

FOR IMMEDIATE RELEASE

February 29, 2016

Fact Sheet: Commitments from health care industry to make electronic health records work better for patients and providers

U.S. Department of Health and Human Services Secretary Sylvia M. Burwell announced today that the top five largest private healthcare systems in the country have agreed to commitments that will help make electronic health records used by hospitals and other healthcare providers work better for patients and providers. The commitments include:

Consumer Access: To help consumers easily and securely access their health information, direct it to any desired location, learn how their information can be used, and be assured that this information will be effectively and safely used to benefit their community.

No Information Blocking: To help providers share individuals' health information with other providers and their patients whenever permitted by law, and not block electronic access to information (defined as knowingly and unreasonably interfering with information sharing).

Standards: Implement federally recognized, national interoperability standards and practices for electronic health information and adopt best practices in privacy and security.

The organizations that have made commitments today represent hospitals, i organizations, medical groups and physician offices, academic facilities, long healthcare settings, professional and advocacy organizations, and patients t include:

- Vendors who provide 90 percent of hospital electronic health records usec
- The top five largest private health systems in the nation and, in total, healt patient care in 46 states;
- More than a dozen leading healthcare provider, hospital, technology, and

These market leaders provided individual statements outlining how they are shared principles in the months ahead, available at www.healthit.gov/commi

The full list of committed organizations is below.

Health IT Developers: The health IT developers below provide 90 percent c records used nationwide. One of the products is used by 95 percent of all ph

These organizations develop electronic health records, information exchange products that are used by a wide range of hospitals and providers and touch healthcare consumers each year.¹

- Aprima
- Athenahealth
- Allscripts
- Cerner

- CPSI
- CureMD
- Epic
- GE Healthcare
- Intel
- McKesson
- MedHost
- Meditech
- NextGen
- Phillips
- SureScripts
- Optum
- Greenway Health

Healthcare Systems: Among the providers below are the five largest private health systems in the United States. In total, the health systems below operate in 46 states.²

- Ascension Health
- Carolinas Healthcare
- Catholic Health Initiatives

- Community Health Systems
- Dignity Health
- Geisinger Health System
- Hospital Corporation of America (HCA)
- John Hopkins Medical
- Intermountain Healthcare
- Kaiser Permanente
- LifePoint Health
- Mountain States Health Alliance
- Partners Healthcare
- Tenet Healthcare
- Trinity Health
- University of Utah Health Care

Leading provider, technology, and consumer organizations: The organization provides a wide range of professional associations and stakeholder groups that support consumers and provide a range of education, technical assistance and best practices. Their pledges demonstrate the shared commitments among the diverse stakeholders including providers, consumers, and the technology industry.

- **American Academy of Family Physicians (AAFP).** AAFP and its chapters represent family physicians, residents, and medical students.
- **American College of Physicians (ACP).** ACP is a national organization representing 143,000 internists-physician specialists.
- **American Medical Association (AMA).** AMA represents approximately 250,000 physicians, residents, and medical students.
- **American Medical Informatics Association (AMIA).** AMIA is an organization representing healthcare professionals, informatics researchers, and thought-leaders in the field of informatics science.
- **American Hospital Association (AHA).** AHA is a national organization that represents all types of hospitals, healthcare networks, and their patients and communities. AHA represents 2,000 hospitals, healthcare systems, networks, other providers of care, and 43,000 beds.
- **American Health Information Management Association (AHIMA).** AHIMA is a national association representing 103,000 health information management professionals in all 50 states, the District of Columbia, and Puerto Rico.
- **American Society of Clinical Oncology (ASCO).** ASCO is a leading professional organization representing more than 40,000 physicians worldwide who care for people with cancer.
- **Center for Medical Interoperability.** The Center is an organization led by the industry to drive change in how medical technologies work together. The Center leverages the expertise of their members to compel change and improve the safety, quality, and efficiency of healthcare.

- **College of Healthcare Informatics Management Executives (CHIME).** CHIME is a national organization with more than 1,800 Chief Information Officer (CIO) members, including hospital vendors and professional services firms.
- **CommonWell.** CommonWell is a not-for-profit trade association comprising software developers and organizations with a focus on the development and promotion of interoperable members.
- **Health Information and Management Systems Society (HIMSS).** HIMSS has 61,000 individual members, 640 corporate members, and over 450 non-profit members.
- **Healthcare Leadership Council (HLC).** HLC is a coalition of chief executives from leading American healthcare. Members of HLC lead hospitals, health plans, pharmaceutical companies, medical device manufacturers, biotech firms, health product distributors, and health centers.
- **Premier healthcare alliance.** Premier is a healthcare performance improvement organization serving approximately 3,600 U.S. hospitals and 120,000 other providers nationwide.
- **Sequoia Project.** The Sequoia Project, previously Healthway, advances interoperable nationwide health exchanges and supports key interoperability goals for Carequality.
- **National Partnership for Women and Families.** The Partnership is a national coalition that advances policy to help women and families and advances access to quality care.
- **National Rural Health Association (NRHA).** NRHA is a national non-profit organization with more than 20,000 members that provides leadership on rural health issues, including communications, education and research.

To view the individual pledges, or to make the pledge to the commitments or

visit www.healthit.gov/commitment.

¹ Hospital EHR market share percentages are based off of Office of the National Coordinator for Health Information Technology (ONC) staff analysis of products reported through participation in the EHR Incentive Program. For more information, visit <http://dashboard.healthit.gov/datadashboard/documentation/ehr-products-metrics> or <http://www.healthit.gov/commitment/documentation.php>.

