year
- SLR – State Level Repository
- SMA – State Medicaid Agency
- SMHP – State Medicaid HIT Plan
- SMM – State Medicaid Manual
- TIN – Tax Identification Number
- WIREC – Washington and Idaho Regional Extension Center

The Idaho Medicaid EHR Incentive Program team uses the CMS-definitions for this program. In addition, IDAPA 16.03.25 defines other items which CMS did not already define.

Section 1 – Executive Summary

1.1 – Purpose

The purpose of this SMHP (*previous SMHP version submitted March 03, 2015 and approved May 13, 2015*) is to provide CMS and IDHW with a common understanding of the SMHP Idaho Medicaid has relative to Section 4201 Medicaid provisions of ARRA. This section of the act provides 90% FFP HIT Administrative match for three activities to be done under the direction of the IDHW:

- Administer the incentive payments to EPs and EHS
- Conduct adequate oversight of the program, including tracking MU by providers
- Pursue initiatives to encourage the adoption of CEHRT to promote health care quality and the exchange of health care information

The most recent update to the SMHP has been submitted concurrently with this IAPD-U.

1.2 – Introduction

Idaho recognized the importance of HIT prior to the passing of ARRA. In 2006, the Idaho Legislature codified the state's interest in HIT through creation of a Health Quality Planning Commission and recognition of the potential to improve health outcomes and quality of care through investment in HIT. In early 2010, Governor Butch Otter signed a bill making the Idaho Health Quality Planning Commission permanent.

1.3 – Future Submissions of the Idaho SMHP

As Idaho's needs evolve and the HIT vision is realized, updates to this SMHP will be submitted to CMS for consideration. All future iterations of the document will require approval from CMS. The update process will allow Idaho Medicaid to be responsive to changes in the Idaho HIT landscape, continue to tailor the Idaho Medicaid EHR Incentive Program to best serve EPs and EHS, and to learn from best practices established as Idaho and other states implement HIT initiatives with the potential to improve health care.

Section 2 – “As-Is” HIT Landscape Assessment

A baseline assessment of the Idaho EHR as-is landscape was conducted in 2010. Following an initial survey of potential EPs and EHs to gather information on the current state of HIT adoption and the use of EHRs, Idaho Medicaid interviewed internal and external stakeholders to further understand the existing HIT environment and technical capabilities. Idaho Medicaid met with stakeholders from IDHW (related Medicaid program managers) as well as statewide stakeholders (including, but not limited to, professional organizations and broadband industry leaders) to identify initiatives which would position Idaho for successful implementation of Idaho Medicaid’s EHR Incentive Program.

Idaho Medicaid conducted a survey of the provider community in 2010 to assess current and planned usage of EHR technology. Among respondents, 100% of hospitals had already implemented EHR systems or planned to implement a system within the next three years. Among medical practices, the move toward these systems was much lower, with approximately half of total respondents stating they have adopted or planned to adopt within three years. As of June 2016, approximately 31% of non-hospital medical practices have adopted and implemented an EHR system.

A follow-up provider survey was conducted in June 2011 to determine the extent EPs and EHs were moving toward the adoption, implementation, or upgrade of EHR systems. There were three main entities engaged in the promotion of HIT in collaboration with Idaho Medicaid. A grant-based State HIT Coordinator served as the key point of contact for ARRA funding for HIT and HIE projects including workforce and broadband programs. Technical assistance and provider outreach was conducted in collaboration with WIREC for HIT, which also received funding from ARRA. The IHDE, a non-profit 501(c)6, is responsible for the statewide HIE which already has several participating providers, including eight hospitals and clinical networks. In the fall of 2011, Idaho Medicaid prepared for CMS certification of a new MMIS. Given this focus on certification of the HIPAA compliant system, integration with the MMIS and activities to support the Idaho Medicaid EHR Incentive Program have been given greater consideration for future years since certification has been attained.

2.1 – HIT Landscape Assessment (Environmental Scan)

Idaho Medicaid conducted a survey of providers during in 2010 to gather information about the current state of HIT adoption and use in provider offices and hospitals. The survey was sent to all providers and hospitals considered eligible types for the Idaho Medicaid EHR Incentive Program at the time under the proposed rule: physicians, pediatricians, nurse practitioners, certified nurse midwives, dentists, and all EHs in the state. This included both Medicaid providers as well as non-Medicaid providers. The decision to extend the survey beyond just current Medicaid providers was made for several reasons. First, the project team believed expanding the survey to include non-Medicaid providers would produce a more accurate picture of provider adoption of EHR in Idaho. Second, the information would be helpful to other entities in the state.

The survey was available through a variety of venues making it impossible to know the exact number of professionals who had access to the survey. The Idaho Medical Association contacted approximately 1,500 individual providers. It is not known if they are Idaho Medicaid providers. As of March 2010, there were 3,525 Idaho Medicaid providers in the EP types in Idaho (excluding dentists). There were 982 dentists in the state, and 680 of them were Idaho Medicaid providers. All 680 Idaho Medicaid dentists were given access to the survey via the Medicaid dental contractor. It is not known how many dentists received the information from the Idaho Dental Association. Forty-six hospitals, forty-six RHCs, thirty-eight FQHCs, and five tribal clinics were contacted. Extra effort was made to ensure the survey reached small and rural providers. To this end, Idaho Medicaid designated a liaison between Medicaid and Idaho's RHCs through the Office of Rural Health. The liaison communicated directly with clinics to ensure their interests were addressed and the survey was distributed to their providers. Idaho Medicaid focused the survey on in-state providers. However, out-of-state provider responses were accepted as there are border communities where non-Idaho providers provide care to Idaho residents.

In an effort to maximize opportunities for survey participation, Idaho Medicaid collaborated with 15 professional associations to design and administer the survey through established distribution channels identified by key associations. Professional associations which contributed to the survey effort included:

- American Academy of Family Physicians, Idaho Chapter
- American Academy of Pediatrics, Idaho Chapter
- Northwest Portland Indian Health Board - Representing the Indian Health Clinics/Tribes
- State Office of Rural Health and Primary Care
- Idaho Health Data Exchange
- Idaho Hospital Association
- Idaho Medical Association
- Idaho Medical Group Management Association
- Idaho Nurses Association
- Idaho Physicians Network
- Idaho Primary Care Association
- Idaho State Dental Association

Idaho Medicaid continues to engage in assessment activities of the program to monitor the progression of EHR activities over time. Another follow-up survey is proposed to be conducted in 2017 to determine EP and EH participation in the Medicare and Medicaid EHR Incentive Programs.

Ongoing EHR Adoption Assessment

A short, follow-up survey for hospitals was released in June 2011. 22 hospitals responded to the follow-up survey, accounting for 48% of the hospitals in the state. 73% have implemented or were implementing an EHR, a slight increase from the previous survey. All hospitals without an EHR planned on implementing one within five years. Of the 16 hospitals with EHRs, 63% (10

hospitals) were using an ONC certified system. Five were unsure if their system is certified and one was not using an ONC certified system. 71% (15 hospitals) planned to apply for both Medicare and Medicaid incentives, while 24% (five hospitals) were still undecided.

We continue to actively engage the healthcare community and their associations in an effort to encourage all providers to adopt, implement, or upgrade their EHR technology to become meaningful users. Idaho has expanded their definition of nurse practitioner and certified nurse midwife to include registered nurse anesthetist and clinical nurse specialist, which are advanced practice professional nurses.

Providers and hospitals are using various EHR systems throughout the state. The table below identifies the most common CEHRT systems currently in use.

Table 2.1

EP CEHRT Systems	EH CEHRT Systems
eClinicalWorks	MediTech
GE Centricity	Cerner
NextGen	McKesson Paragon
Greenway	Epic
Sage	Genesis
AllScripts	Vista
Practice Partner	RPMS
Epic Ambulatory	
Pulse	
Aprima	

Idaho Medicaid continues to engage in assessment activities of the program to monitor the progression of EHR activities over time. Another follow-up survey is proposed to be conducted in 2017 to determine EP and EH participation in the Medicare and Medicaid EHR Incentive Programs.

2.2 – Broadband Internet Access

Idaho has a diverse geographical layout with mountainous wilderness lands, high deserts in southern Idaho, and vast farmlands throughout the state. The northern panhandle, southwest Idaho, and southeast Idaho are urban population areas. The counties in these regions account for 70% of Idaho’s population. Idaho has 44 counties – 9 urban (20%) and 35 rural (80%). A county is considered urban if it has at least one city with a population of 20,000 or greater. Idaho’s urban counties are:

- Ada
- Bannock

- Bonneville
- Canyon
- Kootenai
- Latah
- Madison
- Nez Perce
- Twin Falls

Broadband Grants in Idaho

Idaho has received several broadband grants from the National Telecommunications and Information Administration. These specific grants are detailed in Appendix B.

Broadband penetration across Idaho is similar to other western states; greater access and more options in urban areas and few or no options in rural areas. While any individual provider can implement an EHR system internal to the organization, the ability to participate in an exchange network is limited or impossible if broadband access is unavailable, too slow (speed and latency), or unreliable.

Lack of high-speed access to the Internet has been an obstacle in the adoption of HIT in Idaho's rural areas. Idaho's population centers are separated by vast tracks of sparsely populated wilderness. Rugged terrain, narrow roadways, and long distances between population centers have hindered investment in infrastructure, both wire-line and wireless. Many rural hospitals and clinics do not have adequate broadband connectivity. Without this access, they are not able to participate in health data exchanges, telehealth and telemedicine programs, video conferencing systems, and home-based health systems. This situation is improving but some rural areas still find themselves without reliable high-speed connections, or have wireless dead spots due to the topography of the area.

Satellite access is available for anyone with a clear view of the southern sky. However, this service is not considered adequate to fulfill the speed and latency requirements necessary to send multiple medical imaging documents. Maximum speeds are 1.5 megabits per second and prices range from \$1,000 to \$6,000 for installation and \$150 to \$1,000 per month for service.

A major problem with broadband service for rural health care is the cost of the last-mile connection, meaning the connection of a building to the network. Most of these rural communities are served by a single broadband provider (monopoly). In very few cases, a fiber backbone exists in the area, but the provider is unwilling to make last-mile connections because of profit concerns. While access is improving, cost remains an issue. Other barriers include not only Idaho's geography, but also the large percentage of sparsely populated regions and the resulting non-aggregated demand.

The Idaho Regional Optical Network – in a joint effort with Northwest universities, the state of Idaho, the Idaho Hospital Association, and the Idaho National Laboratory – has established a high-performance fiber network throughout the state of Idaho, with interconnects to neighboring states. The network can transmit data at one gigabit per second within the state, and 10 gigabits

per second to locations in neighboring states (Salt Lake City, UT; Clarkston, WA; Pullman, WA; and Spokane, WA). As the Idaho Hospital Association is a charter member of the Idaho Regional Optical Network, all 46 hospitals in the state of Idaho are eligible to connect to the Idaho Regional Optical Network, facilitating high-bandwidth information exchange.

Beacon Community Grants

Currently, there are no Beacon Communities physically located in the state of Idaho. However, the Inland Northwest Health Services Beacon Community located in Spokane, Washington serves both eastern Washington and northern Idaho.

2.3 – FQHC Networks Receiving HIT/EHR Funding

Idaho's FQHCs have not received HIT/EHR funding from the Health Resources Services Administration. The FQHCs in Idaho are not part of a centralized IT solution such as a health center control network system and therefore are not positioned to employ a single EHR solution which would support and integrate with individual systems which FQHCs are currently using. There are limited opportunities for FQHCs to collaborate on system development.

2.4 – Veterans Administration and Indian Health Facilities Operating EHRs

Veterans Administration

Idaho has one primary Veterans Administration hospital located in Boise. The hospital has five satellite clinics, known as Community Based Outpatient Centers, around the state. All use an electronic record known as Computerized Patient Record System. This system was successfully deployed across the Veterans Hospital Association network over the past several years beginning in 2003.

Computerized Patient Record System functions include electronic order entry for medications, consultations, lab testing, documentation, radiologic image viewing, and more. There is an exchange with other Veterans Administration hospitals and the Department of Defense, so remote records collected in those systems are available to Idaho Veterans Administration clinics and the hospital.

The Veterans Administration in Boise has a system connected to the IHDE. This connection is providing access to data from care provided to veterans by hospitals and clinics which participate in the exchange.

Indian Health Service and Tribal Clinics

There are six federally recognized tribes in Idaho, of which five are served by four Indian/Tribal health centers in Idaho. The other recognized tribe is served by a health center in Nevada.

Not-Tsoo Gah-Nee Indian Health Center is operated through a partnership between the Indian Health Service and the Shoshone-Bannock Tribal Health and Human Services Department, while the other clinics are operated by the respective tribes. Two clinics currently utilize the Indian Health Service Resource and Patient Management System for EHR.

Idaho Medicaid also pays for services provided to Idahoans of the Shoshone-Paiute tribe of southwest Idaho (and north central Nevada) who receive care at the Owyhee Community Health Facility, an Indian Health Service center over the border in Nevada. Information about individual clinics and EHR adoption are provided in the table below.

Table 2.4

Facility	Tribe	Location	Operated By	EHR	Patient Population	Barriers to CEHRT adoption/upgrade
Kootenai Tribal Health Facility	Kootenai Tribe	Bonnors Ferry, Idaho	Tribe	None	300	Limited staffing
Benewah Medical and Wellness Center	Coeur d’Alene Tribe	Plummer, Idaho	Tribe (Collaborative venture with City of Plummer)	NextGen Healthcare	6,000	None
Nimiipuu Health Center	Nimiipuu Health Center	Lapwai, Idaho and small satellite station in Kamiah, Idaho	Tribe (formerly IHS)	IHS RPMS	4,500	Staffing and overall cost
Not-Tsoo Gah-Nee Health Center	Shoshone-Bannock Tribes and the Northwestern Band of Shoshoni	Fort Hall, Idaho	IHS/Tribe	IHS RPMS	6,000	None

2.5 – Existing HIT and HIE Relationships and Activities

Idaho Medicaid continues to work with the following professional associations and stakeholder groups to support HIT and HIE activities and initiatives in Idaho. These include:

- American Academy of Family Physicians, Idaho Chapter
- American Academy of Pediatrics, Idaho Chapter
- State Office of Rural Health and Primary Care
- Idaho Health Data Exchange
- Idaho HIT Workgroup

- Idaho Hospital Association
- Idaho Medical Association
- Idaho Medical Group Management Association
- Idaho Nurses Association
- Idaho Physicians Network
- Idaho Primary Care Association
- Idaho State Dental Association
- Northern Idaho College (HIT Training)
- Northern Idaho Health Network

2.6 – State Medicaid Agency Relationships

Idaho Medicaid is collaborating with IHDE on a range of activities impacting Idaho’s overall HIT planning efforts, including collection of health measures. Individuals from each organization have participated in provider and hospital meetings, explaining the EHR incentive programs and answering questions from the health care community. Medicaid, the IHDE, and the REC have been integrating HIT and HIE in state-level efforts in the following ways:

- Working together in communicating information about the incentive payment program with professional associations, providers, and hospitals.
- Sharing information for defining the “As-is” Landscape.
- Working together to set the vision for HIT in Idaho in the vision portion of the SMHP.
- Working together to promote the adoption and meaningful use of EHRs.
- Identifying barriers to adoption and strategies to address those barriers.

In addition, Idaho Medicaid is a contracted participant in the statewide HIE and provides Medicaid medication history information to the exchange through the Medicaid Pharmacy Benefit Manager. Providers using the HIE are able to query Medicaid medication history to better manage recipient health care. As part of the governance structure between Medicaid and the IHDE, the Director of IDHW sits on the IHDE Board of Directors. The IHDE also has a staff person on the Medicaid project team for HIT and HIE efforts.

2.7 – Idaho’s Collaboration and Coordination with Statewide HIE

Currently there is one functional HIE in Idaho; the IHDE. IHDE is a 501(c)(6) non-profit corporation, and was established to govern the development and implementation of a statewide HIE in Idaho. A 12 member Board of Directors provides oversight to the project. The vision of the IHDE is to assure the ongoing development and implementation of a sustainable, secure statewide HIE to allow Idaho health care providers to achieve MU of EHRs. The IHDE is neither a direct arm of government nor part of any other organization in the state’s healthcare environment. It is a true example of a public-private partnership. The IHDE began exchanging data in 2008.

The IHDE is the work product of the Health Quality Planning Commission, which was created in 2006 as a result of House Bill 738. During the first two years of its work, the Health Quality

Planning Commission focused its efforts on creating a plan to implement a statewide HIE for Idaho. In order to fund such an effort, the major payers in Idaho, including Medicaid, as well as the large hospitals in Idaho, all agreed to support the exchange financially during implementation. In 2008, after a 501(c)(6) not-for-profit corporation was established, Medicaid, along with Blue Cross of Idaho and Regence Blue Shield of Idaho, signed a participation agreement with the exchange. All of the participation agreements bound the participants for five years. It is helpful to note this happened prior to the passage of the ARRA. The IDHW's Director is a board member for the IHDE and has been since its inception. This gives Medicaid a voice along with the other payers (who are also board members) in guiding the development of the exchange.

