

State of New Jersey

Department of Human Services

State Medicaid Health Information Technology Plan (SMHP)

December 2016



STATE OF NEW JERSEY

DEPARTMENT OF HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

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Introduction

In 2009, the American Recovery and Reinvestment Act (ARRA) allocated approximately \$19 billion to provide incentive payments for Medicaid and Medicare providers that adopt and meaningfully use electronic health records systems. It is expected that these systems will gradually replace paper-based patient files and provide great improvements in the health care of Medicaid beneficiaries through the exchange of patient health data amongst providers, hospitals, labs, and other care settings. This data exchange will also increase patient safety through the sharing of medication history and information to allow for provider detection of harmful interactions between prescriptions and reduce health care costs through the reduced incidence of duplicate procedures (lab tests, radiology tests, etc.).

The New Jersey State Medicaid Health Information Technology Plan (SMHP) has been developed in accordance with all provisions of ARRA section 4201 and is intended to provide CMS with an understanding of the activities New Jersey Medicaid currently anticipates engaging in over the next five years relative to implementing these ARRA provisions. This plan will guide CMS through New Jersey's plans by presenting the current HIT landscape throughout the State of New Jersey, where Medicaid would like to take the landscape over the next five years, and how the State intends to get from one to the other. It will also describe Medicaid's role in the overall New Jersey HIT environment, and how New Jersey Medicaid will participate in statewide health information exchange activities. Finally, it will discuss New Jersey Medicaid's plans for implementing, administering, and overseeing the EHR Incentive Payment Program established in Section 4201 of ARRA and its strategy to audit incentive payments to ensure they are only made to providers that meet all eligibility criteria. The IT development projects discussed throughout this document will comply with CMS's Seven Conditions and Standards for IT development investment issued April 19, 2011. The methods each project incorporates to comply with these standards will be included in the IAPD and other supporting documentation for each individual project.

New Jersey Medicaid received conditional approval of its original SMHP from CMS on August 22, 2011, with final approval of its most recent SMHP update received on May 6, 2013. This 2014 SMHP update provides the most up-to-date responses to all questions included in CMS's SMHP template. A general description of the major areas of change is included in the cover letter accompanying this version of the New Jersey SMHP.



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The construction of this document continues to be directly connected to the CMS template for State Medicaid HIT Plans and is again presented in a “question and answer” format showing each item from CMS’s SMHP template followed by New Jersey’s response. Each response has been reviewed by the applicable state staff members and updated for any new information received since New Jersey’s last SMHP submission. Except where noted, the responses provided are based on New Jersey’s current HIT environment and all current CMS guidance and include those projects and activities New Jersey is pursuing or committed to pursue. As New Jersey develops additional projects, the New Jersey HIT environment changes, or there is additional CMS guidance on uses for HITECH funding, New Jersey Medicaid will submit revisions to this SMHP to include these projects and changes.

The New Jersey Department of Health has developed the State’s overall HIT Strategic and Operational plan. This Plan has been approved by the Office of the National Coordinator (ONC) and is incorporated into this document as appropriate. Initial revisions to this Plan were submitted to ONC in June 2012; this updated SMHP incorporates these updates where appropriate.

Section A: New Jersey’s “As-Is” HIT Landscape

Question A-1

What is the current extent of EHR adoption by practitioners and by hospitals? How recent is this data? Does it provide specificity about the types of EHRs in use by the State’s providers? Is it specific to just Medicaid or an assessment of overall statewide use of EHRs? Does the SMA have data or estimates on eligible providers broken out by types of provider? Does the SMA have data on EHR adoption by types of provider (e.g. children’s hospitals, acute care hospitals, pediatricians, nurse practitioners, etc.)?