² Size of healthcare systems is based off of ONC staff analysis of HIMSS Annual Report on Healthcare. For more information, visit www.himss.org.

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Note: All HHS press releases, fact sheets and other news materials are available at <http://www.hhs.gov/news>.

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Last revised: February 29, 2016



SMD# 16-003

RE: Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers

February 29, 2016

Dear State Medicaid Director:

This letter updates guidance issued by the Centers for Medicare & Medicaid Services (CMS) about the availability of federal funding at the 90 percent matching rate for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers. CMS previously issued guidance on this topic in State Medicaid Director (SMD) Letter #10-016 (August 17, 2010)¹, SMD Letter #11-004 (May 18, 2011)², and a 2013 guidance document, “CMS Answers to Frequently Asked Questions (9/10/2013)” (2013 guidance).

This updated guidance expands the scope of State expenditures eligible for the 90 percent matching rate, and supports the goals of, “Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Version 1.0,”³ published by the Department of Health and Human Services, Office of the National Coordinator (ONC) for Health Information Technology, on October 6, 2015. In this letter, we are expanding our interpretation of the scope of State expenditures eligible for the 90 percent HITECH match, given the greater importance of coordination of care across providers and transitions of care in Meaningful Use modified Stage 2 and Stage 3. This letter supersedes the 2013 guidance but many of the principles of that guidance, as indicated in this letter, remain valid. We intend to issue updated, detailed guidance that integrates those principles with the interpretive changes set forth in this letter.

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, added sections 1903(a)(3)(F) and 1903(t) to the Social Security Act. These provisions make available to States 100 percent Federal matching funding for incentive payments to eligible Medicaid providers to encourage the adoption and use of certified EHR technology through 2021, and 90 percent Federal matching funding (the 90 percent HITECH match) for State administrative expenses related to the program, including State administrative expenses related to pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information, subject to CMS approval. CMS has implemented these

¹ Available at <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10016.pdf>

² Available at <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD11004.pdf>

³ Available at <https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf>

provisions in regulations at 42 CFR Part 495. When attesting to Meaningful Use modified Stage 2 or Stage 3, professionals and hospitals that are eligible for Medicaid EHR Incentive Payments (collectively referred to in this document as Eligible Providers) must demonstrate the ability to electronically coordinate with other providers across care settings under the CMS regulations at 42 CFR Part 495. In order to meet these Meaningful Use objectives, Eligible Providers will often need to electronically coordinate care with other Medicaid providers that are not eligible for Medicaid EHR incentive payments.

SMD Letters #10-016 and #11-004 explained that state costs related to HIE promotion may be matched at the 90 percent HITECH matching rate only if they can be directly correlated to the Medicaid EHR Incentive Program. In the 2013 guidance, we therefore explained that States' costs of facilitating connections for providers to an HIE may be matched at the 90 percent HITECH matching rate only if the providers are Eligible Providers. We now explain that State costs of facilitating connections between Eligible Providers and other Medicaid providers (for example, through an HIE or other interoperable systems), or costs of other activities that promote other Medicaid providers' use of EHR and HIE, can also be matched at the 90 percent HITECH matching rate, but only if State expenditures on these activities help Eligible Providers meet the Meaningful Use objectives. Subject to CMS prior approval, States may thus be able to claim 90 percent HITECH match for expenditures related to connecting Eligible Providers to other Medicaid providers, including behavioral health providers, substance abuse treatment providers, long-term care providers (including nursing facilities), home health providers, pharmacies, laboratories, correctional health providers, emergency medical service providers, public health providers, and other Medicaid providers, including community-based Medicaid providers.

For example, an Eligible Provider might be a physician needing to meet the modified Stage 2 or Stage 3 Meaningful Use objective for health information exchange (*see* 42 CFR 495.22(e)(5)(i) or 495.24(d)(7)(i)(A)) when transitioning patients to another Medicaid provider such as a nursing facility, or a home health care provider. Or an eligible hospital might need to meet the objective for Medication Reconciliation and compare records with other providers to confirm that the information it has on patients' medication is accurate when it admits patients into its care (*see* 42 CFR 495.22(e)(7)(i) or 495.24(d)(7)(ii)(B)(3)(i)). Subject to CMS approval, States can claim 90 percent HITECH match in the costs of developing connectivity between Eligible Providers (whether eligible professionals or eligible hospitals) and other Medicaid providers if this will help the Eligible Providers demonstrate Meaningful Use.

CMS explicitly encourages and welcomes multistate collaboratives partnering on shared solutions for HIE and interoperability, including for the activities discussed in this letter (facilitation of EHR Meaningful Use and related communications through the HIE system). CMS will aggressively support such collaboratives as potentially cost-saving opportunities to increase adoption of interoperability standards and help Eligible Providers demonstrate Meaningful Use. Such collaboratives should promote Medicaid Information Technology Architecture (MITA) principles on scalability, reusability, modularity, and interoperability. We note that ONC is a willing partner in helping States develop open source and open architecture tools for HIE that are consistent with MITA principles.