Currently, Richard Armstrong, Director of the IDHW, is an officer on the Board of Directors. Mr. Armstrong is committed to integrating IDHW operations into the statewide HIE as fully as possible. The Idaho Division of Medicaid, within the IDHW, provides patient medication history to the exchange through their pharmacy benefits manager system which is connected by Sure Scripts.

The IDHW also donated administrative support and office space to the IHDE for two and a half years. A State Deputy Attorney General provides advice and counsel on matters related to privacy and security. Idaho Medicaid is a paying participant of the statewide HIE and provides medication data to the exchange.

Idaho Medicaid EHR Incentive Project staff work closely with the IHDE staff. The EHR Incentive Program Manager and the IHDE Director sit on many of the same workgroups where information is shared and whose purposes are to receive feedback and recommendations from community members and to share program information about provider outreach and health IT adoption. Additionally, Idaho Medicaid and the IHDE have jointly participated in numerous presentations to professional organizations and provider groups since the program inception and will continue to do so.

To date, Idaho Medicaid has worked closely with IHDE on several outreach opportunities. In panel presentations, Idaho Medicaid focused on explaining the basics of eligibility for the Medicaid incentives, the state's timeline and tasks for implementation, as well as how Idaho would continue to communicate progress with providers and share information via the state website. The IHDE focused on the role of exchanging data in meeting MU as well as the value of the exchange in relationship to improving the quality of care. This distinction has allowed the state to share costs for outreach while avoiding duplicate roles and efforts.

2.8 – Role of MMIS in HIT and HIE Environment

On June 1, 2010, Idaho Medicaid went online with a new MMIS. The new MMIS supported standardized EDI transactions compliant with HIPAA for eligibility inquiries, claims processing, prior authorizations, and other administrative transactions. However, the system does not currently have an active role in the Medicaid HIT and HIE environment. The Idaho MMIS project team primarily focused on preparing the system for CMS certification. Once CMS certification was achieved, Idaho Medicaid updated their MITA Transition Plan to account for

new functionality within the MMIS, statewide HIT and HIE initiatives, and other federal initiatives (e.g., adoption of HIPAA X12 Version 5010).

2.9 – Activities Currently Underway to Facilitate HIE/EHR Adoption

Idaho Medicaid has been and will continue to be committed to implementing the EHR incentive payment program to support providers in their adoption and meaningful use of EHRs.

Previously, a major effort to promote the adoption and use of EHRs was being led by the Washington & Idaho REC. However, the Washington & Idaho REC has since changed business models and no longer actively facilitates the promotion and adoption of EHRs.

2.10 – Medicaid’s Relationship with the State HIT Coordinator

The State HIT Coordinator served as the key point of contact for ARRA funding for HIT and HIE projects including workforce and broadband programs. The State HIT Coordinator position was grant funded; when the applicable grant ended in 2014, the position was removed. There is no longer a State HIT Coordinator for Idaho.

2.11 – Prospects for Participation in the Medicaid EHR Incentive Program

Idaho Medicaid is currently involved in another project which assists in promoting the use of HIE and EHRs – the development of the Idaho Health Home Program as a new optional Medicaid service. The Idaho Health Home Program was implemented in January of 2013 and was designed to provide intensive case management and coordination of services for Medicaid participants with chronic health conditions in the interest of improved outcomes, client satisfaction, and reducing the need for institutional based services.

Idaho Medicaid is also currently involved in a multi-payer medical home pilot, in concert with the Idaho Department of Insurance, large private payers, medical associations, and residency programs. Inclusion of the Idaho Health Home Program under Medicaid will be part of this effort and will be influential in the development of the private pay medical home service delivery model as well.

The expectation is HIT will play a key role in organizing and coordinating services, communication between all significant providers of care, promotion of best practices, quality assurance, and management reporting for the health home. Idaho Medicaid will work closely with the IHDE during its concurrent development, as it has the potential of supporting the expectations of the medical home pilot.

2.12 – Recent Relevant Changes to State Laws or Regulations

An analysis of Idaho state law revealed there are no changes to state laws which might affect the EHR Incentive Program directly.

The 2010 State Legislature did pass legislation, Senate Bill 1335, which amended existing law related to Idaho's IRIS. It removed certain authorization requirements for inclusion in the registry, making participation in the registry an opt-out service instead of an opt-in.

The Idaho Legislature demonstrated their support of the use of HIT in 2006 with the passage of House Bill 738 which states, "It is the intent of the legislature the Department of Health and Welfare promote improved quality of care and improved health outcomes through the investment in health information technology and in patient safety and quality initiatives in the state of Idaho".

2.13 – Activities across State Borders

Accessing Health Care across State Lines

A previous expenditure analysis of medical trading areas was performed using data from state fiscal year 2007. The primary regions where Medicaid recipients cross state boundaries are in the northern (cross into Washington) and southeastern (cross into Utah) counties of Idaho. Roughly 15% of Idaho Medicaid expenditures for Medicaid recipients living in northern counties went to out-of-state providers. In the southeastern counties, approximately 10% of Idaho Medicaid expenditures went to out-of-state providers.

During the 2014 legislative session, the Health and Welfare Sub-committee put forth House Concurrent Resolution No. 49 stating findings of the Legislature and instructing the IDHW to investigate the creation of a hospital discharge database and a comprehensive system of healthcare data and to establish an advisory committee to create an implementation plan for such data.

HIT and HIE Coordination and Exchange with Other States

The IHDE received development support from the neighboring state of Utah and other HIE initiatives including the Nebraska Health Information Initiative and the Rochester Regional Health Information Organization in New York. IHDE's current focus is on an Idaho statewide HIE but is committed to working with Montana, Oregon, Washington, and Utah to ensure the development of regional strategies to share clinical and administrative information. In order to enable interstate exchange, differences in states' consent models must be considered and the impact differences will have on how data can be exchanged must be accommodated. IHDE also plans to participate in the quarterly meetings to be held by the National Governor's Association to facilitate exchange of information and ideas among the Region 10 states.

In March 2014, IHDE selected Orion Health to replace their existing HIE solution. The planning, migration, and implementation of Orion Health is complete. With Orion Health, the IHDE has a flexible and scalable core solution, offering greater value at no additional fees to existing IHDE participants.

Inland Northwest Health Services

Kootenai Medical Center in Coeur d'Alene serves as the major referral hospital in northern Idaho. There is extensive movement of patients between northern Idaho and eastern Washington, particularly Spokane. Because of these referral relationships, well coordinated HIE activities in Idaho and Washington are critical. The IHDE is committed to working with Inland Northwest Health Services and the northern Idaho health care providers to implement HIE solutions to allow the seamless exchange of data between Idaho and Washington. The IHDE Executive Director has agreed to participate in a steering committee for the Beacon Community Grant which was awarded to Inland Northwest Health Services.

Kootenai Medical Center in Coeur d'Alene is currently connected to the IHDE's statewide HIE and Inland Northwest Health Services. It is unclear how Inland Northwest Health Services will fit into the overall HIE strategy for the state of Washington. There are too many unknowns at this time to commit to a concrete approach.

Inland Northwest Health Services worked with the IHDE to develop an interface between Idaho's statewide HIE and the Kootenai Medical Center. The interface was completed in February 2009. Inland Northwest Health Services also provided technical assistance through the participation of Pat Holmstead, the Director of Quality Improvement Services and Mike McDaniels, the Director of Data Security and System Readiness, as resources to the IHDE Security and Privacy Subcommittee.

2.14 – Current Interoperability of State Immunization Registry and Public Health Reporting Databases

State Immunization Registry

The Idaho IRIS is Idaho's immunization registry. It is a statewide system to help individuals and healthcare providers keep track of immunization records. IRIS is completely confidential and secure. Immunization information can only be accessed by enrolled healthcare providers, schools, or childcare programs. Although the system is not currently interoperable, it is currently receiving unidirectional exports from provider EHRs. The system does not currently send information out to any system with the exception of the Washington state immunization registry, which can query IRIS registry directly.

Public Health Reporting Databases

Idaho maintains a variety of public health reporting databases with varying levels of interoperability. Healthcare providers, laboratories, and hospital administrators are required to report communicable diseases and conditions to their local health district or Office of Epidemiology in IDHW. Reports must be made within three working days of identification or diagnosis, unless otherwise noted, according to the Rules and Regulations Governing Idaho Reportable Diseases (IDAPA 16.02.10).

The National Electronic Disease Surveillance System: promotes the use of data and information system standards to advance the development of efficient, integrated, and interoperable

surveillance systems at federal, state, and local levels. The primary goal of the National Electronic Disease Surveillance System is the ongoing automatic capture and analysis of data already available electronically. Idaho uses the Centers for Disease Control and Prevention-developed National Electronic Disease Surveillance System Base System as the primary general communicable disease surveillance tool to meet the goals of the program. The design of the base system allows for the protection of confidentiality and collection of disease surveillance data used to monitor disease trends, guide prevention programs, and inform public health policy. The system is programmed to connect with other systems and is interoperable with the Centers for Disease Control and Prevention and other databases, not including the Sexually Transmitted Disease Management System or the Cancer Data Registry of Idaho. The system has the capacity to receive EHRs for public health reporting and electronic lab data.

HIV/AIDS Reporting System: a confidential, name-based reporting system developed by the Centers for Disease Control and Prevention to manage HIV/AIDS surveillance data. The system is programmed to connect with other systems and is interoperable with the Centers for Disease Control and Prevention. The system has the capacity to receive electronic lab data.

The Sexually Transmitted Disease Management Information System: a data management system developed by the Centers for Disease Control and Prevention to capture and manage data on sexually transmitted diseases, not including HIV/AIDS. The system is not interoperable.

The Cancer Data Registry of Idaho: a population-based cancer registry which collects incidence and survival data on all cancer patients residing in the state of Idaho, or diagnosed or treated for cancer in the state of Idaho. The Cancer Data Registry of Idaho is essential for assessing the extent of cancer burden in the state. The system is not interoperable.

2.15 – CHIPRA Grants

Idaho Medicaid, in collaboration with the Utah Department of Health and the University of Utah's Department of Health Sciences, was awarded a five year CHIPRA Quality Demonstration Grant by CMS in February of 2010. This grant was to support the establishment of the Children's Healthcare Improvement Collaboration (CHIC). CMS awarded \$10,277,361 to CHIC from 2010 to 2015 to improve health outcomes and satisfaction among children and families with a focus on those with special health care needs through the use of EHRs, HIEs, and other HIT tools. Idaho's total portion was \$2,032,593. Idaho and Utah will develop a regional quality system guided by the medical home model to enable and assure ongoing improvement in the healthcare of children enrolled in Medicaid and the Children's Health Insurance Program.

The state's plan to pilot a new administrative service using Medical Home Coordinators embedded in primary and sub-specialty care practices to support ongoing improvements in care, coordination of care, and support for children with chronic and complex conditions and their families. Utah and Idaho also plan to use learning collaborates', practice coaches, and parent partners to train primary and sub-specialty child health practices in medical home concepts. The ultimate outcome will be improved health care for children in the two states, robust integration of HIT into child health practices, a regional quality system, and valuable quality improvement tools and resources which can be shared with other states and regions.

Three of the objectives of this grant are HIT specific. Objective number one is to develop and implement a cross-state connection between the IHDE and the Utah Health Information Network improving the sharing of health information for Idahoans who use Utah's health care services. The goal of this effort is to create a fully functional interface between Idaho's statewide HIE and the Utah Health Information Network. This is particularly important for children from Idaho who receive sub-specialty care at the University of Utah's Primary Children's Medical Center. This included 1711 children enrolled in Idaho Medicaid over the past two years. Interstate exchange of health information between Utah and Idaho will provide greater access to patient data and will provide additional value for those healthcare providers who are hesitant to adopt EHRs or participate in the electronic exchange of health information.

The second HIT related grant objective is to assist the IDHW to create a bi-directional interface between IRIS and IHDE. This will optimize accessibility as well as practice utilization of the immunization reminder system, and result in more accurate reporting of immunizations which will improve health outcomes for Idahoans.

The third objective of the CHIPRA Quality Demonstration Grant is to integrate Idaho services and resource data into the Medical Home Portal created by Utah. The portal will provide ongoing support to both physicians and parents who have children with special healthcare needs. It is expected this work will lead to a complete integrated service, resource, and referral data system in the Idaho Medical Home Portal.

Section 3 – “To-Be” HIT Landscape and Vision

The overarching goal of the Idaho Medicaid EHR Incentive Program is to improve the quality and coordination of care by connecting providers to patient information at the point of service through meaningful use of EHRs.

Through implementation of the Idaho Medicaid EHR Incentive Program, in five years Idaho Medicaid has increased provider EHR adoption and subsequently increased participation in the statewide HIE, setting the foundation for improved care coordination and better health outcomes.

3.1 – HIT and HIE Goals and Objectives

Idaho Medicaid’s vision supports a broader-reaching and more integrated HIT environment. As such, Idaho Medicaid has established a set of three HIT and HIE related objectives to guide the EHR Incentive Program toward this goal. The objectives are to:

- Maintain implementation of the Idaho Medicaid EHR Incentive Program.
- Coordinate assistance to providers in reaching all stages of MU.
- Leverage the statewide HIE.

Maintain Implementation of the Idaho Medicaid EHR Incentive Program

Idaho Medicaid has implemented all required Year 1 components of an EHR Incentive Program as identified by CMS. In addition to meeting established program requirements, the program team will focus on increasing the adoption of certified EHR systems across the Idaho Medicaid provider community with an emphasis on FQHCs and critical access hospitals.

Idaho Medicaid recognizes challenges to estimating the number of providers which will register for the EHR Incentive Program due to a number of factors facing the Idaho medical provider community. In addition to constraints in broadband access in rural areas, discussed in Section 2.2, Idaho was ranked 49th in the U.S. for doctors per capita as of 2012 , and in 2014 the University of Washington School of Medicine reported 39% of Idaho’s physicians were age 55 or older . This population may choose not to invest in an EHR system at this point in their careers. These types of challenges may lead to lower overall interest in EHR adoption by Idaho providers.

Idaho Medicaid does not currently have sufficient information to accurately estimate how many providers have a percentage of Medicaid patients high enough to meet eligibility requirements for the EHR Incentive Program. As such, Idaho has chosen an approach used in other states where the measurable objectives focus on the transition of Medicaid EHR Incentive Program participants from adoption of EHR technology to meaningful use achievement. The Idaho Medicaid EHR Incentive Program aimed to have 12% of EPs and 25% of EHs which enroll in the first year of Idaho’s program to meet MU within the second year of the program. By the end of the third year, the program aimed to have MU compliance with 25% of EPs and 40% of EHs enrolled during the first two years of the program. The program budget has been designed to accommodate higher participation than these percentages, as this goal is intended to focus on

assisting providers through the graduated phases of the program as MU standards become more rigorous.

Coordinate Assistance to Providers in Reaching All Stages of MU

To meet the transition to MU measurable objectives stated above, Idaho Medicaid anticipates communication campaigns and coordination of technical assistance to providers will be a major objective. This includes supporting and augmenting the REC's technical assistance. This also includes outreach about the specifics of the Idaho Medicaid EHR Incentive Program, the application process, and pre-training of providers relating to IIMS. Outreach will focus on the expected outcome and goals of MU and the specific steps of attesting to MU.

Planned communication activities are presented in Section 3.5, including specific activities focused on critical access hospitals. Technical assistance for providers is discussed in Section 3.7.

Leverage Statewide HIE

Idaho's statewide HIE is maintained by the IHDE, which was created as a result of the efforts of the Health Quality Planning Commission established by the Idaho Legislature in 2006.

Idaho Medicaid will leverage the services and functionality of the exchange to promote HIT across the provider community. This includes working with the IHDE to educate providers about the statewide HIE and the capacity of the exchange to assist providers in meeting MU. In addition, Idaho Medicaid will work with the IHDE to explore how they will support the EHR Incentive Program in areas such as aggregated reporting of clinical quality measures.

Additional information about the IHDE and forthcoming advancements can be found in Section 3.2 under "Major Planned Initiatives".

3.2 – Future IT System Architecture Relating to HIT and HIE

In order to progress the objectives set forth in Section 3.1, Idaho Medicaid needs to fully leverage existing technology, add functionality to integrate existing technology, and implement new technology.

All Payer Claims Database

Currently, there is not an all payer claims database in Idaho. In the fall of 2011, the Idaho Health Quality Planning Commission recommended the creation of an all payer claims database in Idaho for consideration by the Idaho State Legislature. Additionally, during the 2014 legislative session, the Health and Welfare Sub-committee put forth House Concurrent Resolution No. 49 stating findings of the Legislature and instructing IDHW to investigate the creation of a hospital discharge database and a comprehensive system of healthcare data and to establish an advisory committee to create an implementation plan for such data.