Eligible Providers:

Based on the “Use and Characteristics of Electronic Health Record Systems Among Office-based Physician Practices: United States, 2001–2013” study, published by the Center for Disease Control’s National Center for Health Statistics in January 2014, the estimated EHR adoption rate for New Jersey’s office-based physicians using any type of



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EHR system is 66%.¹ Only 21% stated they use a basic EMR/EHR system, defined as a system that has all of the following functionalities: patient history and demographics, patient problem list, physician clinical notes, comprehensive list of patient's medications and allergies, computerized orders for prescriptions, and ability to view laboratory and imaging results electronically. The data for this study has been collected continuously since 2008, and represents an estimate for statewide use of EHRs (including both Medicaid and non-Medicaid providers). The study focuses on office-based physicians, and does not offer a further breakdown by office-based provider type.

Based on Medicaid EHR Incentive Program payments made through September 7, 2016, 3,005 Medicaid eligible professionals have adopted electronic health records, including 1,049 physicians, 796 pediatricians, 759 dentists, 329 nurse practitioners, 48 certified nurse midwives and 19 optometrists. This represents about 2/3 of the estimated total eligible provider population. There are also 62 Medicaid eligible hospitals that have adopted electronic health records, including 60 acute care hospitals and 2 children's hospitals; this represents approximately 90% of the total eligible hospital population.

Table A.1 (below) presents an estimate of the number of providers that may be eligible for the Medicaid EHR Incentive Program broken out by provider type. The first column shows the types of eligible providers. The second column shows the number of *potential* Medicaid providers eligible for the EHR Incentive Program, based solely on active claims submission, active fee-for-service and/or managed care servicing providers, and excludes those providers with 90% or more of their Medicaid claims classified as inpatient hospital or emergency room. The third column presents an estimate of the number of eligible providers that meet the required Medicaid patient encounter volume to be eligible to receive incentive payments by assuming that 30% of all eligible professionals (except pediatricians) would meet the Medicaid volume criteria to be eligible for the program. This is increased from the previous SMHP based on the program experience to date and the ability for all Medicaid providers within a group (even those not meeting the required Medicaid patient volume individually) to receive Medicaid EHR Incentive Program payments if the entire group's volume meets the applicable patient volume threshold. Since the patient volume threshold for pediatricians is lower than for other eligible professionals, the table estimates that 40% of all Medicaid pediatricians would be eligible for Medicaid EHR Incentive Program payments.

¹

Hsiao C-J, Hing E. Use and characteristics of electronic health record systems among office-based physician practices: United States, 2001–2013. NCHS data brief, no 143. Hyattsville, MD: National Center for Health Statistics. 2014.



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Table A.1: Estimate of Eligible Providers by Type

EP Category	Total Active, Non Hospital Based Medicaid Professionals	Estimated EPs Based on Medicaid Volume
Physician (M.D., D.O.)	12,635	3,791
Pediatricians	1,258	503
Dentists	986	296
Nurse Practitioners / Advanced Practice Nurses	476	142
Certified Nurse Midwives	86	26
Physician Assistants practicing in a PA-led FQHC or RHC	0	0
Total	15,441	4,758

Eligible Hospitals:

Table A.2 below shows hospital EHR adoption based on Medicare and Medicaid EHR Incentive program payments as of September 2016, as reported on the CMS.gov website. This report shows that 67% of the State's 100 licensed general acute care, comprehensive rehabilitation, and specialized hospitals have adopted certified EHR systems and received incentive payments.



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Table A.2: New Jersey Hospital EHR Adoption Rates

Hospital Category	EHR Adopters	Total	EHR Adoption Percentage
General Acute Care	65	71	91.5%
Comprehensive Rehabilitation	1	14	7.1%
Special	1	15	6.7%
Total	67	100	67%

Question A-2

To what extent does broadband internet access pose a challenge to HIT/E in the State’s rural areas? Did the State receive any broadband grants?

According to the interactive broadband map compiled by the U.S. Dept of Commerce’s National Telecommunications and Information Administration and available at <http://broadbandmap.gov/>, New Jersey is one of only 4 states where the entire state has access to broadband internet access (defined as download speeds greater than 3 megabits per second and upload speeds greater than 786 kilobits per second); therefore, New Jersey should have no challenges implementing HIT programs in its rural areas due solely to shortcomings in the state’s broadband network.