Cost controls, cost allocations, and other payers

States must ensure that any 90 percent HITECH match claimed under the guidance in this letter supports Eligible Providers' demonstration of Meaningful Use modified Stage 2 and Stage 3, and must therefore report on the extent to which the activities they are funding help Eligible Providers demonstrate Meaningful Use. CMS will require States to describe in advance which specific Meaningful Use measures they intend to support in the Implementation Advance Planning Document (IAPD) as well as to confirm such measures are indeed supported post-implementation. Under no circumstances may States claim 90 percent HITECH match in the costs of actually providing EHR technology to providers or supplementing the functionality of provider EHR systems. This funding is available, subject to CMS approval, as of the date of this letter, and will not be available retroactively.

Additionally, States should claim the 90 percent HITECH match for HIE-related costs relating to Medicaid providers that are not eligible for Medicaid EHR incentive payments only if those HIE-related costs help Eligible Providers demonstrate Meaningful Use. For example, it would not be appropriate for States to claim the 90 percent HITECH match for costs related to an HIE system that did not connect to or include Eligible Providers and therefore would not help Eligible Providers demonstrate Meaningful Use.

States should continue to adhere to the guidance in SMD Letter #11-004 detailing how Medicaid funding should be part of an overall financial plan that leverages multiple public and private funding sources to develop HIEs. Similarly, States are reminded that per SMD Letter #11-004, the 90 percent HITECH match cannot be used for ongoing operations and maintenance costs. This updated guidance makes no changes to the general cost allocation principles and fair share principles States should follow in proposing funding models to CMS for HIEs or interoperable systems, although under this updated guidance, the Medicaid portion of such cost allocations may increase to include costs associated with connecting Eligible Providers to other Medicaid providers. CMS has approved several different cost allocation methodologies for States and those various methodologies will be affected differently by this guidance. CMS will provide technical assistance on the impact of this guidance on specific States. Similarly, States should continue to complete and update the "Health Information Technology Implementation Advance Planning Document (HIT IAPD) Template⁴," developed by CMS and the Office of Management and Budget, in which States detail cost allocation models and other financial considerations. States should meet with CMS to review cost allocation models that carefully consider the extent to which the HIE or other interoperable system benefits Eligible Providers, other Medicaid providers, non-Medicaid providers, and other payers.

Medicaid Information Technology Architecture (MITA) emphasizes the importance of interoperability and industry standards. States should take an aggressive approach to HIE and interoperability governance for purposes of supporting interoperability while focusing on security and standards to keep interface costs to a minimum. The CMS final rule published on December 4, 2015, "Mechanized Claims Processing & Information Retrieval Systems (90/10)"

⁴ https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/medicaid_hit_iapd_template.pdf

requires in 42 CFR 433.112 a new focus on industry standards in MITA that support more efficient, standards-based information exchange as described in 45 CFR Part 170. Specifically, 45 CFR Part 170 defines the Common Clinical Data Set, transport standards, functional standards, content exchange standards and implementation specifications for exchanging electronic health information, and vocabulary standards for representing electronic health information. In implementing these standards, we encourage States to develop partnerships with non-profit collaboratives and other industry participants such as DirectTrust that further support Direct Secure Messaging through trust frameworks that reduce the costs and technical complexities of electronic health information exchange for providers.

The interoperable systems described in this letter are part of the MITA and interfaces to these systems should appropriately follow a Service-Oriented Architecture (SOA) as well as adhere to industry standards. States should aggressively pursue HIE and interoperability solutions for Medicaid providers that either obviate the need for costly interfaces, or utilize open architecture solutions that make such interfaces easily acquired. For example, consistent with the software ownership rights held by the state under 45 CFR § 95.617, States might require that HIE interfaces designed, developed, or installed with Federal financial participation be made available at reduced or no cost to other Medicaid providers connecting to the same HIE. Furthermore, States could require that such interfaces (or the code for such interfaces) be made publicly available. Additionally, CMS and ONC support States in sharing open source tools and interfaces with other States to further drive down the costs of HIEs, interfaces, and other interoperable systems.

States are also reminded that careful alignment and coordination with other funding sources should be thoroughly discussed with CMS and addressed in an Implementation Advance Planning Document Update (IAPD-U), specifically Appendix D. States continue to be encouraged to consult with CMS in advance of formal State Medicaid HIT Plan (SMHP) and IAPD submissions to obtain technical assistance regarding the funding options and boundaries outlined in this and the previous SMD Letters, and additional technical assistance will be provided when we release an update to the 2013 guidance that reflects the new criteria for the 90 percent HITECH match described here. States should reach out to their CMS regional office's Medicaid HIT staff lead as the initial point of contact.

Below are some examples of the types of state costs for which 90 percent HITECH match might be available, subject to CMS approval.

Federal Financial Participation (FFP) for On-boarding Medicaid providers to HIEs or interoperable systems

On-boarding is the technical and administrative process by which a provider joins an HIE or interoperable system and secure communications are established and all appropriate Business Associate Agreements, contracts and consents are put in place. State activities related to on-boarding might include the HIE's activities involved in connecting a provider to the HIE so that the provider is able to successfully exchange data and use the HIE's services. The 90 percent HITECH match is available to cover a state's reasonable costs (e.g., interfaces and testing) to on-board providers to an HIE. Subject to the parameters and cost controls described above, States