The Idaho EHR Program would benefit greatly from the creation of these databases in the facilitation of EHR Incentive Program eligibility based on claims data. Any decision will be documented in a future annual update to the SMHP, if appropriate.

HIE Projects

A project is underway to create an interface from Idaho's HIE to IRIS. This will optimize accessibility as well as improve utilization of IRIS, resulting in more accurate reporting of immunizations and providing the potential to improve health outcomes for Idahoans. Registered users will also have the ability to display IRIS data on a provider's computer.

Additionally, IHDE is in discussion with both Washington state's HIE 'One Health Port' and Inland Northwest Health Services (a Beacon Community grantee) to link HIEs. The entities are currently reviewing and comparing data sharing agreements and policies to see what collaboration will be appropriate.

IDHW Projects

Idaho Medicaid has an objective to improve care coordination to produce improved health care outcomes. This objective is reliant on the ability to gain access to necessary clinical data, link clinical data to Medicaid claims/encounter data, and the application of decision support tools to make effective clinical and program decisions. The HIT architecture necessary to achieve this objective, at a minimum, requires Idaho Medicaid to extend the capabilities and functionality of the MMIS DSS. A future interface between the statewide HIE and the MMIS DSS could serve as the conduit for MU CQMs in support of the EHR incentive program as it moves into its downstream stages. A decision regarding the implementation of this interface and other improvements to the MMIS DSS will be considered by Idaho Medicaid, and reflected in a future update to this SMHP, if appropriate.

In January 2015, Idaho was approved funding to create a Statewide Healthcare Innovation Plan. This plan will establish Patient Centered Medical Homes by executing a four-year care management redesign program. Updates of the progress of this program will be reflected in future SMHP updates, if appropriate.

3.3 – Idaho Medicaid EHR Incentive Program Interface

Idaho Medicaid maintains its focus on the deployment of modern, flexible technology and in keeping with this technology thrust, sought a web-based application EPs and EHs could access utilizing a standard web browser.

In 2012, IIMS managed the attestation process associated with adoption, implementation, and upgrade of CEHRT.

In 2013, IIMS managed the attestation process associated with MU and the storage of the clinical quality measures, menu measures and core measures for EPs and EHs.

In 2014, the state of Idaho allowed providers to meet MU with EHRs certified to the 2011 or the 2014 edition criteria. This action was in agreement to the new flexibility rule which went into effect on October 1, 2014. Providers were required to report using 2014 edition CEHRT for an EHR reporting period beginning in 2015 and Idaho extended stage 2 through 2016. Providers could use either 2014, 2014/2015 combination, or 2015 edition CEHRT in 2017.

In 2015, the state of Idaho allowed providers to meet MU with EHR ranges of 90-days for all stages, and consolidated the core, menu, and CQMs into one set of MU Objectives. This action was in relation to the modification rule which went into effect on January 4, 2016.

Detailed information about IIMS can be found in Section 4.12.

3.4 – Vision for HIE Governance

Currently, the state has three primary mechanisms for the governance of HIT and HIE related initiatives. Firstly, the SMHP development has oversight from project sponsors within IDHW. Closely monitoring the progress of the effort, the project sponsors provide guidance and direction to the Idaho Medicaid EHR Incentive Program Manager for the oversight of the content of the SMHP and the implementation of the EHR Incentive Program.

Secondly, IHDE has in place a Board of Directors with representation from both the public and private sectors, including the health care delivery and financing systems, health care providers, the Idaho Employer Coalition, and consumers. This board provides guidance and direction for the IHDE.

The third mechanism is the Idaho Health Care Council, created in 2010 by Idaho Governor Otter's Executive Order. The Idaho Health Care Council coordinates initiatives in healthcare to support and implement Idaho's best solutions. As of their June 2011 meeting, the council was considering ways to improve Idaho's system of healthcare within the areas of HIT, affordability and accessibility, and health service delivery.

3.5 – EHR Adoption Initiatives

Idaho Medicaid encourages the adoption of CEHRT through the implementation of the Idaho EHR Incentive Management System. By making incentive payments available to qualified providers, Idaho Medicaid encourages Medicaid providers to engage in moving their practices to an environment where the use of EHRs is commonplace.

Additionally, Idaho Medicaid continues to implement a communication and outreach plan on the incentive program. This outreach effort is anchored by a website located at:

<http://healthandwelfare.idaho.gov/default.aspx?TabId=1405>.

This website provides a wealth of information regarding the EHR incentive program including eligibility requirements, important links, and other information relevant to the program. Idaho Medicaid continues to inform providers of the website by including the website address on outreach presentation materials presented to stakeholder groups (including, but not limited to,

professional associations and provider groups) for subsequent distribution through respective communication channels. Additionally, the address is printed in program brochures, business cards, Medicaid's email correspondence footer information, remittance advance banner notices, and through verbal communication during standing teleconference meetings with provider groups.

In addition to this resource, the Idaho Medicaid Incentive Program staff are available to field questions and inquiries by phone or e-mail.

Future efforts to increase Idaho Medicaid provider knowledge about CEHRT and encouragement of CEHRT adoption will expand on existing outreach methods and potentially include webinars, social media, and electronic brochures.

Communications and outreach activities are compliant with CMS rules and guidelines as well as state-specific requirements, and are developed with phase-specific information leading up to provider registration, attestation, and payment of Medicaid EHR incentives.

3.6 – Health Resources Service Administration HIT/EHR Funding in Idaho

No Health Resources Service Administration grants have been identified within the state. If Health Resources Services Administration grants are identified in the future, staff will ensure funding does not duplicate activities of the Idaho Medicaid EHR Incentive program.

3.7 – Technical Assistance for Medicaid Providers

IDHW develops training materials for providers. These resources include a provider handbook, webinars, and standing teleconferences in support of AIU and MU attestation.

Idaho Medicaid made available, prior to launch of program registration and attestation, a standing phone number and e-mail address for providers to contact the Idaho Medicaid EHR Incentive Program. These contact points were communicated to providers prior to program launch via outreach partnerships. Currently, there is a standing e-mail address, ehrincentives@dhw.idaho.gov, which a number of providers have already contacted to inquire about the status of the program to date. This e-mail address continues to be promoted in print and electronic outreach materials.

As a low-volume state, Idaho Medicaid anticipates managing inquiries with existing Medicaid staff. Incoming phone and e-mail inquiries are directed to a dedicated support phone line and e-mail address established specifically for the Idaho Medicaid EHR Incentive Program. Incoming calls to the dedicated line or e-mail address are routed to Idaho Medicaid EHR Incentive Program staff for management.

During the program, providers have the opportunity to contact a live person during business hours of 8 a.m. to 5 p.m. Mountain Time, Monday through Friday, except state holidays. Messages left on voicemail or e-mail receive responses no later than two business days. Written

correspondence, other than e-mail, requesting information or action is responded to within 10 calendar days.

To minimize administrative burden, general program information and frequently asked questions are published on the Idaho Medicaid EHR Incentive Program website on an ongoing basis. In the event Idaho Medicaid EHR Incentive program staff experience a high volume of common inquiries which appear to have a significant impact on providers, Idaho Medicaid distributes key messages through mass e-mail distribution and publishes key program information on the Idaho Medicaid EHR Incentive Program website.

3.8 – Addressing Populations with Unique Needs

Idaho Medicaid recognizes the importance of making the incentive program available to all providers, particularly those who reside in more rural settings where the unique needy populations may exist. As such, Idaho Medicaid ensures the following steps are taken:

- Specifically address intentions to reach out to more rural providers utilizing other than electronic means within the outreach and communications plan.
- Develop communication materials regarding the program which account for cultural differences.

Through these efforts, Idaho Medicaid provides all Medicaid providers an even footing on which to make decisions about pursuing the Idaho Medicaid EHR Incentive Program and adoption of CEHRT.

Additionally, Idaho is working to implement a Medical Home model as part of the Children’s Health Improvement Collaborative Project, which will target children with special health needs.

3.9 – Leveraging HIT-Related Grant Awards

This section summarizes these grants and how they will be leveraged in the implementation of the EHR incentive program, and objectives identified in Section 3.1.

Grant	Impact on EHR Incentive Program
CHIPRA	<p>Provides value to those healthcare providers who are hesitant to adopt EHRs by:</p> <ul style="list-style-type: none"> • Connecting the IHDE and the Utah Health Information Network • Establishing an interface between Idaho’s IRIS and the HIE (initial interface will be uni-directional, bi-directional interface also planned) • Establishing the Medical Home Portal to support information needs for families caring for special needs children <p>Funding Timeframes: Statewide HIE and IRIS - 3/11-12/13 IHDE and Utah Health Information Network - On Road Map Plan with no timeframe</p>

Broadband Grants	The availability of broadband access increases the likelihood providers in rural areas will adopt CEHRT and be able to achieve MU.
Magic Valley Hospital EHR Grant	Enables the hospital to implement an ambulatory EHR in multiple rural primary care and specialist settings.

3.10 – New State Legislation

AIU for the EHR Incentive Program required administrative rules and chapter to be published to fully implement the program. IDAPA chapter 16.03.25 was published 04/04/13.

Idaho Medicaid has found no need for new legislation or changes to existing state laws for implementation of the Idaho Medicaid EHR Incentive Program.

Section 4 – Administration of the EHR Incentive Program Development Plan

Idaho Medicaid designed an EHR incentive program which balances the federal requirements of the program with reasonable and available data sources through which providers can demonstrate they are eligible for incentive payments for adopting, implementing, and upgrading EHR systems in a meaningful way while serving Idaho Medicaid enrollees.

This section outlines the administration of the Idaho Medicaid EHR Incentive Program and the processes IDHW employs to ensure providers have met federal and state statutory and regulatory requirements for the EHR incentive payments.

4.1 – Professional and Hospital Eligibility

Idaho Medicaid EHR Incentive Program staff will obtain sanction data from CMS' Medicare & Medicaid EHR Incentive Program Registration and Attestation System to identify providers with federal sanctions as reported on the National Practitioner Data Bank, and Office of Inspector General's list of excluded individuals and entities.

For state-based sanctions and licensure, Idaho Medicaid EHR Incentive Program staff will review the provider file within the new Idaho MMIS to verify providers are not sanctioned and are properly licensed and qualified.

Some potentially providers may not be enrolled through the MMIS. In such cases, the Idaho Medicaid EHR Incentive Program staff will do one of the following:

- Identify whether the provider is a dentist in good standing with DentaQuest, the private administrator of Idaho's dental program, as listed on their roster of active providers. The existing contract between the IDHW and DentaQuest requires participating providers not be sanctioned.
- Identify whether the provider is a behavioral health provider in good standing with Optum, the private administrator of Idaho's Behavioral Health Plan, as listed on their roster of active providers.
- Confirm whether the provider is listed in good standing on a FQHC or RHC roster maintained within the MMIS. Idaho policy requires facilities alert Medicaid Provider Services within 30 days of any change to the roster. The Health Resources and Service Administration's Bureau of Primary Care requires health centers to confirm the licensure or credentialing of their health care practitioners, both employed and contracted, every two years in accordance with the Credentialing and Privileging Policy of the Bureau. Additionally, FQHCs which participate in the malpractice liability coverage under the Federal Tort Claims Acts provide evidence of credentialing.

In the event a provider's licensure qualification cannot be confirmed based on data available in the aforementioned sources, Idaho Medicaid EHR Incentive Program staff will inquire with the MMIS provider enrollment team, the Idaho Board of Medical Licensure, as well as review bordering state websites to confirm qualification as an EP or EH.

4.2 – Identifying Hospital-Based Professionals

Hospital-based providers are ineligible as an EP to participate in the incentive program and are defined as those professionals who provide more than 90% of their services in a hospital setting (inpatient and emergency room). To ensure hospital-based providers are excluded from the program, Idaho Medicaid EHR Incentive Program staff analyze professional claim and encounter data available from the Idaho MMIS, Optum, and DentaQuest reported data, for the appropriate reporting period to determine the rendering provider's NPI and the HIPAA standard transaction place of service codes on the claim and encounter data. Idaho Medicaid uses Place of Service Codes 21-Inpatient Hospital, and 23-Emergency Room as a basis for determining hospital-based services.

In the absence of an All Payers Database, the Idaho Medicaid EHR Incentive Program makes these hospital-based determinations based on Medicaid claims, but will consider expanded data if from an auditable source and presented by a provider as part of an eligibility reconsideration request.

When the predominant (greater than 90%) place of service is found to be an inpatient hospital and emergency room, the provider is considered hospital-based and is contacted by the program and provided the opportunity to submit documentation of auditable data to demonstrate 90% or less of their total claims are for services provided at an inpatient hospital or emergency room.

Additionally, Idaho Medicaid's EHR Incentive Program auditor(s) prepare and provide information for use in projections and pre-payment reviews of applications to include identification of all EPs who are hospital-based, using data from the MMIS and hospital cost reports. Idaho Medicaid's audit strategy is presented in Section 5 of this plan and the Audit Guide.

For FQHC- and RHC-based providers, claims data is not available in the MMIS at the provider level. The Idaho Medicaid EHR Incentive Program will consider a provider to not be hospital-based if they can provide attestation of "practicing predominantly" at an FQHC or RHC which includes demonstrating more than 50% of an EP's encounters over a six-month period in the most recent calendar occurred at an FQHC or RHC. Effective January 1, 2013, if the PV is less than the amount necessary to meet eligibility criteria for an incentive payment, the "preceding calendar" year in the formula will be replaced with a "12-month period" prior to the attestation date.

Additionally, EPs who can demonstrate they fund the acquisition, implementation, and maintenance of CEHRT, including supporting hardware and any interfaces necessary to meet MU without reimbursement from an EH or CAH, and uses such CEHRT in the inpatient or emergency department of a hospital (instead of the hospital's CEHRT), will be eligible for EHR incentive payments.

4.3 – Verification of Provider Attestations

EPs and EHs utilize IIMS to submit attestation information to Idaho Medicaid. Idaho Medicaid EHR Incentive Program staff carefully review and verify the attestation content provided through the portal. Idaho Medicaid’s eligibility verification process for EPs and EHs consists of a quantitative and qualitative review of attestation information and support materials submitted by the provider.

The quantitative review ensures all required attestation information and supportive materials submitted by the EP or EH are deemed complete. The qualitative review consists of a thorough review of attestation content by Idaho Medicaid EHR Incentive Program staff and verification of reported attestation content against information on file with Idaho Medicaid including, but not limited to:

- Fee-For-Service encounter claims data from the Idaho MMIS and the Medicaid DSS
- Hospital Cost Reports for EHs
- Claims reports from FQHCs, Tribal clinics and RHCs
- Review ONC for CEHRT

Idaho Medicaid’s audit services contractor also verifies the overall content of provider attestations as part of their audit services task, post-payment. In these instances, content reviews for a sampled population are conducted in a manner as described above, to achieve specific Idaho Medicaid EHR Incentive Program audit objectives. The comprehensive audit strategy is presented in the Audit Guide.

Providers are informed all attestation documentation must be maintained for a period no less than six years after their first incentive payment has been processed for the purpose of auditing.

4.4 – Communication Approach

Idaho Medicaid’s communication approach promotes flexibility and enables communication with providers in multiple formats. The preferred approach for routine communication is electronic in nature, either through e-mail or through a notification for the provider to retrieve information residing in IIMS. Formal communication with the provider such as when payment should be expected, denials of eligibility, selection for audit, and appeal correspondence occur via electronic correspondence and written letter where applicable.

Methods of direct communication with EPs and EHs which have applied to the Idaho Medicaid EHR Incentive Program for an incentive payment are, at a minimum, telephone, e-mail, and United States mail. Providers are required to supply contact information during the process of registering with CMS’ Medicare & Medicaid EHR Incentive Program Registration and Attestation System, which is used to communicate with providers. For an example of the minimum points of contact Idaho Medicaid EHR Incentive Program staff has with providers during the application process, please refer to Section 4.12.

Official notice of decisions regarding provider applications and incentive payment distributions will be sent in writing by Idaho Medicaid EHR Incentive Program staff by United States mail or e-mail where applicable. If an EP identifies a designated payee to receive the incentive payment, the EP and its designated payee each receive a notice of payment distribution.

4.5 – Calculation of PV

The Idaho Medicaid EHR Incentive Program utilizes provider attestations for PV calculations. Idaho Medicaid uses the “encounter method” for PV, calculated by dividing the total number of Medicaid patients served in a 90-day period in the preceding calendar year by the total number of patients (from all payers) in the same period.