Question A-3

Does the State have Federally-Qualified Health Center networks that have received or are receiving HIT/EHR funding from the Health Resources Services Administration (HRSA)? Please describe.

New Jersey’s FQHCs are actively using EHR systems. Fourteen of the FQHCs are participating in the three-year HRSA Health Center Controlled Network (HCCN) Grant Project which began on December 1, 2012. Due to the success of this grant project, HRSA extended it until July 31, 2016. Southern Jersey Family Medical Centers (SJFMC) is the grantee on behalf of KeyCare, Inc., the NJ HCCN. HRSA awarded SJFMC \$400,000 for each of the three years of the grant and \$266,667 for the eight month budget period extension.



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The December 20, 2012 HRSA News Release for the HCCN Grant Project, “Affordable Care Act helps expand the use of health information technology”, enumerated the purpose of this grant:

- Health Center Network grants will support the adoption and meaningful use of certified EHR technology and technology-enabled quality-improvement strategies in health centers
- The networks, comprised of at least 10 collaborating health center organizations, are designed to promote enhanced sharing of information and expertise, to address key operational and clinical needs through greater program integration

The Core Objectives and Focus Areas for this grant project are:

- (EHR) Adoption and Implementation
- Meaningful Use
 - o Adopt/Implement/Upgrade (A/I/U)
 - o MU Stage 1, Stage 2
- Quality Improvement
 - o PCMH
 - o 8 Clinical Quality Measures (CQMs)
 - o Health Information Exchange (HIE)
 - o Patient Smart Card

On December 2, 2015, HRSA issued Funding Opportunity Announcement HRSA-16-010 for a three year FY 2016 HCCN Grant Project that starts August 1, 2016. The Core Objectives are:

- Health Information Technology Implementation and Meaningful Use
- Data Quality and Reporting
- Health Information Exchange and Population Health Management
- Quality Improvement

The plan is to have SJFMC apply for this new grant on behalf of KeyCare, Inc. so that the work that was done during the first HCCN Grant Project can be continued and brought to the next higher level. The ultimate goal is to use Health Information Technology to improve the health outcomes of the patients served by the participating FQHCs.

Question A-4

Does the State have Veterans Administration or Indian Health Service clinical facilities that are operating EHRs? Please describe.



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New Jersey has 2 major Veterans Administration (VA) hospitals (in East Orange and Lyons) and 14 VA outpatient clinic locations. All of these locations use the VA's VistA (Veterans Health Information Systems and Technology Architecture). VistA enables VA clinicians to access patient records and images throughout the VA multi-site health system. The central application within VistA is the electronic health record management system known as the Computerized Patient Records System (CPRS).

There are no federally recognized tribes in New Jersey, and therefore no Indian Health Service (IHS) clinical facilities in the State.

Question A-5

What stakeholders are engaged in any existing HIT/E activities and how would the extent of their involvement be characterized?

In addition to New Jersey Medicaid and its support of electronic health record adoption and meaningful use and the secure exchange of health information through the administration of the Medicaid EHR Incentive Program, the following stakeholders are highly engaged in the State's HIT/E activities:

New Jersey Health IT Coordinator's Office – The New Jersey Health IT Coordinator's Office, located within the New Jersey Department of Health, is responsible for working with all State departments and agencies, the healthcare provider community and other industry stakeholders to:

- Ensure all providers have the opportunity to demonstrate meaningful use through public health reporting
- Support establishment of regional health information organizations (HIOs)
- Implement the New Jersey Health Information Network (NJHIN) to connect the regional HIOs for statewide HIE, and eventually nationwide HIE through connectivity to the NwHIN.