may claim 90 percent HITECH match for state costs of supporting the initial on-boarding of Medicaid providers onto an HIE, or onto any interoperable system that connects Eligible Providers to other Medicaid providers. Costs can be claimed both if they are incurred by the state to support the initial on-boarding of Eligible Providers and if they are incurred by the state to support the on-boarding of other Medicaid providers, provided that connecting the other Medicaid providers helps Eligible Providers demonstrate, and meet requirements for, Meaningful Use. States should coordinate with CMS on defining benchmarks and targets for on-boarding providers. States are reminded that, consistent with the principles described in both SMD Letter #10-016 and SMD Letter #11-004, the 90 percent HITECH match is for implementation only, and States should work with CMS on establishing an endpoint to onboarding and always ensure costs are allocated as appropriate across other payers. Also, the scope of the onboarding should be clearly defined and reviewed with CMS prior to IAPD submission to ensure that any costs claimed help Eligible Providers meet Meaningful Use and to ensure that HIE-related costs benefiting providers that are not eligible for Medicaid EHR incentive payments are claimed only if these costs help Eligible Providers demonstrate Meaningful Use. States should generally refer to SMD Letters #10-016 and #11-004 for other information about allowable onboarding costs.

Pharmacies: Similarly, subject to the parameters and cost controls described above, States may claim the 90 percent HITECH match for the costs of supporting the initial on-boarding of pharmacies to HIEs or other interoperable systems, if on-boarding the pharmacies helps Eligible Providers meet Meaningful Use objectives, such as the objectives around sending electronic prescriptions or the objectives around conducting medication reconciliations, both described in 42 CFR 495.22 and 495.24.

Clinical Laboratories: Subject to the parameters and cost controls described above, States may also claim 90 percent HITECH match for the costs of supporting the initial on-boarding of clinical laboratories to HIEs or interoperable systems, if on-boarding these laboratories helps Eligible Providers meet Meaningful Use objectives, such as the objectives for Electronic Reportable Lab Results or laboratory orders in Computerized Provider Order Entry (CPOE) described in 42 CFR 495.22 and 495.24.

Public Health Providers: Similarly, subject to the parameters and cost controls described above, States may also claim 90 percent HITECH match for the costs of on-boarding Medicaid public health providers to interoperable systems and HIEs connected to Eligible Providers so that Eligible Providers are able to meet Meaningful Use measures focused on public health reporting and the exchange of public health data, including activities such as validation and testing for reporting of public health measures described in 42 CFR 495.22 and 495.24.

FFP for interoperability and HIE architecture

As with expenses for on-boarding, States may claim 90 percent HITECH match for their costs of connecting Eligible Providers to other Medicaid providers via HIEs or other interoperable systems, if doing so helps Eligible Providers demonstrate Meaningful Use and the cost controls described above are met.

Specifically, 90 percent HITECH match would be available for States' costs related to the design, development, and implementation of infrastructure for several HIE components and interoperable systems that most directly support Eligible Providers in coordinating care with other Medicaid providers in order to demonstrate Meaningful Use. As described in SMD Letter #11-004, the 90 percent HITECH match cannot be used for ongoing operations and maintenance costs after this technology is established and functional. These components and systems include:

Provider Directories: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of provider directories that allow for the exchange of secure messages and structured data to coordinate care or calculate clinical quality measures between Eligible Providers and other Medicaid providers, so long as these costs help Eligible Providers meet Meaningful Use and the cost controls described above are met. The 90 percent HITECH match would not be appropriate for costs of developing a separate subdirectory for a class of providers that are not eligible for Medicaid EHR incentive payments and that are unlikely ever to exchange records with an Eligible Provider. CMS emphasizes the importance of dynamic provider directories with, as appropriate, bidirectional communications to public health agencies and public health registries. CMS particularly supports approaches to provider directories that provide solutions for Eligible Providers to connect to other Medicaid providers with lower EHR adoption rates, if doing so helps the Eligible Providers demonstrate Meaningful Use. Secure, web-based provider directories, for example, might help Eligible Providers coordinate care more effectively with long term care providers, behavioral health providers, substance abuse providers, etc. CMS expects that States will consider provider directories as a Medicaid enterprise asset that can also support Medicaid Management Information System (MMIS) functionality, with the reminder that, per SMD Letter #10-016, States should not claim 90 percent HITECH match for costs that could otherwise be matched with MMIS matching funds.

Secure Electronic Messaging: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of secure messaging solutions that connect Eligible Providers to other Medicaid providers and allow for the exchange of secure messages and structured data, so long as these costs help Eligible Providers meet Meaningful Use and the cost controls described above are met. States are encouraged to utilize Direct Secure Messaging as a transport standard that is secure and scalable. States should refer to the “Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 3 and Modifications to Meaningful Use in 2015 Through 2017” rule for guidance on meeting the Certified Electronic Health Record Technology (CEHRT) requirements for purposes of Meaningful Use⁵. States may also refer to ONC’s 2016 Interoperability Standards Advisory (ISA), a publication that provides the identification, assessment, and determination of the “best available” interoperability standards and implementation specifications for industry use to fulfill specific clinical health IT interoperability needs⁶. States should also be prescriptive in governance requirements to ensure maximal interoperability in the most secure and efficient manner possible. ONC is a willing partner with CMS in helping States deploy Direct Secure Messaging systems and developing

⁵ <https://www.federalregister.gov/articles/2015/10/16/2015-25595/medicare-and-medicaid-programs-electronic-health-record-incentive-program-stage-3-and-modifications>

⁶ <https://www.healthit.gov/sites/default/files/2016-interoperability-standards-advisory-final-508.pdf>

related governance requirements to ensure that Eligible Providers can connect to other Medicaid providers.