After the initial set up of provider attestation, Idaho Medicaid reviews and verifies (or rejects) PV calculations in the following manner:

- For EPs, Idaho Medicaid utilizes encounter claims data from the Idaho MMIS DSS or other MCO contractor’s system. If there are discrepancies between the claim analysis and attestation information, Idaho Medicaid contacts the provider to determine the cause of the discrepancy.
- For EHs, cost report information is reviewed and compared to attestation information to assess the reasonableness of the attestation. Idaho Medicaid utilizes Medicaid discharges and total discharges from the cost report worksheet, for this verification. Idaho MMIS DSS claims data may also be used to monitor and validate (or reject) Medicaid discharges from attestation and cost reports.
- For EPs practicing predominantly at an FQHC, RHC, or Tribal Health Center, PV requirements can be met by using the facility’s “needy individual” encounters. Although these providers may also qualify individually using the “needy individual” volume from their predominant practice at an FQHC, RHC, or Tribal Health Center, Idaho Medicaid anticipates EPs will rarely attest with the individual rather than proxy PV.

Table 4.5

Provider Type	Minimum PV Percentage
Physicians	30%
Pediatricians	20%
Dentists	30%
Certified Nurse Midwives	30%
Physicians Assistants*	30%
Nurse Practitioners	30%
Acute Care Hospitals	10%
<i>*When practicing at an FQHC/RHC led by a PA</i>	

For EPs, a Medicaid encounter is defined as all of the services rendered to an individual in a single day. In calculating Medicaid PV, CHIP encounter data is excluded for all EPs except those practicing predominantly at an FQHC or RHC where it is included as “needy individual” encounter data. EPs must meet the minimum PV thresholds based on encounter data attributable to Medicaid, and CHIP data, where applicable, during the continuous 90-day period selected by the EP during the prior calendar year.

For EHs, a Medicaid encounter excludes all non-acute care services and discharges, such as nursery days, because they are not considered acute inpatient services based on the level of care provided during a normal nursery stay.

Distinguishing Medicaid Encounters from CHIP Encounters

Currently providers in Idaho have no way to distinguish Title 19 (Medicaid) participants from Title 21 (CHIP) participants. As a result, the provider-attested encounter numbers are not likely to match the number of eligible Medicaid encounters in other data sources, including Medicaid claims data. Therefore, program staff have communicated with providers the process for excluding CHIP from calculated PV, even if the difference is insignificant.

Idaho Medicaid has established a standing report from the Idaho MMIS DSS which allows program staff to identify the number of eligible encounters a provider has had during each month in any specified date range. This report is ran after the provider completes their attestation.

Potential Future Updates to PV Calculation and Verification Approaches

Idaho is not currently a managed care state, does not use a “Patient Panel” approach, and does not have an All Payers Database. If any of these conditions change, an update to the SMHP may introduce updates to the PV calculation and verification approaches.

4.6(a) – Verification of PV

The following data sources are used to verify PV for providers:

- Provider attestation application information reported through IIMS
- Fee-For-Service encounter claims data from the Idaho MMIS and the Medicaid DSS
- Hospital cost reports (for EHs)
- Direct communications with providers
- FQHC/RHC reported data, including information from the FQHC Uniform Data System reports which are independently reviewed by John Snow, Inc., prior to final submission to the federal Health Resources and Services Administration
- Information requested from the Indian Health Service’s national data repository
- Information supplied by the private contractor hired to administer Idaho’s dental program
- Information supplied by the private contractor hired to administer Idaho’s Behavioral Health Plan

4.6(b) – Verification of AIU

Idaho Medicaid verifies AIU of CEHRT by reviewing the documentation submitted by providers during the attestation process for the period being claimed for payment is valid. Under the Final Rule for the Electronic Health Record Incentive Program, CMS defined AIU as acquiring or upgrading a system, which requires proof such as a purchase or lease or some other financial agreement. Implementation is defined by the same rule as having installed or commenced utilization of CEHRT. Training, according to this rule, is an implementation activity.

For verification of AIU, Idaho Medicaid receives proof of the number of licenses purchased or leased for the EHR system as well as a binding document (e.g., a contract) or proof of financial investment in an EHR system (e.g., a receipt), such as the following:

- Signed contract or lease with an EHR vendor
- Contract for subscription with a service vendor
- Invoice or purchase order from an EHR vendor
- Payment receipt for an EHR system
- Data use agreement contract

Other reasonable substantiating documents may be deemed acceptable by Idaho Medicaid on a case-by-case basis.

4.7(a) – “Practices Predominantly” Requirement

Idaho Medicaid consulted the August 2011 CMS “Medicaid EHR Incentive Program Eligibility: Patient Volume & Practices Predominantly” publication to design an adequate approach to the “practices predominantly” requirement, as well as the patient volume approach in Section 4.5. CMS has recognized the lack of verifiable data sources from which states can directly verify compliance with this requirement, and Idaho places into the category of states which track FQHC and RHC claims at an organizational level but not at the individual provider level. Without an All Payer Database, Idaho also does not have a data source for all patient encounters with which to compare Medicaid encounters. Therefore, Idaho Medicaid EHR Incentive Program’s selected approach will focus on auditable information available from clinics to be compared with provider self-attested data.

Per program guidance from CMS, Tribal Health Clinics may qualify for incentive payments under the same standards established for FQHCs. The Idaho Medicaid EHR Incentive Program will leverage the approach described below to establish eligibility related to Tribal Health Clinic professionals which attest to the “practices predominantly” requirement.

Definition and Verification Approach

The “practices predominantly” requirement is a combination of two standards:

1. At least 30% of their encounters during any continuous 90-day period in the most recent calendar year or rolling 12-month period were serving “needy individuals” or the same is attested to by the facility as a proxy.
2. More than 50% of a provider’s encounters over a six-month period in the most recent calendar year or rolling 12-month period occurred at an FQHC or RHC.

Idaho Medicaid anticipates many FQHCs, RHCs, and Tribal Health Clinics will apply for proxy “needy individuals” attestations from their affiliated facility to maximize potential payment. For potential EPs serving in these facilities which elect not to use proxy attestations, the Idaho Medicaid EHR Incentive Program staff will work with the individual provider to confirm 30% of encounters in a 90-day period were “needy individuals”.

EPs practicing at FQHCs or RHCs must attest to the “practices predominately” and PA-Led requirements during the registration and attestation process.

If selected for audit, the FQHC, RHC, or Tribal facility at which the provider serves is requested to complete information relating to the “practices predominately” requirement, as well as the facility being led by a PA. The form is submitted directly to the Idaho Medicaid EHR Incentive Program or their designated contractor.

4.7(b) – MU in Second Participation Year

Idaho Medicaid implemented the new CMS 2014 CEHRT Flexibility Final Rule on October 1, 2014. The rule granted flexibility to providers to meet MU in 2014 with EHRs certified to the 2011 or the 2014 edition criteria.

Idaho Medicaid implemented the new CMS 2015 Modification Final Rule on January 1, 2016. The rule allowed EPs and EHs attesting to program year 2015, to utilize a 90-day timeframe for all measures and objectives. Idaho Medicaid also requested, and had approved, an extended tail-period to May 30, 2016.

4.8 – Proposed Changes to Meaningful Use Definition

Idaho Medicaid has not, and does not plan to, propose state-specific changes to the MU definition.

Any subsequent decision to modify the MU definition will be included in a future SMHP update.

4.9 – Verification of Use of CEHRT

Providers are required to submit their CMS EHR Certification Identification to Idaho Medicaid when attesting to MU of CEHRT. Idaho Medicaid EHR Incentive Program staff manually validates provider EHR products against the CHPL maintained by the ONC-HIT.

4.10 – Collection of MU Data

Idaho Medicaid is collecting MU data by having providers submit system-generated reports of MU objectives, CQM data, PV reports, and other necessary documentation to Idaho Medicaid EHR Incentive Program to demonstrate both AIU and MU. Providers have the option of sending in de-identified reports from their CEHRT for each measure domain and from their billing service for PV to support their attestation. Providers can upload their data directly into their attestation by using their provider portal in IIMS.

Idaho Medicaid is accepting MU attestation information from CMS for all EH attestations.

4.11 – Collection of Clinical Quality Measures Data

As part of CHIP, Idaho is looking to implement a Medical Home model. With implementation of a Medical Home model, select practices will be able to use EHRs to communicate with providers and back to the CHIP via the Medical Home. The target population for CHIP is Medicaid individuals with special health needs. The Medical Home concept can especially help individuals with special needs through coordinated care and services. Using this model, the patient and providers involved in the patient's care can access coordinated and integrated information about the patient. In addition, Medical Home Coordinators will be imbedded at practices to assist with care coordination and to provide education and mentorship to families. Practices applying for the Medical Home demonstration will need to have an existing EHR or be adopting an EHR.

The data collected through the Medical Home system can be collected as part of CHIPRA Quality Demonstration Grant's CQMs and analyzed by Idaho Medicaid EHR Incentive Program staff for alignment with CQMs gathered through the Idaho Medicaid EHR Incentive Program. This project ran until February 2015. More information about the CHIPRA Medical Home Model can be found in Section 2.15.

The IDHW is also establishing improvement partnerships to track and identify trends at the provider practice level for improving clinical outcomes. The partnerships will help practices with systematically collecting data and reporting through registries. As part of this effort, providers will not be required to have an EHR, but practices participating in the Idaho Medicaid EHR Incentive Program will be in a better position to participate in the improvement partnerships program.

In addition, the statewide IRIS captures and reports on vaccination data gathered in Idaho. IRIS is a vaccine registry and inventory management system with reporting capabilities. Currently, the IHDE does not exchange data with IRIS, but data captured in Idaho's statewide HIE can be exported for alignment with IRIS data. There are plans for IRIS and the IHDE to exchange data. As part of the CHIPRA Quality Demonstration Grant, IRIS will integrate with the IHDE for capturing and reporting on clinical quality measures. More information about interfacing between the IHDE and IRIS can be found in Section 3.2.

4.12 – IT, Fiscal, and Communication Systems

Idaho Incentive Management System (IIMS)

IIMS is the core management system for operating Idaho Medicaid's EHR Incentive Program. This is a leveraged system from the state of Kentucky which was modified for Idaho Medicaid and put into production on July 2, 2012. IIMS is hosted and maintained in Idaho and includes a public-facing provider and hospital interface. IIMS interface enables direct data entry of application and attestation information by EPs and EHs. The system enables Idaho Medicaid EHR Incentive Program staff to process program applications through a combination of enhanced automated business functions and documented manual procedures.

IIMS is upgraded as appropriate to support ongoing attestation and verification requirements of sequential program years.

The process for entering application and attestation information through IIMS is outlined in Appendix C.

The attestation itself is electronic and requires the provider to attest to meeting all requirements defined in the federal regulations. Some documentation must be provided to support specific elements of attestation. All providers are required to submit supporting documentation for PV claimed in the attestation. Specific guidance on requested documentation is provided in IIMS and the user manuals. Once the electronic attestation is submitted by a qualifying provider and appropriate documentation provided, Idaho Medicaid EHR Incentive Program staff conduct a review of the attestation.

Fiscal System for Incentive Payment Distribution

Idaho Medicaid evaluated two financial management systems for processing and distributing incentive payments to EPs and EHs:

1. The Idaho MMIS Financial Subsystem
2. The Idaho DHW payable system, Navision.

While both systems would enable Idaho Medicaid to leverage existing and proven financial management solutions, the Idaho MMIS would have required extensive system customizations. Customizing the MMIS would negatively impact Idaho Medicaid resources and the resources of its fiscal agent. As such, Idaho Medicaid selected Navision to support payment processing and distribution for the Idaho Medicaid EHR Incentive Program.

Navision, a third-party financial accounting application implemented in Idaho state government in 2001, continues to be supported today by Protean Technologies. Idaho Medicaid leverages Navision by specifically employing the Accounts Payable module within Navision to support EHR incentive payment processing and distribution. IDHW currently utilizes the Accounts Payable, Fixed Assets, and Budget Modules within the financial management software to support Idaho Medicaid and other Divisions within IDHW.

This incentive payment processing method employs a combination of manual and system processes to pass provider incentive payments through Navision. Once EHR Incentive Program staff have verified eligibility and confirmed a duplicate payment was not processed, a payment request form is sent to administration for internal approval. Upon approval, the payment form is scanned into Navision for payment processing by financial operations. The transaction is then combined with an electronic funds transfer/warrant and payment is issued by the State Controller's Office. Notice of payment is sent to the provider and the electronic funds transfer is posted to the state controller's website. Idaho Medicaid EHR Incentive Program staff manually checks Navision for payment information and notify CMS of payment distribution using the D-18 form. This payment processing method does not require an electronic interface between Navision and the EHR incentive program system.

Idaho Medicaid acknowledges payment must be issued within 45 days of being verified as eligible, and this period begins upon receipt of the D-16 response from CMS confirming the provider has not received a duplicate payment.

As part of early outreach to providers, information was shared with providers on how incentive payments are paid and the necessary steps required setting up payment in the state fiscal system called the Statewide Accounting and Reporting System, which is separate from the MMIS currently in place. Providers must enroll as a vendor in this fiscal system to receive an incentive payment.

As part of final eligibility verification, an Idaho Medicaid EHR Incentive Program representative checks to see if the provider currently exists as a vendor in the state vendor table. If not, the provider is contacted via e-mail with instructions on completing the enrollment process. Once the enrollment documents are loaded, it is expected to take one to three days until the vendor can be considered added to the vendor table.

Outreach and Communication Systems

The primary communication method for obtaining EHR Incentive Program application and attestation information from providers is IIMS. IIMS is a component of the Idaho Medicaid EHR Incentive Management System and is described above at the beginning of Idaho's response to question 4.12. Additionally, Idaho relies on the Idaho Medicaid EHR Incentive Program website to communicate with providers throughout the duration of the program. More information about the website can be found in Section 4.17.

4.13 – IT System Changes

No changes are anticipated for existing Idaho Medicaid IT systems. A stand-alone system was adopted by Idaho Medicaid based on the system developed for Kentucky's EHR Incentive Payment program. The Idaho EHR Incentive Management System needs to be localized, meaning it is tailored to meet Idaho's specific aesthetic and functional requirements needed to support the Idaho Medicaid EHR Incentive Program. The following IIMS changes were made to implement the EHR Incentive Program:

- The system name was updated to IIMS.
- The system was reviewed and modified as needed to meet state IT standards.
- The public-facing provider portal was named the Idaho Medicaid Provider Attestation Portal.
- The Idaho Medicaid EHR Incentive Program name and logo, and references to Idaho Medicaid, involved agencies, and the IDHW have been used in accordance with Idaho Medicaid communication standards.
- Where existing business processes are leveraged to support the Idaho Medicaid EHR Incentive Program, when necessary, the Idaho Medicaid EHR Incentive Management System has been modified to support the process.
- System generated document templates including, but not limited to, emails, letters, notices, and forms are being updated to reflect Idaho Medicaid’s EHR Incentive Program and will follow Idaho Medicaid communication standards.
- All system-generated documentation used to support business functions of the Idaho Medicaid EHR Incentive Program (e.g., audit, payment recoupment, appeals, reporting) are being tailored to the specific attributes of the business function.
- The system was reviewed in detail to ensure all system content presented on screens such as program text, Idaho agency and program contact information (i.e., agency names, address, and phone numbers) is updated to reflect the Idaho Medicaid EHR Incentive Program and Idaho Medicaid’s communication standards.

4.14 – IT Systems Modifications Timeframe

The timeframe for IIMS modifications identified in Section 4.13 was a six-month period.

The P-APD funding was used to build a system “proof of concept” to facilitate planning for system changes needed for an EHR Incentive Management System, and to finalize corresponding business processes.

The IT modification time period included CMS file exchange and provider acceptance testing. The start date for system modifications was dependent on assumptions listed in Section 4.27, including CMS’ SMHP review comments and any specific guidance which may have impacted IIMS. The table below presents the registration, attestation, and payment implementation timeline for the Idaho Medicaid EHR Incentive Program and key milestone tasks.

Table 4.14

Task	Timeframe
Transfer, localize, and implement IIMS (includes CMS file exchange and provider acceptance testing)	01/03/12 – 06/29/12
Contact CMS to schedule interface testing	03/01/12
Complete connectivity arrangements, include secure point of entry forms	03/01/12
Initiate data use agreements processing with CMS	03/01/12
Initiate processing of secure access forms with CMS (for reporting	03/01/12

system)	
Test interfaces (to support file exchange) from Idaho Medicaid EHR Incentive Management System to CMS Registration and Attestation System	03/15/12 – 03/30/12
Receive CMS Registration and Attestation System transactions (for testing activities)	03/22/12 – 05/25/12
Establish system and user documentation	04/09/12 – 04/13/12
Conduct provider file testing (user acceptance testing with provider applications)	05/14/12 – 05/25/12
Update existing Idaho Medicaid Business Continuity and Disaster Recovery Plan with IIMS Plans	05/29/12 – 06/01/12
Program go-live date	07/02/12

4.15 – Interface with CMS National Level Repository Timeframe

The Idaho Medicaid EHR Incentive Program’s current timeline identified April 16, 2012, as the date to contact CMS to initiate file exchange testing. This date is dependent on assumptions listed in Section 4.27.