New Jersey Department of Health – The New Jersey Department of Health, in addition to its oversight responsibilities over the State's hospitals and other healthcare facilities, also actively works to ensure that all providers have the opportunity to satisfy the public health reporting meaningful use criteria. The Department of Health is also building towards an eventual goal of participating in statewide HIE through the sharing of immunization and other public health registry for the treatment of patients. Lastly, the Department is launching its Vital Information Platform (VIP), a new electronic birth, fetal



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death, and death certificate system for vital records. VIP will allow for enhanced demographic and clinical data capture to support:

- Essential public health programs
- Verification of Medicaid eligibility
- Improvement of quality outcomes
- Enhanced metrics for managed care
- Fraud, waste, and abuse reduction efforts

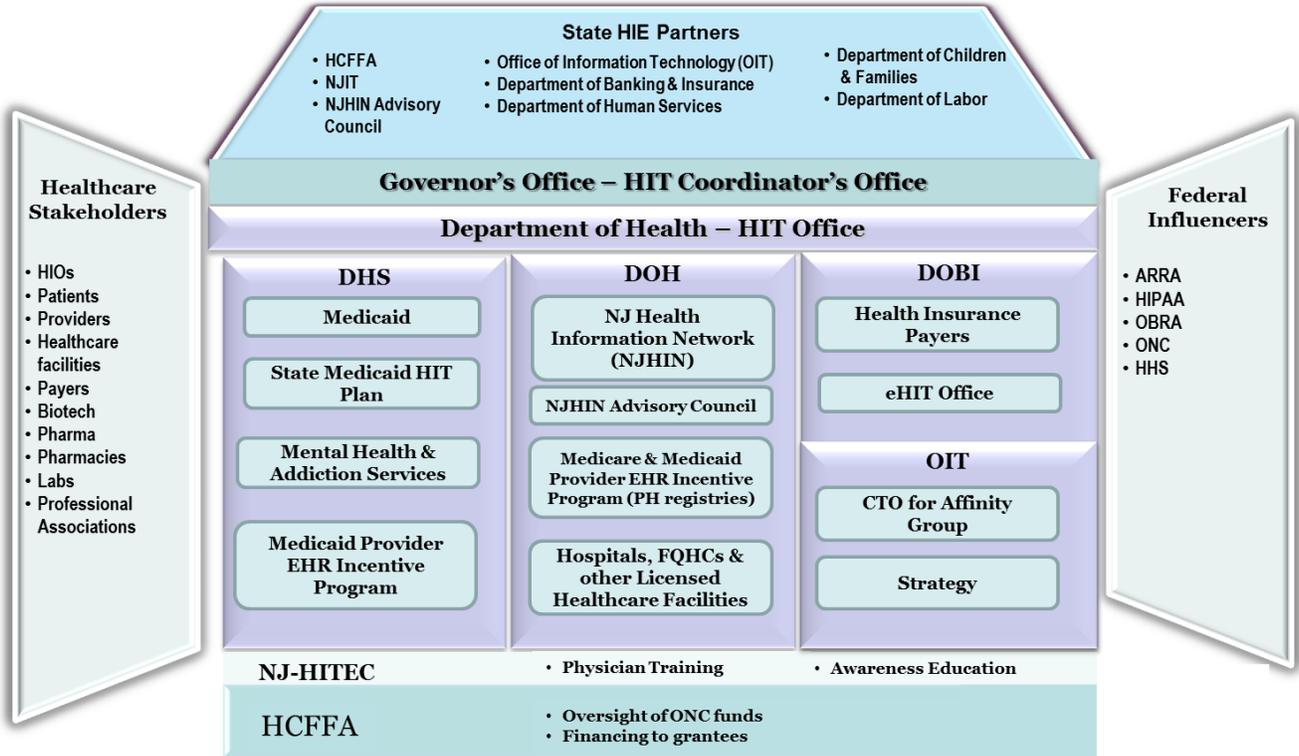
NJ-HITEC, New Jersey's Regional Extension Center – As New Jersey's sole regional extension center, NJ-HITEC is the New Jersey physician's trusted advisor in the timely delivery of high quality healthcare through the selection, implementation, and achievement of meaningful use of accredited EHR systems. NJ-HITEC has far exceeded its original ONC targets for provider membership, EHR adoption, and meaningful use, and continues to expand its service offerings and reach across the State.