Query Exchange: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of query-based health information exchange, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. States may support coordination of care between Eligible Providers and other Medicaid providers by linking them into a query-based HIE that allows for secure, standards-based information exchange with thorough identity management protocols. A Query Exchange might access a state's Clinical Data Warehouse and similarly be integrated with analytic and reporting functions. These activities may support aggregate queries from providers to support population health activities performed by public health or other entities involved in population health improvement, provided that doing so helps Eligible Providers meet Meaningful Use. Given the unique data and exchange governance challenges of Query Exchange, States are encouraged to reach out to ONC to help formulate governance guidance and best practices.

Care Plan Exchange: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of interoperable systems and HIEs that facilitate the exchange of electronic care plans between Eligible Providers and other Medicaid providers, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. Medicaid providers coordinating care across multiple care settings may exchange care plans containing treatment plans and goals, as well as problem lists, medication history and other clinical and non-clinical content added and updated as appropriate by members of a patient's care team, including Medicaid social service providers. States are encouraged to consider care plan exchange for patients with multiple chronic conditions who might be coordinating care between many specialists, hospital(s), long term care facilities, rehabilitation centers, home health care providers, or other Medicaid community-based providers. Similarly, children in the foster care system might benefit from care plans shared across Medicaid providers (including Eligible Providers) to facilitate coordination of the children's care. As discussed above, costs related to exchanging care plans between Medicaid providers and other programs, such as foster care programs, may need to be allocated between benefitting programs.

Encounter Alerting: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of communications within an HIE or interoperable system connecting Eligible Providers and other Medicaid providers about the admission, discharge or transfer of Medicaid patients, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. These communications among Medicaid providers may contain structured data regarding treatment plans, medication history, drug allergies, or other secure content that aids in the coordination of patient care, including coordination of social services as appropriate.

Public Health Systems: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of public health systems and connections to public health systems, so long as the cost controls described above are met, and so long as these costs help Eligible Providers meet Meaningful Use measures focused on public health reporting and the exchange of public health data described in 42 CFR 495.22 and 495.24. It is worth

emphasizing that state costs eligible for the 90 percent HITECH match might include costs related to developing registry and system architecture for Prescription Drug Monitoring Programs (PDMPs), as per FAQ #13413⁷ PDMPs can be considered a specialized registry to which Eligible Providers may submit data in order to meet Meaningful Use objectives. States should, however, keep in mind that MMIS matching funds might in some circumstances be a more appropriate source of federal funding for costs related to developing a PDMP. Again, States should not claim 90 percent HITECH match for costs that could otherwise be matched with MMIS matching funds.

Health Information Services Provider (HISP) Services: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of HISP Services that coordinate the technical and administrative work of connecting Eligible Providers to other Medicaid providers, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. HISP Services may coordinate encryption standards across providers, as well as coordinate contracts, Business Associate Agreements or other consents deemed appropriate for the HIEs or interoperable systems. States should be careful to distinguish between on-boarding services and HISP Services, as the scope of HISP activities overlaps with the scope of on-boarding activities, and the state should confirm that activities are only supported with federal funding once. States should clearly define the scope of HISP activities and on-boarding activities as appropriate.

This is not an exhaustive list of the types of state costs for design, development, and implementation of HIE components and interoperable systems for which 90 percent HITECH match might be claimed. Design, development, and implementation costs associated with other HIE components and interoperable systems might be supported by the 90 percent HITECH match as long as these costs help Eligible Providers achieve Meaningful Use and meet the cost controls described above, and will be considered by CMS accordingly.

Under this updated guidance, States remain able, subject to CMS approval, to claim 90 percent HITECH match for design, development, and implementation costs related to personal health records (PHRs), as utilizing a PHR through an HIE will often be the best way for many Eligible Providers to meet the Meaningful Use modified stage 2 Patient Electronic Access objective (*see* 42 CFR 495.22(e)(8)) and/or the Meaningful Use stage 3 Coordination of Care Through Patient Engagement objective (*see* 42 CFR 495.24(d)(6)). The parameters for HITECH administrative funding discussed in SMD Letters #10-016 and #11-004 continue to be relevant to PHR funding requests from States.

Conclusion

With more States utilizing or exploring the possibilities of vehicles for delivery system reform that benefit from coordination of care, such as health homes, primary care case management, managed care, home and community-based service programs, and performance-based incentive payment structures, there is an expectation that the Medicaid Enterprise infrastructure will be designed to support these efforts. These efforts therefore support the MITA principles of

⁷ <https://questions.cms.gov/faq.php?faqId=13413>

reusability, interoperability, and care management in providing a foundation for further delivery system reform.

As States enter the fifth year of the Medicaid EHR Incentive Program, CMS and ONC expect them to leverage available federal funding for tools and guidance to help Eligible Providers demonstrate Meaningful Use, which might include strengthening data exchange between Eligible Providers and other Medicaid providers. States may have questions about the Health Insurance Portability and Accountability Act (HIPAA) considerations applicable to creating more diverse HIEs and interoperable systems, so we have included links to guidance from the U.S. Department of Health and Human Services Office for Civil Rights and the Office of the National Coordinator for Health Information Technology describing uses and disclosures that are permitted under HIPAA⁸. Note that the discussion in the linked guidance only concerns the uses and disclosures that are permitted under HIPAA, and does not address when state costs related to the discussed activities would be eligible for the 90 percent HITECH match. This next phase of infrastructure development and connectivity will best position all Eligible Providers to successfully demonstrate Meaningful Use of Certified EHR Technology while solidifying a broader network of health information exchange among Medicaid providers, writ large.