4.16 – Collection of Registration Data

According to the current information supplied by CMS, registration information for providers is transmitted from CMS to Idaho Medicaid by electronic data transmission on a daily basis. Idaho Medicaid has determined the file transmission are supported by a direct electronic interface with IIMS. Details associated with the registration data transfer were confirmed during the implementation and localization of IIMS and subsequent testing of the file exchange function with CMS.

4.17 – Program Website

Idaho Medicaid employs a dedicated website which provides a wealth of information regarding the Idaho Medicaid EHR incentive program including eligibility requirements, important hyperlinks, and other information relevant to the program. The outreach effort is anchored by a website located at: <http://healthandwelfare.idaho.gov/default.aspx?TabId=1405>.

This web address is already in use and Idaho Medicaid continues to inform providers of the website by including the website address on outreach presentation materials presented to stakeholder groups (including, but not limited to, professional associations and provider groups) for subsequent distribution through respective communication channels. Additionally, the address is printed in program brochures, business cards, Medicaid’s email correspondence footer information, remittance advance banner notices, and through verbal communication during standing teleconference meetings with provider groups.

Launch readiness assurance was extended to CMS, and state and federal approvals were secured to move into production. Idaho Medicaid published a production hyperlink to the Idaho

Medicaid Provider Attestation Portal to enable access to Idaho Medicaid EHR Incentive Program attestation screens. Enrollment and program information will continue to be made available to EPs and EHS throughout the duration of the Idaho Medicaid EHR Incentive Program through the website. Additionally, hyperlinks to other websites offering program information and associated online resources are maintained on the Idaho Medicaid EHR Incentive Program website.

Provider Testing

Idaho Medicaid conducted provider testing activities prior to launching IIMS, and utilized providers to conduct this user acceptance testing. Several providers volunteered to walk through the application process prior to launch as a way of testing the system. This assisted with testing real scenarios and data. It also allowed those providers to test their understanding of how the registration and attestation process worked, as well as eligibility rules. The registration and attestation process will be quicker for those providers as they will have already tested it; however, test data is saved in the system for use during the provider's official registration and attestation.

Early testing with all provider types allowed Medicaid to test all assumptions on how data would be verified as well as how long it would take to process an application, ensuring both the system and technical assistance staff were prepared.

4.18 – Anticipated MMIS Modifications

IDHW does not plan to modify the MMIS to support the initial implementation of registration, attestation, and payment portions of the Idaho Medicaid EHR Incentive Program. The Idaho Medicaid EHR Incentive Management System will not electronically interface with the MMIS.

4.19 – Addressing Incentive Program Questions

Idaho Medicaid has a support system which is appropriate and scaled to the anticipated volume of applicants to the Idaho Medicaid EHR Incentive Program. The approach to addressing inquiries consists of two key components:

1. Help desk operated by Idaho Medicaid EHR Incentive Program staff
2. Idaho Medicaid EHR Incentive Program website:
<http://healthandwelfare.idaho.gov/default.aspx?TabId=1405>

Contact information, methods, response time standards, and other technical assistance details are described in Section 3.7.

4.20 – Provider Appeal Process

The EHR Incentive Program appeal process is consistent with Medicaid's Administrative Review and Appeal Process for providers who wish to challenge a decision or action. When Medicaid plans to take any action affecting an enrolled provider, the agency sends the provider a notice identifying the action IDHW plans to take and informing the provider of their right to be heard if they disagree with specified action(s). To this end, providers may appeal an incentive

payment decision, provider eligibility determination, or demonstration of efforts to adopt, implement, or upgrade within 28 days of the date the Notice of Decision is mailed. The provider or designated representative may submit a Request for Administrative Review in writing to the program administrator. The Request for an Administrative Review must be signed by the licensed administrator of the facility or by the provider, must identify the challenged decision, and state specifically the grounds for its contention that the decision is erroneous. The provider's case should clearly relate to the requirements in the EHR Incentive Program federal and state regulations. Per Idaho Medicaid Policy, only those appeal requests not filed timely or by an individual who does not have authority to file an appeal can be denied for consideration.

Administrative reviews are conducted by a designee of the Idaho Medicaid Deputy Administrator, based on the type of facility or provider requesting the review. Upon receipt of a Request for an Administrative Review, the Deputy Administrator determines if the request is an administrative review or an inquiry. If it is determined to be an administrative review, the Administrative Assistant for the Deputy Administrator contacts the provider within 14 days of receipt of the request to schedule a review conference. The purpose of the review conference is to clarify and attempt to resolve the issues. If IDHW determines additional documentation is needed to resolve the issues, a second session of the conference may be scheduled. Idaho Medicaid furnishes a written decision to the facility or provider within 14 days of the conclusion of the last review conference.

The facility or provider may appeal the administrative review decision, which will then enter the Contested Case Appeal Process, to be considered by a hearing officer from a contracted law office with three Idaho locations and teleconference capabilities.

If either party (the provider or the IDHW) disagrees with the Hearing Officer's preliminary order decision, the party has 14 days from the date the preliminary order was mailed to file a request for review with the Idaho Medicaid's Administrative Procedures Section.

If neither party disagrees with the preliminary order by requesting a review within the 14-day period, the preliminary order automatically becomes a final order.

Ongoing steps include involvement of the Idaho Office of Attorney General, and eventually the provider may file in District Court. Additional details and policies regarding the Idaho Medicaid Appeals Process can be found in IDAPA 16.05.03:
<http://adminrules.idaho.gov/rules/2012/16/0503.pdf>

Instructions to request an administrative review are provided with all notices of adverse decisions relating to provider eligibility and qualification for incentive payments.

4.21 – Accounting for Federal Funding

As with other Idaho Medicaid programs and projects which currently receive FFP from CMS, IDHW utilizes existing controls and reporting processes to ensure Idaho Medicaid EHR Incentive Program monies are accounted for according to federal and state specifications as well as the approved budget per the IAPD. Idaho Medicaid leverages existing accounting systems to

ensure program payments are not co-mingled and no amounts higher than 100% of FFP will be claimed by the state for reimbursement of expenditures for state payments to Medicaid EPs or EHs for the EHR Incentive Program. Authorized provider incentive payments are processed for payment through IIMS.

Expenditures requested on the CMS-37 form are tracked by expenditure type and reported quarterly to CMS on the CMS-64 Report.

4.22(a) – Frequency for Making EHR Incentive Payments

EPs and EHs who have met federal and state requirements for participation in the Idaho Medicaid EHR Incentive Program will be eligible to receive a single annual incentive payment. Incentive payments are paid in accordance with Idaho's existing financial cycle, which is within the CMS requirement of payment be completed within 45 days of submission of the D-16 form is returned to the state from CMS verifying there have been no duplicative EHR incentive payments. For EHs, Idaho Medicaid's incentive payment schedule is optimized to disburse the total incentive payment amount to each hospital as early in the hospital's participation as possible, while adhering to the restrictions on distribution set forth in ARRA. To this end, the total incentive payment for each EH is disbursed in annual lump sum payments over the course of the first three years of the hospital's participation in the Idaho Medicaid EHR Incentive Program, according to the following schedule:

- 50% of the total incentive amount in the first year of program participation
- 40% of the total incentive amount in the second year of program participation
- 10% of the total incentive amount in the third year of program participation

4.22(b) – Payments Made Directly to the Provider

The provider supplies designated payee information and preferred payment method (paper or electronic funds transfer) during the Idaho Medicaid EHR Incentive Program application and attestation process. As stated in Section 4.4, EHs or both the EP and designated payee will receive communication by e-mail a payment has been issued. A notice provides information about the incentive payment which has been made, including a description of any deductions or changes to the total amount. Idaho Medicaid has identified the following as a potential deduction to the EHR incentive payment:

- Recoupment of any active overpayments made by the Idaho Medicaid EHR Incentive Program.

At this time, Idaho Medicaid does not anticipate using EHR incentive payments to retain any debts to, or overpayments from, any other federal or non-state-of-Idaho program, with the following exceptions:

- Where it is authorized specifically by the Medicaid program (a civil monetary penalty, for example, or a Medicare debt)
- Where there is a court-ordered garnishment for a specific purpose

4.23 – Assuring Payments Promote Adoption of CEHRT

Idaho does not have a paid entity promoting the adoption of CEHRT. Currently there is no option for non-eligible providers to purchase technical assistance services from a regional extension center for the state.

4.24 – Managed Care Methodology

At this time, Idaho is not considered a managed care state. If Idaho Medicaid adopts a managed care model in future years of the EHR Incentive Management Program, this section will be addressed in an SMHP update.

4.25 – Question Removed by CMS

Per “State Medicaid Directors Letter #11-002” dated April 8, 2011, the 15% net average requirement has been removed. The Idaho Medicaid EHR Incentive Program acknowledges this requirement is no longer valid.

4.26 – Role of Medicaid Contractors in Program Implementation

The Idaho Medicaid EHR Incentive Program utilizes information provided by four existing contractors:

DentaQuest

Private contractor hired to administer the state’s dental program, Idaho Smiles. The Idaho Medicaid EHR Incentive Program consults with DentaQuest on an as-needed basis to confirm AP application and attestation information (e.g., PV attestation information) pertaining to dental providers.

Molina

Private contractor hired to administer a portion of the state’s MMIS. The Idaho Medicaid EHR Incentive Program utilizes information from the fiscal intermediary in eligibility determinations and pre-payment verification. Post-payment audits are conducted using the data warehouse and DSS provided by Truven.

Myers and Stauffer

Private contractor hired to administer CPA functions and audit services. Myers and Stauffer provide audit services for post payment MU for EP.

Public Knowledge LLC

Private contractor hired to administer the development of the SMHP and I-APD and has completed their work.

4.27 – EHR Incentive Program Assumptions and Dependencies

Idaho Medicaid has the following assumptions and dependencies by area:

Role of CMS

- The SMHP and I-APDs will be approved in a timely manner (within 60 calendar days of submission).
- Timely reimbursement, or advance payment, from CMS in alignment with the payment schedule to providers.

Status/Availability of CEHRT

- Providers will see value in using certified EHRs.
- Costs for adoption of certified technology will not be prohibitive for providers.

HIE Cooperative Agreement

- The IHDE will provide connectivity assistance (both technical and monetary) to select providers.
- Connectivity costs will not be prohibitive for providers.

State-Specific Readiness Factors

- No modifications or enhancements will be made to the Idaho MMIS to support the EHR Incentive Program.
- Outreach will be effective in promoting the use of the optional Rendering Provider field in claims submission.

Section 5 – Audit Strategy

A description of the audit, controls, and oversight strategy for Idaho’s EHR Incentive Payment Program can be found in Idaho’s approved Audit Guide. Idaho Medicaid is committed to maintaining the integrity of the Idaho Medicaid EHR Incentive Program and continues to identify and investigate potential fraud and abuse by using a proven and effective audit approach which aligns with the specific guidelines created for the Idaho Medicaid EHR Incentive Program.

Section 6 – HIT Roadmap

This section presents a graphical and narrative pathway clearly illustrating the state’s strategy for moving from the “As-Is” HIT Landscape as described in Section 2 of this plan to the achievement of the “To-Be” HIT Environment envisioned in Section 3. This strategic roadmap is based on measurable, annual targets and benchmarks tied to HIT and HIE program goals and objectives.

6.1 – HIT/HIE Pathway

The “As-Is” landscape and “To-Be” vision are detailed in Sections 2 and 3 of this plan, and include a discussion of the broad HIT and HIE environment within the state of Idaho. The HIT roadmap is intended to describe the journey of Idaho Medicaid in general, and the EHR Incentive Program specifically, in achieving the “To-Be” vision within five years. Actions and corresponding milestones to achieve this vision are detailed in the following sections.

Where Idaho Medicaid is today

As this road map was written in early 2013, Idaho Medicaid is already making progress toward the “To-Be” vision. The activities include:

- Submitting this updated SMHP for review and approval by CMS.
- Continual customization of IIMS (Kentucky’s state level repository) for future implementation of progressive MU stages.
- Submitting the Idaho Implementation-Advanced Planning Document (I-APD) to confirm funding for implementation and operation of the Idaho Medicaid EHR Incentive Program for Years 4 and 5.
- Working closely with the Washington & Idaho REC, the IHDE, and the State HIT Coordinator to support providers through the EHR Incentive Program stages.
- Working closely with the Idaho healthcare communities and their associations to support providers through the EHR Incentive Program stages.
- Continue to maintain the strong support network for providers to assist in meeting MU.

Where Idaho Medicaid Plans to be in Five Years

Five years from now Idaho Medicaid intends to have accomplished the following:

- Implemented a fully functioning EHR Incentive Program with the capacity to accept Stage 3 MU.
- Continue to maintain the strong support network for providers to assist in meeting MU.
- Extend EHR Incentive Payments to 50 hospitals within Idaho and at least 2,000 non-hospital based Idaho Medicaid providers.
- Explored interface needs between the MMIS and HIE, and will have implemented interfaces as appropriate.

As described in Section 3, the primary objectives for the “To-Be” environment are to:

- Maintain implementation of the Idaho Medicaid EHR Incentive Program.
- Coordinate assistance to providers in reaching all stages of MU.
- Leverage the statewide HIE.

These objectives support the overarching goal of the Idaho Medicaid EHR Incentive Program, which is to improve the quality and coordination of care by connecting providers to patient information at the point of service through meaningful use of EHRs.

How Idaho Medicaid Plans to Achieve this Vision

Below is a table capturing the current “As-Is” HIT environment and the required tasks for progression to the “To-Be” vision and Planned IT Environment. The full detailed timeline for tasks can be found in the corresponding I-APD, Section 6.

Table 6.1

Objective	Critical Task(s)
Maintain implementation of the Idaho Medicaid EHR Incentive Program	<ul style="list-style-type: none"> • Maintain data use agreements with CMS. • Maintain connectivity arrangements with CMS (SPOE). • Update all technical documents regardless of approval requirements. • Develop, submit, and obtain required CMS approval of updated technical documents. • Develop or modify appropriate program policies and procedures to support administration of the program. • Develop or modify appropriate IT policies and procedures to support the administration of the system. • Conduct program outreach activities detailed in the updated SMHP (webinars, conference calls, website updates). • Modify, test, and implement IIMS system changes for MU requirements, • Submit rule changes as necessary. • Process EP and EH incentive applications through payment. • Employ program audit services. • Notify CMS of incentive payment distributions. • Submit Form CMS-37. • Submit Form CMS-64.
Coordinate assistance to providers in reaching all stages of MU	<ul style="list-style-type: none"> • Provide outreach and training on requirements for MU and reporting requirements. • Communicate with providers regarding methods for submitting CQMs. • Develop incentive program reports based on data captured from EHR Incentive Management System and Navision. • Plan for MU Stage 3.
Leverage the statewide HIE	<ul style="list-style-type: none"> • Determine program and data needs related to documentation of providers’ MU data submission and IHDE’s ability to gather the information. • Identify IHDE’s capacity to support electronic submission of MU data.

	<ul style="list-style-type: none"> • Obtain reports on provider usage of HIE to document potential ability of provider to submit eCQMs. • Establish a formal agreement with IHDE to provide MU data. • Develop bidirectional interface between HIE and IRIS. • Develop bidirectional interface between HIE and MMIS DSS for MU reporting. • Conduct stakeholder outreach in coordination with the IHDE.
--	--

Tasks not identified in the above tables relate to unknown future capabilities of the MMIS and DSS. These include access to necessary clinical data, linking clinical data to Medicaid claims and encounter information, and applying decision support tools to make effective clinical and program decisions. These topics will be considered by Idaho Medicaid and reflected in a future update to this SMHP, if appropriate.

6.2 – Annual Benchmarks and EHR Adoption Expectations

As mentioned in Section 3.1 of this document, Idaho Medicaid set an enrollment goal of 12% of EPs and 25% of EHs in the first year of Idaho’s program who will also meet MU within the second year of the program.

By the end of the third year of the program the Idaho Medicaid EHR Incentive Program aimed to have MU compliance with 25% of EPs and 40% of EHs enrolled.

Idaho Medicaid anticipates increases in CEHRT adoption in subsequent years; among participants in the Medicaid EHR Incentive Program as well as the provider community at-large due to increased broadband access, increased technology adoption by the healthcare community, and greater demand for IT innovations in the healthcare community. Still, Idaho Medicaid is cautiously optimistic about adoption of CEHRT over time based on challenges facing the provider community, described in Section 3.1.

Further development of goals, objectives, and subsequent benchmarks will be informed by reporting, audits, and assessments conducted throughout the life of the program. The SMHP will be updated to reflect additional information gleaned through reporting throughout the life of the program’s implementation.

6.3 – Annual Benchmarks for Medicaid Goals

Below is a table of annual benchmarks for the Idaho Medicaid EHR Incentive Program, based on the goals and objectives from Section 3.1.