In addition to this group, the figure below lists other stakeholders involved in different segments of New Jersey's health information technology planning.



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Table A.3: State Medicaid Health IT Plan Stakeholders



Question A-6

Does the SMA have HIT/E relationships with other entities? If so, what is the nature (governance, fiscal, geographic scope, etc) of these activities?

New Jersey Medicaid is collaborating with NJDOH in support of establishing statewide HIE infrastructure, the New Jersey Health Information Network (NJHIN). In order to facilitate statewide HIE among the regional HIOs, DOH is implementing a slim set of NJHIN shared services to connect these entities.

As a component of NJHIN planning, NJDOH will support efforts to test query/retrieve capabilities with the Immunization Registry. This will ensure that the State's health care providers have the ability to successfully transmit the information needed to comply with all stages of meaningful use criteria and support improvements in public health.



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In addition NJ Medicaid is collaborating with New Jersey Health Information Technology Regional Extension Center (NJ-HITEC) , in assisting Medicaid providers in connecting to a regional health information organization and in meeting meaningful use objectives that require Health Information Exchange capabilities.

Question A-7

Specifically, if there are health information exchange organizations in the State, what is their governance structure and is the SMA involved? How extensive is their geographic reach and scope of participation?

The State of New Jersey has four ONC-funded regional Health Information Organizations (HIOs). There are also other privately funded HIOs in New Jersey. Since the regional HIOs are (or will be) established as 501(c)(3) corporations and not as administrative entities of the State, New Jersey Medicaid will not be operationally involved in the governance of these entities. The following lists document the key hospitals and other partners actively participating in the regional HIOs:

Camden

- Virtua Health*
- Our Lady of Lourdes Medical Center*
- Cooper University Health Care*
- Kennedy Health System* (forthcoming)
- Fairview Village Family Practice
- Dr. Ramon Acosta
- St. Luke's Catholic Medical Services
- Reliance Medical Group Family Medicine & Podiatry, Camden County Offices
- CAMcare Health Corporation
- Project H.O.P.E. Camden
- Holy Redeemer Home Care & Hospice
- Camden County Correctional Facility
- Quest Diagnostics
- LabCorp (forthcoming)

*Contribute clinical data to the CamdenHIE

Highlander (formerly Health-e-Citi)

- Barnabas Newark Beth Israel Medical Center
- East Orange General Hospital



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- Meadowlands Hospital Medical Center
- Jersey City Medical Center
- University Hospital
- St. Michael's Medical Center
- Newark Community Health Centers
- Newark Homeless Health Care
- Horizon Health Center
- North Horizon Community Action Corporation Health Center
- Metropolitan Family Health Network
- Visiting Nurse Association of Central New Jersey
- Mental Health Association of Essex County

Jersey Health Connect:

- Atlantic Health System
 - Morristown Medical Center
 - Overlook Medical Center
 - Newton Medical Center
 - Chilton Medical Center
- Barnabas Health
 - Saint Barnabas Medical Center
 - Clara Mass Medical Center
- CentraState Healthcare System
- Central Jersey Information Exchange, Inc
- Children's Specialized Hospital
- Deborah Heart & Lung Center
- Englewood Hospital & Medical Center
- Francis E. Parker Memorial Home
- Hackensack University Medical Center
- Holy Name Medical Center
- Hunterdon HealthCare
- JFK Health System
- Meridian Health System
 - Jersey Shore University Medical Center
 - Ocean Medical Center
 - Southern Ocean Medical Center
 - Riverview Medical Center
 - Bayshore Community Hospital
- Optimus Healthcare Partners
- Palisades Medical Center



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- Raritan Bay Medical Center
- Robert Wood Johnson Health System
 - RWJ University Hospital New Brunswick
 - RWJ University Hospital Hamilton
 - RWJ University Hospital Rahway
- Saint Clare's Health System
- St. Joseph's Healthcare System
- Saint Peter's Healthcare System
- Somerset Medical Center
- Summit Medical Group
- Trinitas Regional Medical Center
- The Valley Hospital
- Vista Health System
- VNA Health Group
- Windsor Healthcare Communities