Sincerely,

/s/

Vikki Wachino
Director

Enclosure

cc:

National Association of Medicaid Directors
National Academy for State Health Policy
National Governors Association
American Public Human Services Association
Association of State Territorial Health Officials
Council of State Governments
National Conference of State Legislatures

⁸ https://www.healthit.gov/sites/default/files/exchange_health_care_ops.pdf and https://www.healthit.gov/sites/default/files/exchange_treatment.pdf



BEHAVIORAL HEALTH HIT/HIE SURVEY

[INSERT LANGUAGE RE: PURPOSE OF SURVEY, USE OF DATA, ANONYMITY, RESULTS AVAILABILITY, WHO TO CONTACT FOR QUESTIONS]

Provider Information

1) Please answer the following questions by clicking on the “Click or tap here to enter text” box.

Name of person filling out survey: Click or tap here to enter text.

Job title: Click or tap here to enter text.

Organization: Click or tap here to enter text.

Number of Providers: Click or tap here to enter text.

Number of full-time employees: Click or tap here to enter text.

Address: Click or tap here to enter text.

Phone number: Click or tap here to enter text.

E-mail Address: Click or tap here to enter text.

For the following questions, please check the box next to the answer, or provide a response by clicking on the “Click or tap here to enter text” box.

2) What type of facility are you responding for?

Single facility Multiple facilities

2.1) If you checked multiple facilities, how many?

[Click or tap here to enter text.](#)

3) Is your facility not-for-profit or for-profit?

Non-profit For-profit

4) What type of area is your facility located in?

Rural Urban Both

Provider Information

5) What type of services does your facility provide? (Please check all that apply)

Outpatient mental health

Residential substance use

Outpatient substance use

Inpatient mental health

Residential mental health

Inpatient substance use

6) Does your facility provide any form of primary care services?

Yes No

6.1) If you checked yes in response to the previous question, please choose your facility's medical record administration status below:

Electronic charts Paper charts

Hybrid record system (both paper and electronic charts)

7) Does your facility use any of the following technology? (check all that apply)

Computers Internet Web-based applications

Point-of-care technology (i.e. tablets, laptops, kiosks, in-room computers)

Electronic Administrative System

Electronic Medication Administration Record (eMAR)

No technology currently in place

8) How is the patient consent process handled within your facility?

Electronically Paper-based Hybrid (Electronic and paper-based)

9) Does your facility have on-site information technology (IT) staff?

Yes, full-time Director or Chief Information Officer

Yes, full-time staff person

Yes, part-time Director or Chief Information Officer

Yes, part-time staff person

No, but available via service contract No

- 10) Does your facility use an electronic health record (EHR)?
- Yes, fully implemented (all electronic, all sites, no paper chart utilization)
- Yes, partially implemented (all electronic at some sites)
- No, but currently in development or selection stage
- No, but currently in planning or information gathering stage
- No, but plan to implement
- No, and no plans to implement

- 11) Which method(s) does your facility use to exchange patient/resident health information with the following recipients? (check all that apply)

	Phone	Fax or electronic fax	Web-based application	EHR	Other
Hospitals	<input type="checkbox"/>				
Labs	<input type="checkbox"/>				
Pharmacies	<input type="checkbox"/>				
Specialists	<input type="checkbox"/>				
Affiliated providers	<input type="checkbox"/>				
Nonaffiliated providers	<input type="checkbox"/>				
Patients	<input type="checkbox"/>				
Family members	<input type="checkbox"/>				

- 11.1) If you indicated other for any of the questions in the previous question, please specify below:

[Click or tap here to enter text.](#)

- 12) Please indicate who you/your facility currently electronically share the following information with by checking the boxes that apply. (Please exclude electronic fax exchange)

	No electronic sharing	Within site	Within organization	With non-affiliated providers	Access only (not sharing)
Clinical notes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician orders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication order	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regulatory assessments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care-service plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Care-service plan summary report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge/transfer report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Consult report	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lab orders and results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diagnostic test orders and results	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- 12.1) If you indicated that your facility uses other technology to capture electronically any of the information listed above, please specify:

Click or tap here to enter text.

- 13) Does your facility plan on changing or expanding its current technology to capture electronically any of the information listed above?

Yes No

- 13.1) If you answered yes to the previous question, please specify what your facility's highest priorities are for technology expansion.

Click or tap here to enter text.

- 14) Which of the following benefits of Electronic Health Record (EHR) system would be most useful for your facility? (select up to five)

Quality monitoring

Billing accuracy and efficiency

Greater efficiency

Decreased errors

Cost savings

Improved care planning

Improved reporting capabilities

Improved oversight of staff

Reduced storage

Improved communication

Data exchange with other providers

Staff empowerment and satisfaction

Increased patient satisfaction

- 15) What functions are you interested in performing with an EHR system? (Check all that apply)

Basic functions (i.e. patient notes)

Claims and billing support

Enter care plans electronically

Track medications electronically

Scan & store paper records

Track behavior electronically

User-activated emergency response systems

Automated medication administration

Barcode medication administration system

Electronic vital-sign monitoring capabilities

Telehealth and behavioral monitoring capabilities

Access to internet and social networking sites

Video conferencing (i.e. skype)

- 16) From your facility's perspective, what are the most important reasons to adopt an EHR? (select up to five)

Quality monitoring

Billing accuracy and efficiency

Greater efficiency

Decreased errors

Cost savings

Patient safety

Improved care planning

Improved reporting capabilities

Improved patient care management

Improved oversight of staff

Reduced storage

Improved communication within facility

Data exchange with other providers

Staff empowerment and satisfaction

Increased patient satisfaction

Other: Click or tap here to enter text.