Table 6.3

Timeline	Benchmark	Corresponding Objective
Year 1 of Idaho Medicaid EHR Incentive Program	Reach at least 85% of Medicaid providers through outreach efforts conducted in coordination with the	Coordinate assistance to providers in reaching MU

	WIREC and IHDE.	
Year 1 of Idaho Medicaid EHR Incentive Program	Have contact with 100% of FQHCs and CAHs through outreach efforts.	Coordinate assistance to providers in reaching MU
Year 1 of Idaho Medicaid EHR Incentive Program	Receive MMIS Certification.	Achieve CMS certification for Idaho's new MMIS
Year 2 of Idaho Medicaid EHR Incentive Program	Demonstrate a minimum of 12% of EPs and 25% of EHs who applied in Year 1 to meet MU in Year 2.	Implement the Idaho Medicaid EHR Incentive Program
Year 3 of Idaho Medicaid EHR Incentive Program	Demonstrate a minimum of 25% of EPs and 40% EHs who applied in Years 1 or 2 to meet MU by Year 3.	Maintain the Idaho Medicaid EHR Incentive Program
Year 4 of Idaho Medicaid EHR Incentive Program	.	Leverage the statewide HIE

6.4 – Annual Benchmarks for Audit and Oversight Activities

As described in Section 5, a detailed audit services plan has been developed for the auditing procedures to ensure achievement of state and federal audit requirements for the program.

Appendix A – Activity Schedules

The proposed tasks and subtask schedule presented details key Idaho Medicaid EHR Incentive Program activities scheduled to occur through the end of the FFY 2018. The schedule includes activities involving the final rule from CMS and the new Federal requirements. The new activities will support future Idaho Medicaid EHR Incentive Program years and will be provided to CMS in subsequent updates to the SMHP and IAPD-U accordingly.

A.1 – Previous Activity Schedule

Activity	Start Date	End Date	Status
CMS approval of I-APD Update – Yr. 4	01/01/15	02/28/15	Complete
Develop and submit annual SMHP Update – Yr. 4	01/01/15	02/28/15	Complete
CMS approval of SMHP Update – Yr. 4	03/01/15	05/01/15	Complete
Develop and submit annual SMHP and I-APD Update – Yr. 5	03/01/15	05/01/15	Complete
CMS approval of SMHP and I-APD Update – Yr. 5	04/01/16	04/30/16	Complete
Support efforts of IHDE for statewide data exchange activities as related to meaningful use	04/02/16	Ongoing	Complete
Submit Form CMS-37 (quarterly, beginning the quarter the IAPD is approved)	Every January, April, July, and October	Quarterly	Complete
Submit Form CMS-64 (quarterly, end of each federal fiscal year quarter)	Every February, May, August, November	Quarterly	Complete
Review, modify, and submit IAPD-U – Version 5	03/01/16	05/31/16	Complete
Review, modify, and submit SMHP Update – Version 5	03/01/16	05/31/16	Complete
Update EP Manual to reflect MU requirements	04/01/16	04/30/16	Complete
Update EH Manual to reflect MU requirements	04/01/16	04/30/16	Complete
Update business process to support MU function	04/01/16	04/30/16	Complete
Update system and user documentation	04/01/16	04/30/16	Complete
Perform operational readiness test of MU requirement	04/01/16	04/30/16	Complete
Update EHR Audit Guide to reflect MU requirements	04/01/16	05/31/16	Complete
Review, modify, and submit Audit Guide update	06/01/16	06/01/16	Complete

A.2 – Proposed Activity Schedule

Activity	Start Date	End Date	Status
CMS approval of IAPD-U – Version 5	06/01/16	07/31/16	In Process
CMS approval of SMHP Update – Version 5	06/01/16	07/31/16	In Process
CMS approval of Audit Guide Update	06/01/16	07/31/16	In Process
Update EHR Incentive Program website with program MU requirement communication	Ongoing	Ongoing	Ongoing
Notify CMS of incentive payment distributions for MU attestations (no later than)	Quarterly (Ongoing)	Quarterly (Ongoing)	Ongoing
Submit Form CMS-37 (quarterly, beginning the quarter the IAPD is approved)	Quarterly (Ongoing)	Quarterly (Ongoing)	Ongoing
Submit From CMS-64 (quarterly, end of each FFY quarter)	Quarterly (Ongoing)	Quarterly (Ongoing)	Ongoing
Review, modify, and submit IAPD-U – Version 6	03/01/17	05/31/17	Not Started
Review, modify, and submit SMHP Update – Version 6	03/01/17	05/31/17	Not Started
Update EP Manual to reflect MU requirements	04/01/17	04/30/17	Not Started
Update EH Manual to reflect MU requirements	04/01/17	04/30/17	Not Started
Update business process to support MU function	04/01/17	04/30/17	Not Started
Update system and user documentation	04/01/17	04/30/17	Not Started
Perform operational readiness test of MU requirement	04/01/17	04/30/17	Not Started
Update EHR Audit Guide to reflect MU requirements	04/01/17	05/31/17	Not Started
Review, modify, and submit Audit Guide update	06/01/17	06/01/17	Not Started
CMS approval of IAPD-U – Version 6	06/01/17	07/31/17	Not Started
CMS approval of SMHP Update – Version 6	06/01/17	07/31/17	Not Started
CMS approval of Audit Guide Update	06/01/17	07/31/17	Not Started
Review, modify, and submit IAPD-U – Version 7	03/01/18	05/31/18	Not Started
Review, modify, and submit SMHP Update – Version 7	03/01/18	05/31/18	Not Started
Update EP Manual to reflect MU requirements	04/01/18	04/30/18	Not Started
Update EH Manual to reflect MU requirements	04/01/18	04/30/18	Not Started
Update business process to support MU function	04/01/18	04/30/18	Not Started
Update system and user documentation	04/01/18	04/30/18	Not Started
Perform operational readiness test of MU requirement	04/01/18	04/30/18	Not Started
Update EHR Audit Guide to reflect MU requirements	04/01/18	05/31/18	Not Started
Review, modify, and submit Audit Guide update	06/01/18	06/01/18	Not Started

Appendix B – Broadband Grants in Idaho

The National Telecommunications and Information Administration awarded Idaho a variety of broadband-related grants in 2009 and 2010¹:

Idaho Mapping and Planning Grant

Total Award: \$4,450,000

Awarded to EdLab/LinkAMERICA to complete a statewide broadband mapping and planning effort, known as LinkIDAHO. The LinkAMERICA Alliance works closely with Idaho's Office of the Chief Information Officer to perform all mapping and planning functions related to the grant. In addition to mapping existing broadband, the initiative is charged with developing a long-term, sustainable plan for increasing access to and use of broadband across the State. A second award was received to continue the project for a total of five years.

Last Mile Broadband for Underserved Portions of Cassia, Jerome, and Twin Falls Counties, Idaho

Total Award: \$1,862,197 (Cassia), \$984,134 (Jerome), \$1,360,653 (Twin Falls)

The Last Mile Broadband projects for underserved portions of Cassia, Jerome, and Twin Falls Counties plan to bring affordable wireless broadband service to rural, underserved communities in south-central Idaho. The projects intend to expand Digital Bridge Communications' existing network by adding 16 towers, 64 miles of new fiber, and 12 microwave links. The project also proposes to offer speeds of up to three Mbps using both fixed and mobile wireless technology, as well as directly connect approximately 25 community anchor institutions at no charge in each county.

Central and North Idaho Regional Broadband Network Expansion

Total Award: \$2,393,623

First Step Internet proposes to build a regional network of 10 microwave towers to extend high-capacity Internet service in the rural counties of Latah, Idaho, Clearwater, Lewis, and Nez Perce in north-central Idaho. The project intends to connect 42 anchor institutions, including healthcare facilities, emergency response agencies, libraries, and government offices, as well as institutions serving the Nez Perce Tribe. The 550-mile network plans to offer speeds of 50 Mbps to 100 Mbps for anchor institutions and facilitate more affordable broadband Internet service for local consumers, including as many as 21,000 households and 700 businesses, by enabling local Internet service providers to connect to the project's open network. In addition, the Nez Perce Tribe has already made plans to use the new network to provide enhanced last-mile services.

Nez Perce Reservation Broadband Enhancement

Total Award: \$1,569,109

¹ <http://www2.ntia.doc.gov/idaho>

The majority of the Nez Perce Tribe's members and anchor institutions are limited to dial-up or inadequate satellite Internet connections on the 1,200 square miles of reservation land, limiting opportunities to access the digital economy. The Nez Perce Reservation Broadband Enhancement project intends to build a wireless microwave network to provide high-speed, affordable broadband services across four northern Idaho counties: Clearwater, Idaho, Lewis, and Nez Perce. Another Broadband Technology and Opportunities Program grantee, One Economy, will utilize the Nez Perce Tribe middle and last mile network to extend its broadband adoption efforts into tribal communities. In addition, the project plans to expand sparse wireless coverage through partnerships with regional providers Inland Cellular and First Step Internet, also Broadband Technology and Opportunities Program grantees.

Delivering Opportunities: Investing in Rural Wyoming Broadband

Total Award: \$5,063,623

Silver Star Telephone Company will use Broadband Technology and Opportunities Program funding to complete key portions of its broadband network. The Expanding Greater Yellowstone Area Broadband Opportunities project proposes to close an 89-mile gap in its existing Wyoming fiber network between the continental divide at Togwotee Pass and Jackson, bringing comprehensive broadband services to 11 counties in the western part of the state. The Delivering Opportunities: Investing in Rural Wyoming Broadband project proposes to close a 38-mile network gap in northwest Wyoming over the Teton Pass to southeast Idaho, bringing broadband to five additional counties.

United States Unified Community Anchor Network

The University Corporation for Advanced Internet Development has proposed a comprehensive 50-state network benefitting approximately 121,000 community anchors. This is part of a longstanding project to connect essential community anchor institutions across the country, and facilitate closer collaboration and long-term benefits for education, research, healthcare, public safety, and government services. The project proposes a large-scale, public-private partnership to interconnect more than 30 existing research and education networks, creating a dedicated 100-200 Gbps nationwide fiber backbone with 3.2 terabits per second (TBps) total capacity which would enable advanced networking features such as IPv6 and video multicasting. The project plans to connect community anchors across all disciplines into virtual communities with shared goals and objectives, including colleges, universities, libraries, major veterans and other health care facilities, and public safety entities, with additional benefits to tribes, vulnerable populations, and government entities. The planned (draft) 100 gigabit-per-second national network backbone will cross Idaho in two locations, both northern Idaho as well as the southwest portion of the state with an access point in Boise².

Midvale Telephone Exchange, Incorporated

² <http://www.usucan.org/about>

Total Award: \$1,200,000

This US Department of Agriculture award³ will allow Midvale Telephone Exchange to offer last-mile broadband service speeds of at least 20 Mbps in the rural town of Stanley using fiber-to-the-home technology. Approximately 513 people stand to benefit, as do roughly 31 businesses and 6 community institutions.

Potlatch Telephone Co.

Total Award: \$2,000,000

In September 2010, the Rural Utilities Services awarded this \$2 million grant, with an additional \$671,241 in applicant-provided match, to Potlatch Telephone Company. Potlatch Telephone Company is a subsidiary of TDS Telecom. The grant is intended to bring high-speed DSL broadband service to un-served establishments within its rural service territory in Idaho. Potlatch Telephone Company's project stands to benefit over 700 people, as well as 10 businesses.

Coeur d'Alene Tribe Project

Total Award: \$6,100,000

The Coeur d'Alene Tribe received Rural Utilities Services support, a \$6.1M grant and \$6.1M loan, to deploy a fiber-to-the-home broadband system to provide improved broadband services to anchor institutions, critical community facilities, and approximately 3,770 unserved and underserved households in the communities of Plummer, Worley, Tensed, and DeSmet. The project will include service to isolated farms and rural home sites on the Coeur d'Alene Indian Reservation in North Idaho⁴.

Pend Oreille Valley Network, Inc.

Total Award: \$834,164

In 2009, Pend Oreille Valley Network, Inc. received \$834,164 in Rural Utilities Service funds⁵ to provide wireless broadband services to Clark Fork, a community in the mountainous panhandle region of Idaho. A community center was to be established, where broadband Internet access is provided to local residents free of charge for two years. In addition, Pend Oreille Valley Network will offer education and training programs at the center.

Shoshone-Bannock Tribes

Total Award: \$115,000

³ <http://linkidaho.org/lid/default.aspx?page=19>

⁴ <http://linkidaho.org/lid/default.aspx?page=19>

⁵ <http://www.rd.usda.gov/files/UTP-CCProjectSummariesIdaho.pdf>

A \$115,000 planning grant⁶ was awarded in September 2010, to develop strategic plans to attract broadband investment and best use their broadband capability for sustainable economic development, and the Rural Business Opportunity Grants program which support regional planning activities to improve economic conditions in rural areas.

⁶ http://www.raconline.org/news/news_details.php?news_id=14476

Appendix C – Provider Attestation Portal Application Steps

The Idaho Medicaid EHR Incentive Program has a comprehensive user manual for both EPs and EHS. These documents are publicly available at:

<http://healthandwelfare.idaho.gov/default.aspx?TabId=1405>

Appendix D – Incentive Program Process Flows

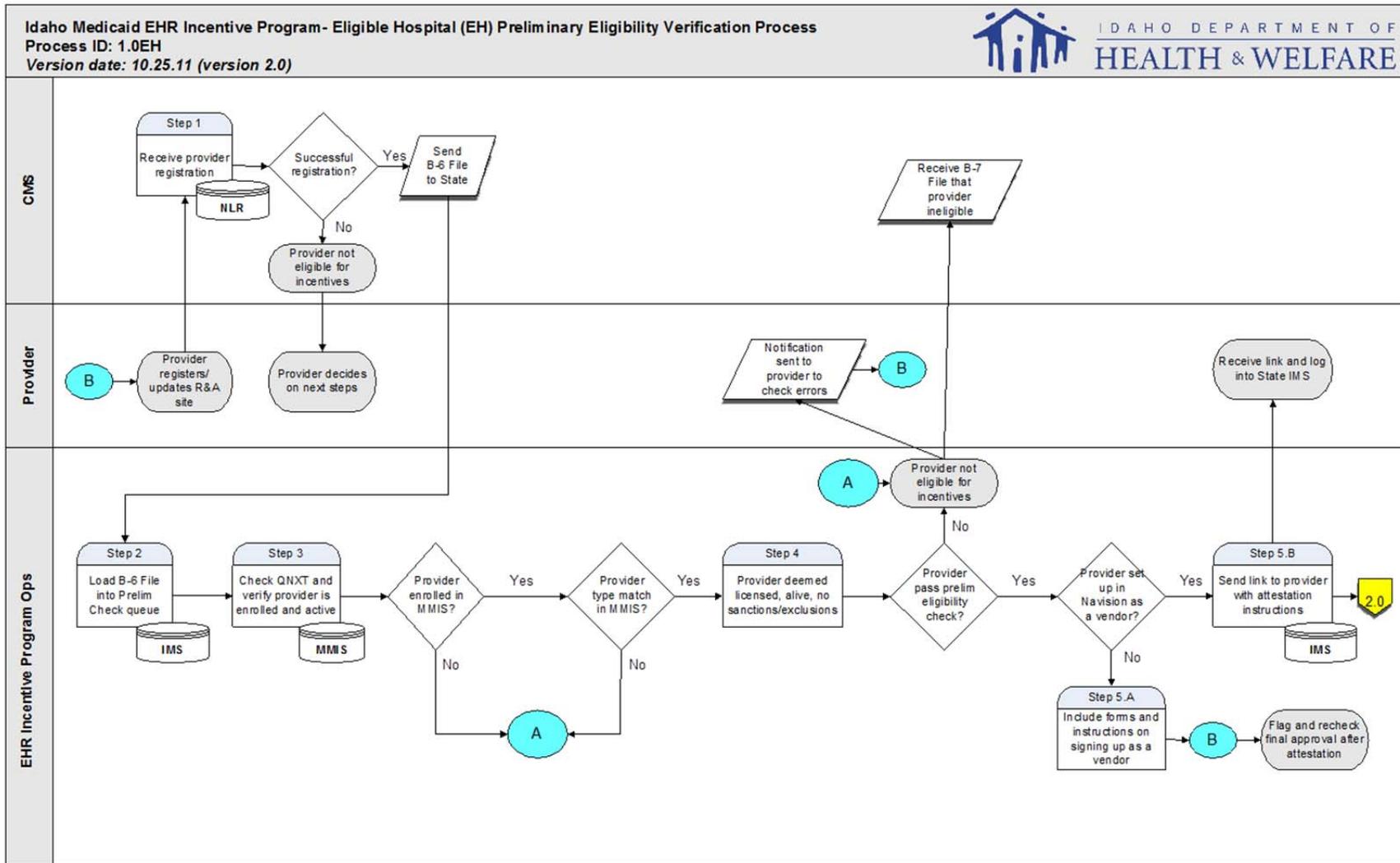
D.1 – Program Process Flows Glossary

Glossary

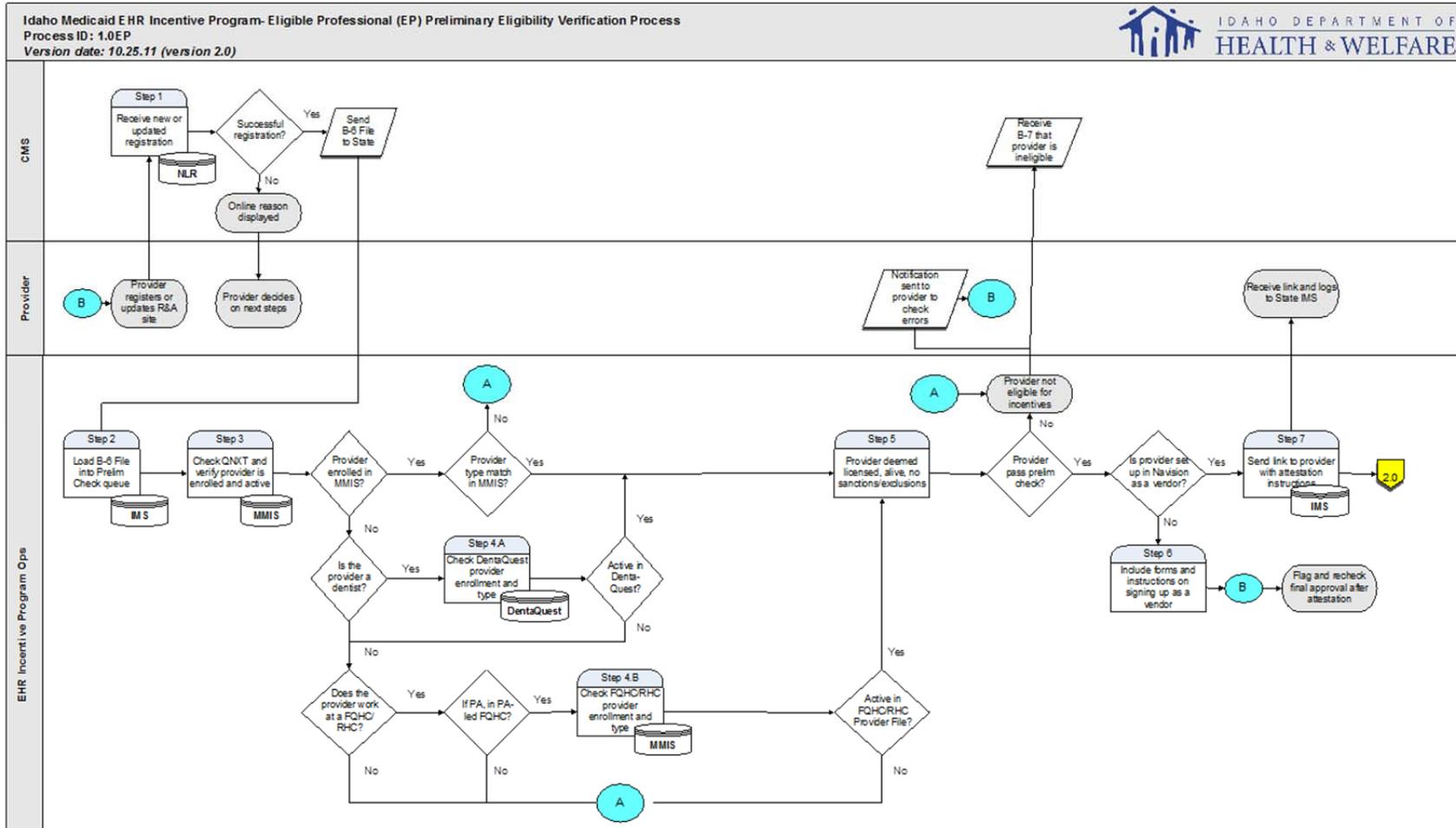
Idaho SMHP - Idaho Medicaid EHR Incentive Program Process Flows

- 0.0 - Idaho SMHP Business Process Flows Legend
- 1.0EP - Eligible Professional - Preliminary Eligibility Verification Process
- 1.0EH - Eligible Hospital - Preliminary Eligibility Verification Process
- 2.0 - Eligible Professional/Eligible Hospital Final Eligibility Verification Process
- 2.1EP - Eligible Professional - Patient Volume Check
- 2.1EH - Eligible Hospital - Patient Volume Check
- 3.0 - Annual Provider Navision Provider Payment Process
- 4.0 - Incentive Payment Recoupment Process
- 5.0 - Provider Appeals - Administrative Review Process
- 5.0 - Provider Appeals - Administrative Review Process SIMPLIFIED
- 5.1 - Provider Appeals - Contested Case Process
- 6.0 - Program Integrity Unit Provider Audit Process

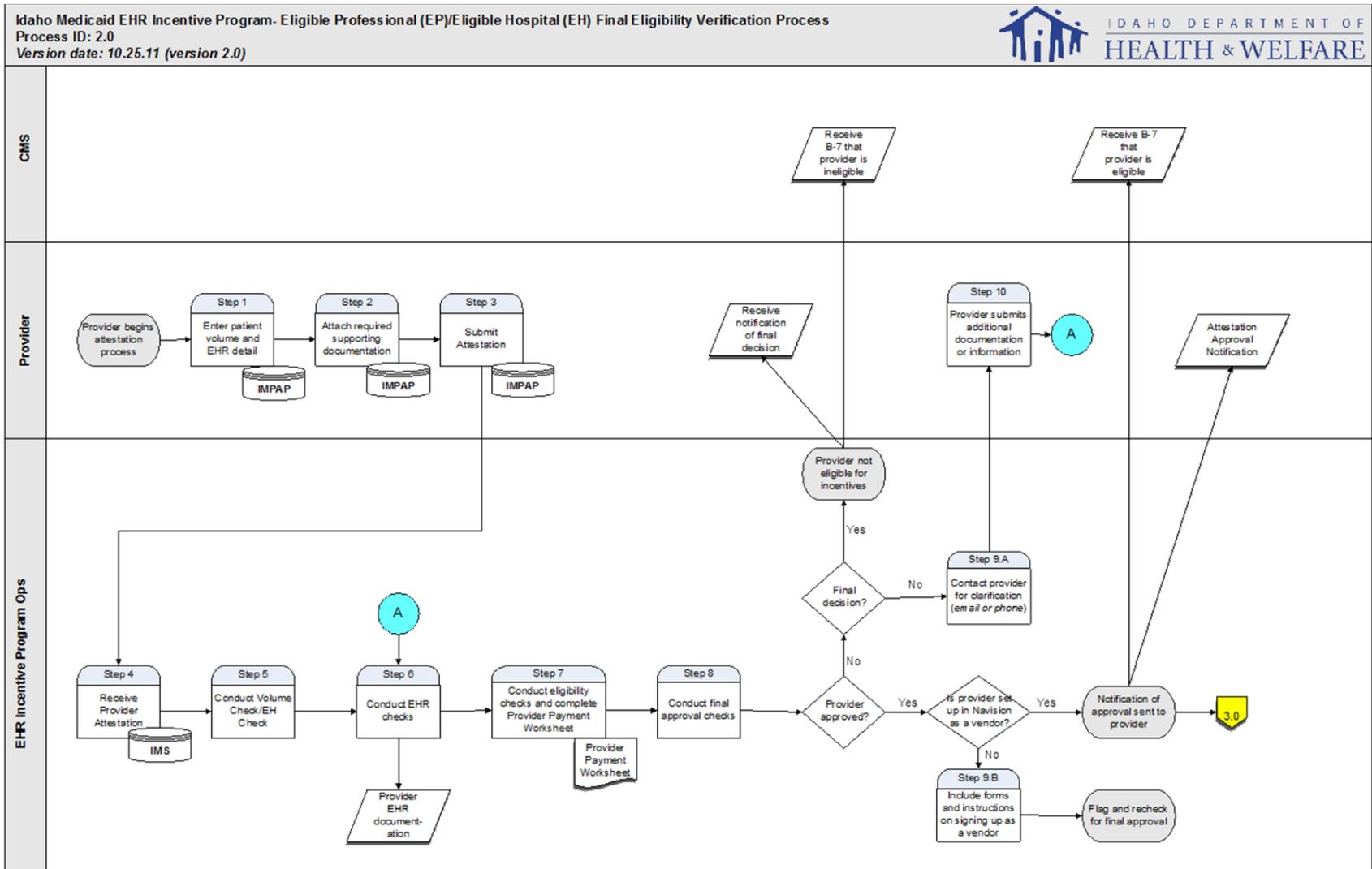
D.2 – EH Preliminary Eligibility Verification



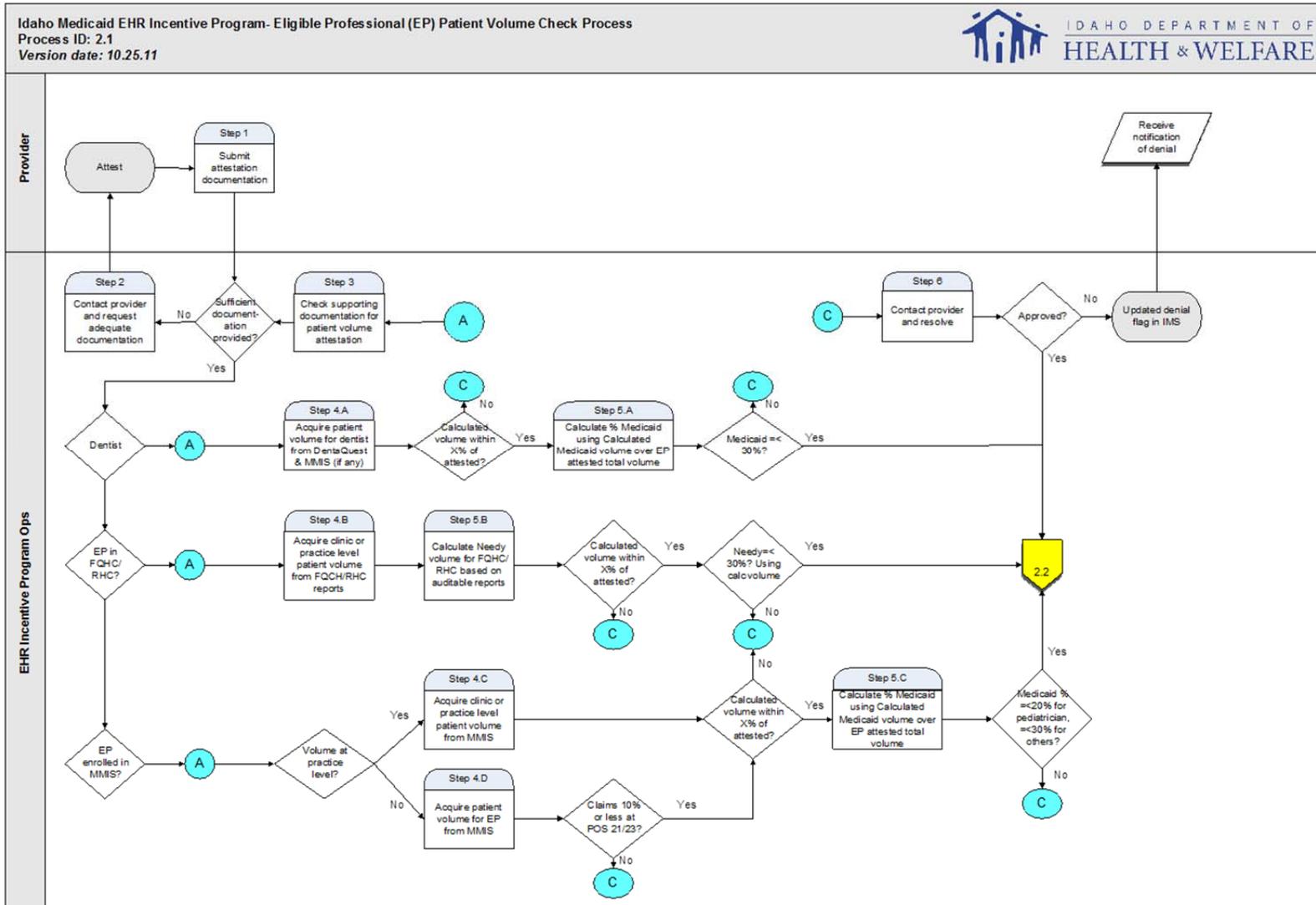
D.3 – EP Preliminary Eligibility Verification Process