NJSHINE

- Cape Regional Medical Center
- Shore Medical Center
- Inspira Health Network
 - Inspira Medical Center Elmer
 - Inspira Medical Center Vineland
 - Inspira Medical Center Woodbury

Trenton Health Team / Trenton HIE

- Capital Health
- City of Trenton, Department of Health and Human Services Clinics
- Henry J. Austin Health Center
- Quest Diagnostics
- St. Francis Medical Center
- Trenton Health Team

Virtua Health System HIO

- Children's Hospital of Philadelphia
- Kennedy Cherry Hill
- Kennedy Stratford
- Kennedy Washington Township
- Virtua Berlin
- Virtua Burlington



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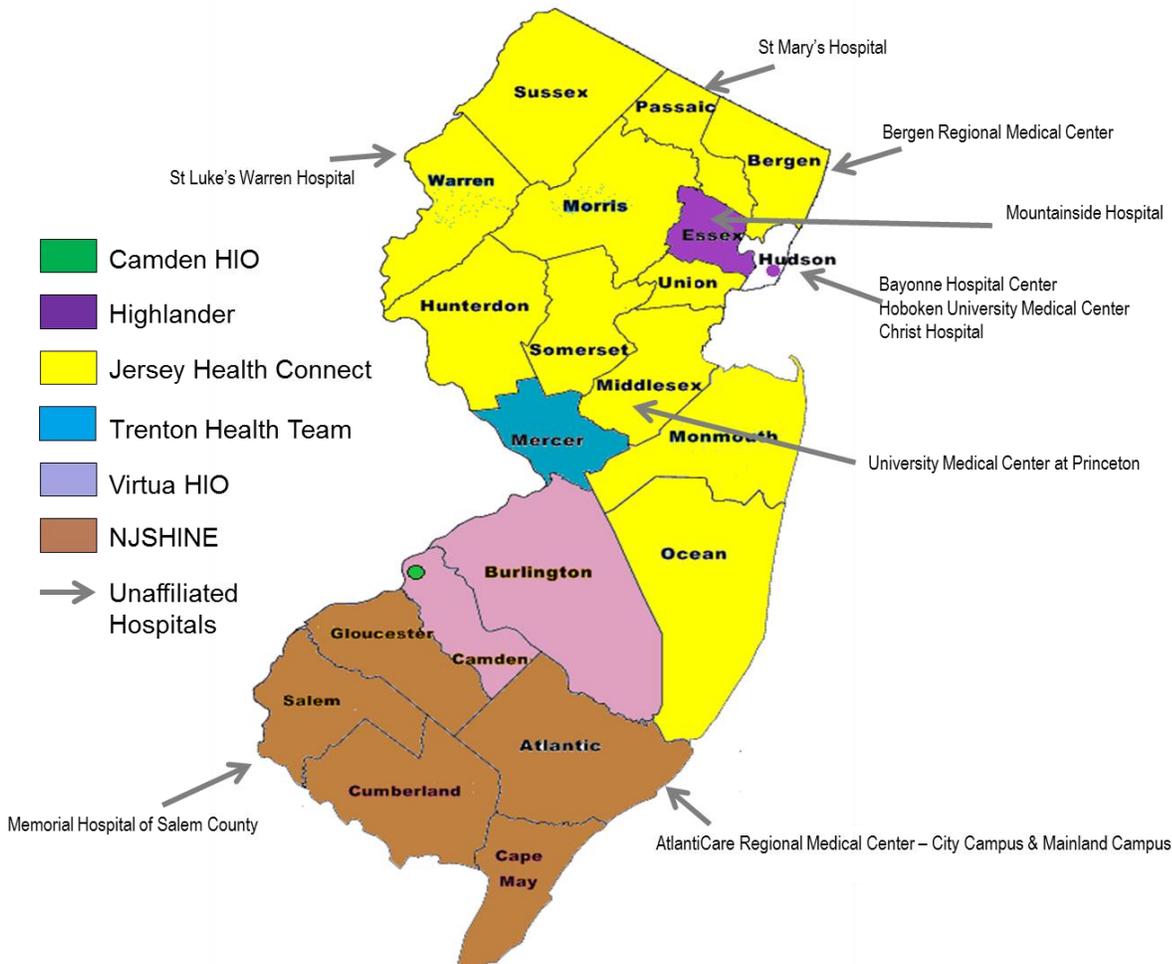
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- Virtua Marlton
- Virtua Voorhees