- 17) **Please provide any capabilities that your facility may already have in place for preparation of Data Segmentation for Privacy (DS4P).**

Click or tap here to enter text.

- 18) **Please provide any concerns that your facility may have in relation to the implementation of DS4P.**

Click or tap here to enter text.

If you are currently using an EHR, or are in the process of adopting an EHR, please answer the questions under the section "EHR User Questions" section. If you have not yet adopted an EHR, please move onto and answer the questions within the "EHR Non-Adopter Questions" section.

EHR User Questions

- 19) **What brand or software of EHR is your facility currently using or implementing?**

Click or tap here to enter text.

- 20) **Is the EHR that you're currently using or implementing a certified electronic health record (CEHRT)?**

Yes No I am uncertain

- 21) **Was your EHR implemented in-house, or by a vendor?**

In-house Vendor

- 21.1) **If you selected vendor for question **, please indicate what vendor implemented your facility's EHR.**

Click or tap here to enter text.

- 22) **How long has your facility been using its EHR?**

My facility is still within the implementation phase

Less than a year 1-2 years

2-3 years 4 or more years

- 23) **For what purposes did your facility implement an EHR? (Check all that apply):**

Maintain competitive advantage

Ability to communicate with other providers to improve care coordination

Improve organization operations

Position the organization for growth and expansion

To improve billing and collections

Enhance capabilities to capture data for reporting abilities

- 24) **Which of the following benefits of Electronic Health Record (EHR) system are the most useful for your facility? (select up to five)**

- Quality monitoring
- Billing accuracy and efficiency
- Greater overall clinic efficiency
- Decreased errors
- Cost savings
- Improved care planning
- Improved reporting capabilities

- Improved oversight of staff
- Reduced storage
- Improved communication
- Data exchange with other providers
- Staff empowerment and satisfaction
- Increased patient satisfaction
- Other: [Click or tap here to enter text.](#)

25) What functions do you perform with your EHR system? (Check all that apply)

- Basic functions (i.e. patient notes)
- Claims and billing support
- Enter care plans electronically
- Track medications electronically

- Track behavior electronically
- User-activated emergency response systems
- Automated medication administration
- Video conferencing (i.e. skype)

26) What functions does your facility perform with its EHR system? (Check all that apply)

- Documentation of clinical notes
- Receiving external clinical documents
- Claims and billing support
- Assessment and care planning
- Census management
- Medication Administration Record (MAR)
- Scan & store paper records

- Track behavior electronically
- Update and review lists
- Electronic Prescribing (EPrescribing)
- Enter and review orders
- Computerized physician order entry (CPOE)
- Other: [Click or tap here to enter text.](#)

27) What barriers currently apply or may have applied to your facility during its EHR implementation phase? (Check all that apply)

- Financial costs
- Lack of project management
- Ongoing maintenance costs
- Issues with selection of an EHR
- Lost revenue during implementation
- Provider resistance
- Lack of staff skill-set for implementation process

- Loss of productivity
- Inadequate return on investment
- Expense of purchase
- Security and privacy issues
- Privacy concerns
- Other: [Click or tap here to enter text.](#)

28) Does your facility's patients have access to a patient portal through the facility's EHR?

- Yes No

28.1) If you answered yes to the previous question, are there are any existing barriers to patient portal use? (Check all that apply)

- Computer literacy
- English language proficiency
- Lack of patient interest

- Lack of provider interest
- Other: [Click or tap here to enter text.](#)

29) Does your EHR provide the following decision support tools? (check all that apply)

- Warnings of drug interactions and side effects
- Highlighting out of range lab levels

Reminders for guideline-based interventions and screening

Follow-up notifications

Prompts to order tests, studies, or other services

Other: [Click or tap here to enter text.](#)

30) What are or were the main barriers to implementing an EHR? (Check all that apply)

Staff required extensive training

Expense of implementation

Expense of purchase

Security and privacy issues

Insufficient time to select, contract, install, and implement software/technology

Lack of expertise to lead or organize the project

EHR products currently available do not satisfy our needs

Loss of productivity

Staff is satisfied with paper-based records

Inadequate return on investment

Community is too small

Concern that product will fail

Lack of capital resources to invest

Lack of technical infrastructure (e.g. networking, servers, other hardware)

Inability to easily input historic medical record data into new system

Other: [Click or tap here to enter text.](#)

31) Please provide any additional information regarding your facility's EHR:

[Click or tap here to enter text.](#)

EHR Non-Adopter Questions

32) Please identify your facility's current status in regards to implementing an EHR:

Currently in process of implementing

In the next 3-4 years

In the next 6 months

In the next 5 years

In 6-12 months

Interested, but no plans

In the next 1-2 years

Not interested in implementing

33) Which of the following benefits of Electronic Health Record (EHR) systems would be most useful for your facility? (select up to five)

Quality monitoring

Improved oversight of staff

Billing accuracy and efficiency

Reduced storage

Greater efficiency

Improved communication

Decreased errors

Data exchange with other providers

Cost savings

Staff empowerment and satisfaction

Improved care planning

Increased patient satisfaction

Improved reporting capabilities

Other: [Click or tap here to enter text.](#)