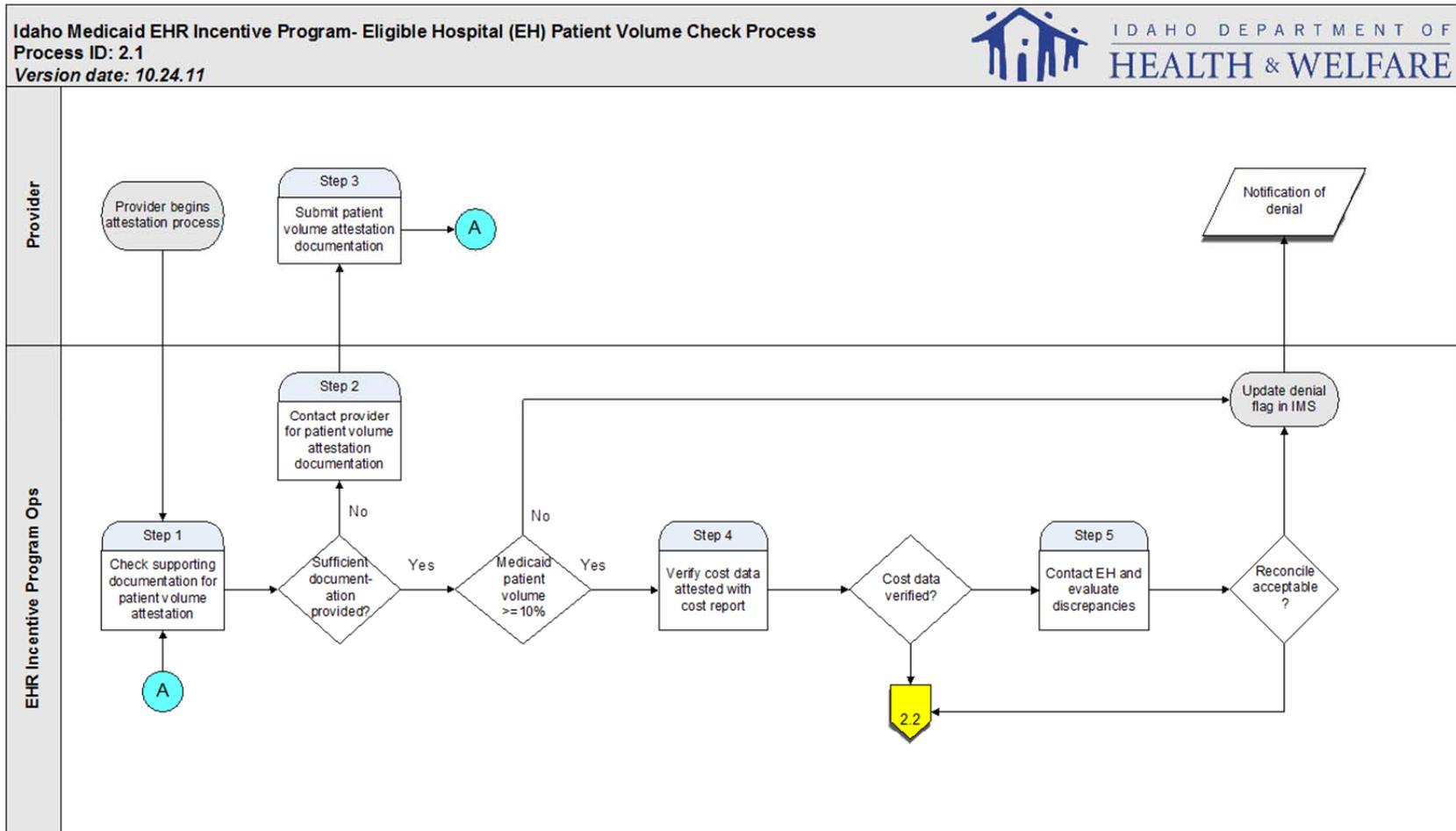
D.4 – Final Eligibility Verification



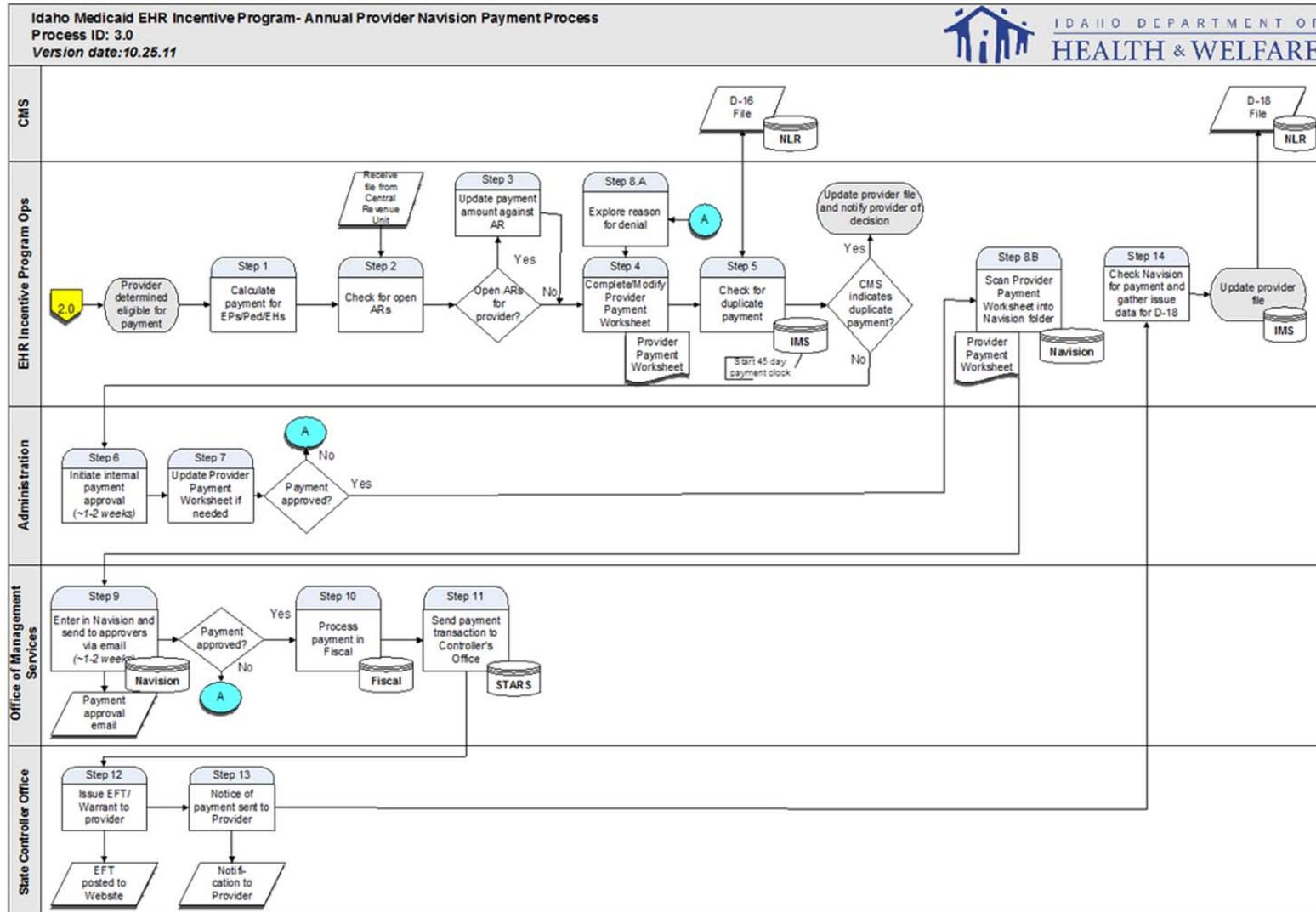
D.5 – EP PV Check



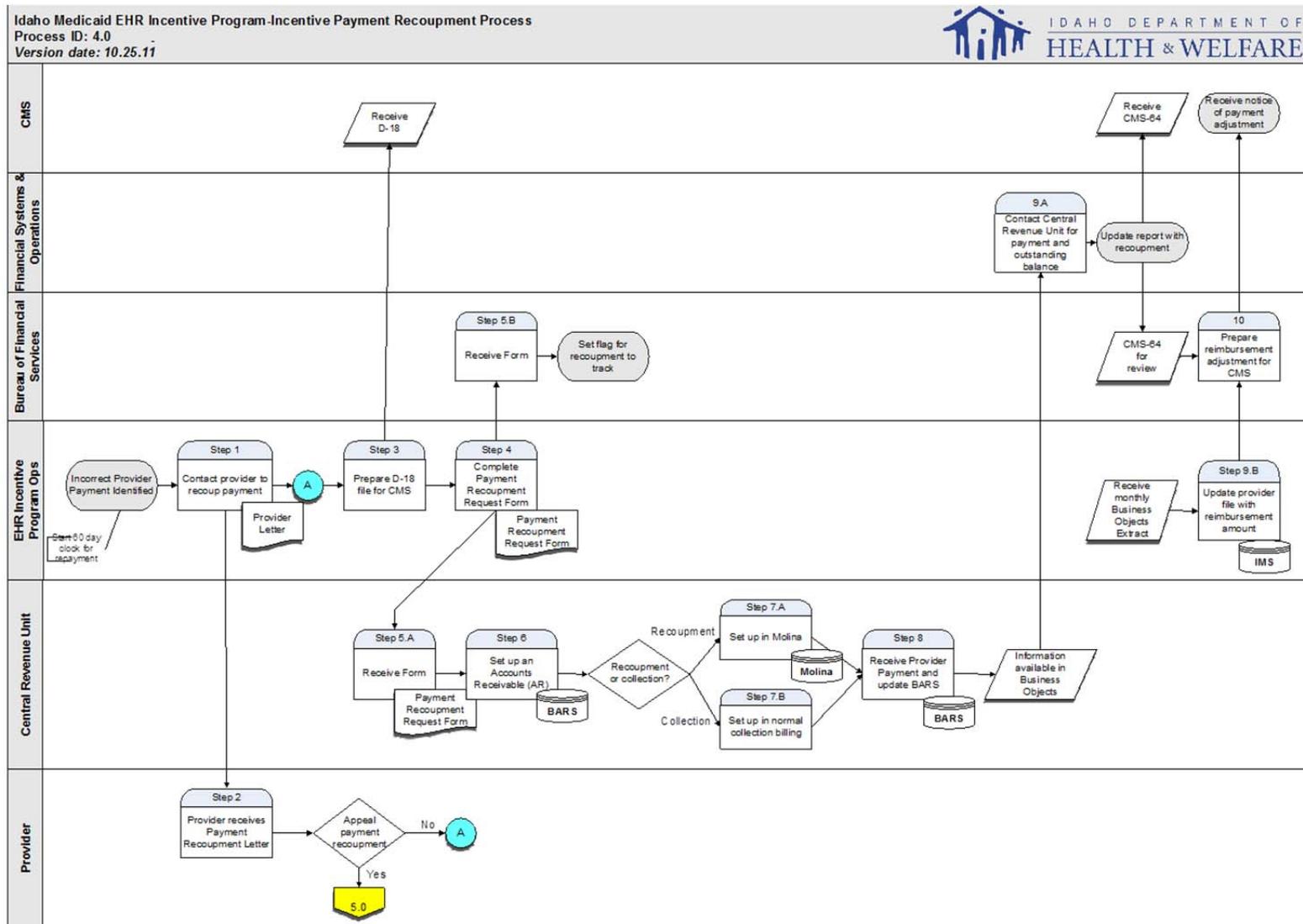
D.6 – EH Patient Volume Check



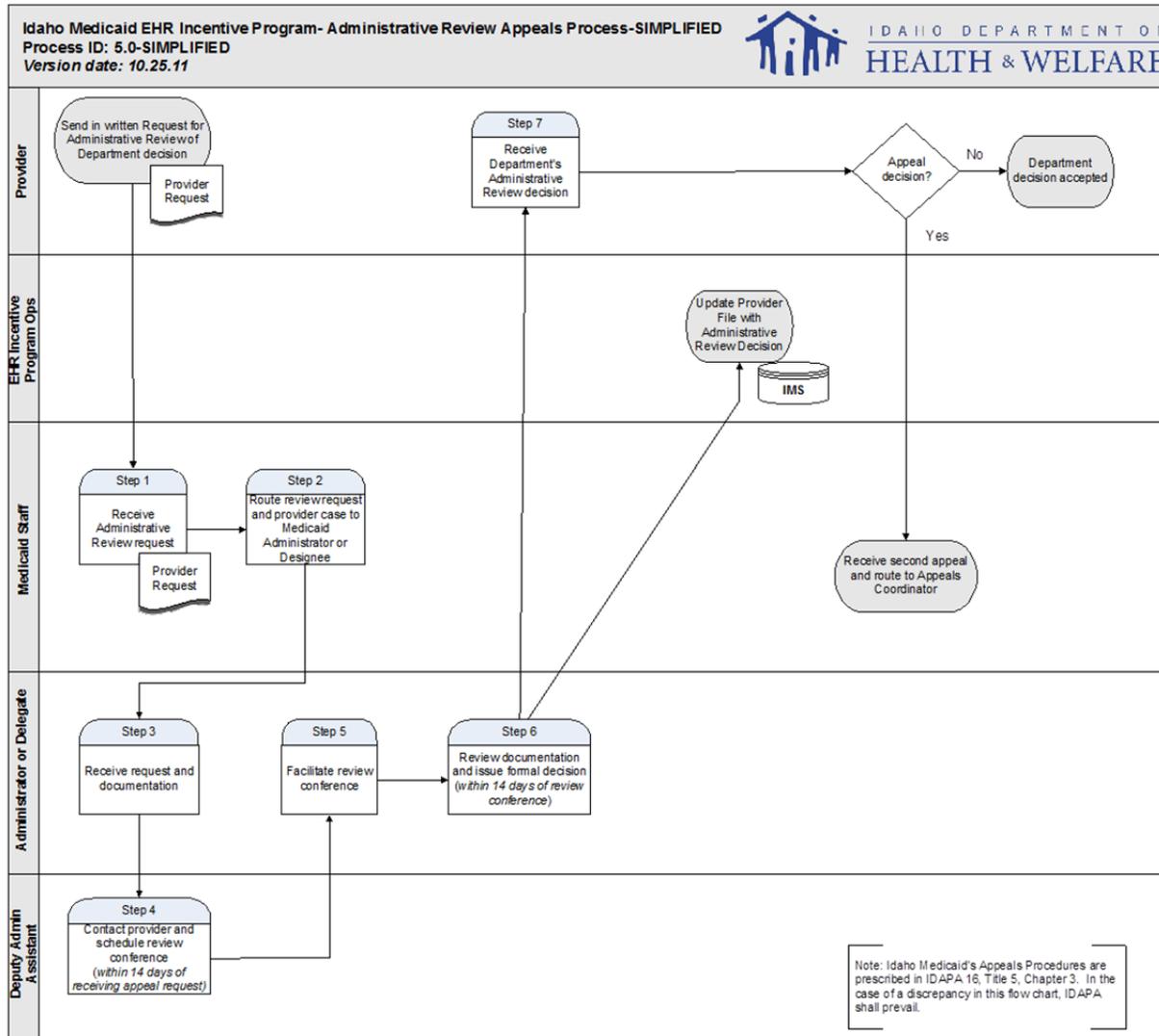
D.7 – Navision Provider Payment



D.8 – Payment Recoupment



D.9 – Provider Appeals



Appendix E – Hospital Calculation Worksheet

E.1 – Eligibility Details



Idaho Medicaid EHR Incentive Program Hospital Incentive Payment Eligibility Details

All fields are required for completion. Fields highlighted in **RED** are auto-calculated and should not be altered. Fields in **BROWN** are the responsibility of the EH attesting.

Patient Volume		
1.	Select a starting date (in 2011) of the 90-day period for the department to calculate Medicaid patient volume percentage:	10/01/12
2.	Total Medicaid patient discharges during the 90-day period (excluding Chip numbers which are provided by the department)	1,000
3.	Total patient discharges during the 90-day period:	2,000
4.	Medicaid patient volume percentage:	50.00%
EHR Details		
1.	Enter the CMS EHR Certification ID of your EHR:	<Blank>
2.	Indicate the status of your EHR:	<Blank>
Growth Rate		
1.	Total number of discharges that fiscal year:	634
2.	Total number of discharges one year prior:	894
3.	Total number of discharges two years prior:	896
4.	Total number of discharges three years prior:	908
Medicaid Share		
1.	Total Medicaid inpatient bed days (exclude nursery beds):	120
2.	Total Medicaid HMO inpatient bed days (exclude nursery beds):	0
3.	Total inpatient bed days:	3,091
4.	Total hospital charges:	\$ 22,303,454.00
5.	Total uncompensated care charges:	\$ 386,157.00



**Idaho Medicaid EHR Incentive Program
Hospital Incentive Payment Calculation**

The following calculation indicates the dollar value of the Medicaid EHR incentive payment due to **St. Mary's Hospital**, as authorized by the American Recovery and Reinvestment Act (ARRA) of 2009. Hospital incentive payments will be distributed over four years. In the first year, the payment is available when certified EHR technology is adopted, implemented, or upgraded (AIU), or such technology is "meaningfully used" under the Medicare EHR Incentive Program; the subsequent three payments will be issued when meaningful use is demonstrated under either Medicare and Medicaid, according to the rules set forth by the Centers for Medicare & Medicaid. Values below in **GREEN** are hospital specific, derived from your Medicaid Hospital Cost Report. If you do not register for the Medicaid EHR Program this year, these data sets can be changed to reflect more current information as future cost report data is certified and becomes available.

All fields are required for completion. Fields highlighted in **RED** are auto-calculated and should not be altered. Fields in **BLUE** and **GREEN** are the responsibility of the Medicaid EHR staff.

The graph below shows the maximum Medicaid EHR incentive payments available to qualifying hospitals based on a three-year payment distribution determined by Idaho Medicaid. This graph outlines the payment amount for each year along with the total payment amount distributed for the duration of the project. The payment amounts are derived from the latest certified hospital cost report data.

NPI:	1841292307
Medicare Certification Number (CCN):	1301321
Enter expected year (between 2011 and 2016) when hospital will start participating and receiving funds.	2016

Overall Medicaid EHR Incentive Payment Calculation				
Aggregate EHR Incentive Payment Amount:		\$	197,532	
Base EHR Incentive Amount:	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000	\$ 2,000,000
Transition Factor:	100%	75%	50%	25%
Medicaid EHR Payment Year :	Year 1	Year 2	Year 3	
Idaho Hospital Payment:	50%	40%	10%	
Aggregate EHR Incentive Payment by Year:	\$ 98,766	\$ 79,013	\$ 19,753	

Incentive Payment Amounts



Base Data

Trending			Payment Year	Payment Percentage	Years of Participation
634	634		Medicare (0)	0%	2015
569	569		Year 1	50%	2016
511	511		Year 2	40%	2017
459	459		Year 3	10%	2018

Criteria Requirement

Medicaid EHR Incentive Payment Parameters	Criteria Met
Payment percentages entered over a minimum of 3 years, maximum of 6 years.	Yes
Payment percentage entered is equal to 100%.	Yes
No more than 50% of the max incentive amount can be made in any one year.	Yes
No more than 90% of the max incentive amount can be made in a two-year period.	Yes

Discharge Growth Factor

Reporting Period (w/s* S-3 part 1, col. 15, line 12)	Year	Total Discharges	Percentage of Increase/ Decrease	Average Annual Discharge Rate
* First Year	2009	908		
* Second Year	2010	896	-1.32%	
* Third Year	2011	894	-0.22%	
* Base year (Latest Fiscal Year Data)	2012	634	-29.08%	-10.21%

Discharge-Related Amount Trended Based on Growth Factor				
Total All-Payer Hospital Discharges (w/s S-3 part I, col. 15, line 12)	634	634	569	511
Discharge Growth Factor		-10.21%	-10.21%	-10.21%
Trended Total All-Payer Hospital Discharges	634	569	511	459
Discharges Eligible for Add-On Amount	0	0	0	0
Per Discharge Add-On Amount	\$ 200	\$ 200	\$ 200	\$ 200
Discharge-Related Amount	\$ -	\$ -	\$ -	\$ -
Initial EHR Amount By Year	\$ 2,000,000	\$ 1,500,000	\$ 1,000,000	\$ 500,000
Overall EHR Amount	\$ 5,000,000			

Discharge-Related Amount Trended Based on Growth Factor	
Total Medicaid Fee-for-Service Inpatient Days	120
Total Medicaid Managed Care (w/s S-3 part I, col. 5, line 2)	0
Total Chip Days subtracted out. start Jan 1, 2010 (1cy)	0
Total Medicaid Days	120
Total Charges (w/s C part I, col. 8, line 101)	\$ 22,303,454
Charity Care (w/s S-10, col. 1, line 30)	\$ 386,157
Total Charges Excluding Charity Care	\$ 21,917,297
Charity Care Ratio	0.98269
Total Inpatient Hospital Days (w/s S-3 part I, col. 6, line 12)	3,091
Medicaid Share	3.95%