The map below illustrates the geographic reach and participation of each of New Jersey's regional HIOs. Only a very small minority (10) of hospitals are not participating in a regional HIO within the State.

Figure A.1: New Jersey Regional HIO Scope and Participation





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Question A-8

Please describe the role of the MMIS in the SMA's current HIT/E environment. Has the State coordinated their HIT Plan with their MITA transition plans and if so, briefly describe how.

The NJMMIS website contains a secure provider web portal allowing for the exchange of information with fee for service providers and the New Jersey Medicaid managed care organizations. Through the portal, providers and managed care organizations are able to submit claims to the MMIS and access/download their last 12 Remittance Advices. Fee for service providers can use the Direct Data Entry application available through the portal to create and submit certain claim types instead of submitting paper claims. The managed care organizations can use the portal to download NJMMIS extract files created specifically for them and submit their member ID files to Medicaid. Medicaid providers can use the eMEVS application available through the portal to perform eligibility verifications.

The NJMMIS interacts with pharmacies through a Point of Sale (POS) system that provides real time authorization of pharmacy claims to pharmacy providers.

The NJMMIS captures both pharmacy and non-pharmacy managed care encounters. Managed Care pharmacy encounters are currently submitted to New Jersey Medicaid in the NCPDP D.0 format, and managed care non-pharmacy encounters are submitted primarily in the HIPAA 5010 837 format. Files containing managed care pharmacy encounter data are uploaded to a secure area of the NJMMIS website (www.njmmis.com). The pharmacy encounters are then retrieved from the website by the State's Point of Sale system, converted into a fixed format, and uploaded to the NJMMIS mainframe for translation into the NJMMIS internal encounters format. The files containing non-pharmacy encounters are also submitted via secure web drop-off and uploaded to the NJMMIS mainframe for translation into the NJMMIS internal encounters format. Both pharmacy and non-pharmacy encounters are adjudicated weekly and are stored in an active encounter history until they are periodically transferred to archive encounter history. Remittance advices are created on the NJMMIS mainframe in the HIPAA 835 format and are transferred to the secure area of the NJMMIS website for HMO retrieval.

New Jersey Medicaid is also planning to provide access to New Jersey Medicaid's fee-for-service (FFS) medication history on the state's commercial e-prescribing infrastructure sometime in 2014. When the MCOs and FFS medication history are both



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available 100% of New Jersey Medicaid's medication history will be available for e-prescribing and hospital emergency departments.

Finally, the NJMMIS also has a Medicaid Eligibility Verification System (MEVS) that allows Medicaid providers to verify eligibility for Medicaid services either in real time or in batch mode. Eligibility inquiries are submitted using the Health Insurance Portability and Accountability Act (HIPAA) X12 270 Eligibility Benefit Inquiry format, and responses are returned in the HIPAA X12 271 Eligibility Benefit Response format.

New Jersey is implementing a new MMIS. An RFP was released in May 2013, and a contract awarded to Molina Medicaid Solutions in May 2015. The Replacement MMIS will be MITA 3.0 aligned, and compliant with CMS Seven Conditions and Standards. The solution emphasizes modularity, configurability, and a Service Oriented Architecture (SOA).