34) What functions are you interested in performing with an EHR system? (Check all that apply)

Documentation of clinical notes

Assessment and care planning

Receiving external clinical documents

Census management

Claims and billing support

Medication Administration Record (MAR)

Decision support tools

Scan & store paper records

- Track behavior electronically
- Update and review lists
- Electronic Prescribing (EPrescribing)

- Enter and review orders
- Computerized physician order entry (CPOE)
- Other: [Click or tap here to enter text.](#)

35) From your facility's perspective, what are the most important reasons to adopt an EHR? (select up to five)

- Quality monitoring
- Billing accuracy and efficiency
- Greater efficiency
- Decreased errors
- Cost savings
- Patient safety
- Improved care planning
- Improved reporting capabilities

- Improved patient care management
- Improved oversight of staff
- Reduced storage
- Improved communication within facility
- Data exchange with other providers
- Staff empowerment and satisfaction
- Increased patient satisfaction
- Other: [Click or tap here to enter text.](#)

36) What does your facility believe are the main barriers to EHR implementation? (Check all that apply)

- Staff would require training
- Expense of purchase
- Insufficient time to select, contract, install, and implement software/technology
- Lack of expertise to lead or organize the project
- EHR products currently available do not satisfy our needs
- Loss of productivity
- Inadequate return on investment
- Concern that product will fail
- Staff is satisfied with paper-based records
- Community is too small
- Lack of capital resources to invest
- Lack of technical infrastructure (e.g. networking, servers, other hardware)
- Inability to easily input historic medical record data into new system
- Other: [Click or tap here to enter text.](#)

37) How interested is your facility in expanding its ability to exchange information electronically with the following?

	Not Interested	Interested	Very Interested
Hospitals			
Labs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharmacies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specialists	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Affiliated providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nonaffiliated providers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patients (e.g. patient portal or PHR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	Click or tap here to enter text.		

- 38) Would you, or someone in your organization, be interested in participating in planning and strategizing technology-related initiatives for the behavioral health community?
Yes No

38.1) If you answered yes to the previous question, please provide the appropriate contact name and phone number for who should be contacted: [Click or tap here to enter text.](#)

- 39) Please provide any additional comments that you or your facility may have regarding EHRs below:
[Click or tap here to enter text.](#)

Behavioral Health Provider's Beliefs About HIE

Imagine a system that enables you to electronically share client information with medical and behavioral health providers at other organizations, who have the appropriate release of information systems. While keeping this idea in mind, please answer the questions presented below by clicking on the box that applies to your opinion.

- 40) This system would improve access to client medical/physical health records.
Strongly agree Agree Disagree Strongly disagree
- 41) This system would improve coordination of care among all providers working with the same client.
Strongly agree Agree Disagree Strongly disagree
- 42) This system would improve my facility's ability to track medication history.
Strongly agree Agree Disagree Strongly disagree
- 43) This system would improve my facility's communication with other providers.
Strongly agree Agree Disagree Strongly disagree
- 44) This system would reduce the chance of duplicating client evaluations, assessments, or tests that have already been conducted by other providers.
Strongly agree Agree Disagree Strongly disagree
- 45) This system would improve the quality of care that my facility's clients receive.
Strongly agree Agree Disagree Strongly disagree
- 46) This system would be time consuming for my practice to implement.
Strongly agree Agree Disagree Strongly disagree
- 47) This system would result in extra work for my facility on a daily basis.
Strongly agree Agree Disagree Strongly disagree

- 48) This system would more than likely cost my practice too much to implement.
Strongly agree Agree Disagree Strongly disagree
- 49) This system would more than likely require more training than my facility has time for.
Strongly agree Agree Disagree Strongly disagree
- 50) This system would be resisted by staff at my facility.
Strongly agree Agree Disagree Strongly disagree
- 51) This system would create an access concern when being used by third party payers.
Strongly agree Agree Disagree Strongly disagree
- 52) This system would increase my facility's legal vulnerability.
Strongly agree Agree Disagree Strongly disagree
- 53) This system would require my facility to use an overly templated behavioral health record.
Strongly agree Agree Disagree Strongly disagree
- 54) This system would cause my facility to become too reliant on technology that could crash.
Strongly agree Agree Disagree Strongly disagree
- 55) This system would improve the privacy and security of confidential clientele information.
Strongly agree Agree Disagree Strongly disagree
- 56) This system would improve my facility's office work flow.
Strongly agree Agree Disagree Strongly disagree
- 57) This system would improve my facility's billing accuracy.
Strongly agree Agree Disagree Strongly disagree
- 58) This system would reduce the time that my facility currently spends on paperwork.
Strongly agree Agree Disagree Strongly disagree

Resources:

Oregon LTC survey (2011)

The Office of Health Information Technology is conducting this survey to determine the extent of technology use among behavioral health care facilities in Oregon. Survey results will be used to inform strategic planning related to technology and behavioral health policy, as well as efforts to seek new opportunities to further the goals of improving health, reducing costs, and improving the quality of care through the effective use of technology in different care settings.

National Council Survey on HIT Adoption and Readiness for Meaningful Use in Community Behavioral Health (2012)

Minnesota Nursing Home Health Information Technology Survey Results, submitted by StratisHealth (2008)

J Am Med Inform Assoc. (2012);19:562e569. doi:10.1136/amiajnl-2011-000374

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