The R-MMIS will have a strong emphasis on technology that is dynamic and agile enough to respond to changes in both federal and State programs and policies. As New Jersey's HIE infrastructure develops beyond individual, localized HIOs into the NJHIN, Medicaid, via its R-MMIS, will be a source of data for member and provider inquiry, as appropriate. The R-MMIS will be fully HIPAA 5010, NCPDP D.0, and ICD-10 compliant. The R-MMIS implementation is finishing up the Planning Phase (Phase 2) and is moving into Phase 3, Requirements Verification and Design. This phase focuses heavily on plans for data conversion, solution configuration, and testing. System implementation/deployment is targeted for 2nd calendar quarter of 2018.

Question A-9

What State activities are currently underway or in the planning phase to facilitate HIE and EHR adoption? What role does the SMA play? Who else is currently involved? For example, how are the regional extension centers (RECs) assisting Medicaid eligible providers to implement EHR systems and achieve meaningful use?

Below is a description of several specific activities that were either recently completed or currently underway to facilitate EHR adoption and health information exchange in New Jersey.

Public Health Reporting for Meaningful Use: The New Jersey Department of Health continues to improve its systems for public health reporting to support providers in the demonstration of meaningful use. DOH implemented registration process and



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technology system enhancements to support providers with public health enrollment, streamlined interface setup, and improved data quality. DOH also updated its public health reporting MU website to clarify all of the reporting options and resources available to providers. DOH can report that immunization registry, syndromic surveillance, electronic lab reporting (ELR), and cancer reporting are all available public health MU Stage 1 and Stage 2 options for providers.

In order to successfully support providers with public health reporting and the demonstration of meaningful use, DOH will require additional resources to process the backlog of 1,400 providers who have registered their intent to establish an HL7 interface with NJIIS. Additionally, many of these providers are requesting a real-time, bidirectional HL7 interface with NJIIS. Onboarding onto NJIIS so that providers can attest to MU will require additional NJIIS resources in order to provide the necessary technical assistance to eligible providers and eligible hospitals. Funding through an IAPD-Update Appenix D (HIE IAPD) was approved by CMS for federal fiscal years 2017 and 2018 to provide personnel support for onboarding providers to the NJIIS.

As a major component of improving public health in New Jersey, the Department of Health is actively working to integrate its public health data sources with New Jersey Medicaid's Master Client Index. Creating this link among patients across State Departments will provide numerous opportunities for enhanced insights, efficiencies, and improved outcomes. Adoption of the Medicaid MCI also sets both Medicaid and DOH on the path to participating in the State's broader health information exchange landscape. Future planning, development, testing, data conversion, and ongoing remediation will be required to support this initiative.

NJIIS Personnel Support for Establishment of HIE Interfaces and Medicaid Provider Onboarding:

Vital information Platform (VIP): The New Jersey Department of Health's Office of Vital Statistics and Registry (OVSR) is launching the New Jersey Vital Information Platform (VIP). VIP will replace the current paper-based processes and legacy applications with a web-based system for registration of vital event information including births and fetal deaths. VIP will enable:

- Adoption of data collection standards consistent with federally mandated requirements;
- Improved timeliness and accuracy of vital event registration at local and State Registrar levels;



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- Reduction of redundant activities by improving the data collection, quality and timeliness of all birth record functions;
- Online access to real-time birth record data; and
- Establishment of a central repository of vital statistics data for enhanced data security, backup, and disaster recovery capabilities.

Since the VIP launch in 2015, New Jersey now has the capability to support expanded data capture for birth and fetal death registrations to both enhance important DOH programs and satisfy federal data collection standards. Additionally, VIP provides New Jersey Medicaid with increased capacity to better perform:

- Verification of Medicaid eligibility
- Improvement of quality outcomes
- Enhanced reporting/metrics for managed care populations and programs
- Fraud, waste, and abuse reduction efforts

NJ-HITEC: NJ-HITEC is New Jersey’s regional extension center whose mission includes assisting New Jersey physicians in achieving “Meaningful Use” of certified EHR systems. As of May 2015, NJ-HITEC had over 9,400 participating providers, including over 8,200 that have gone live with certified EHR technology, and over 6,250 certified meaningful users. NJ-HITEC is focused on serving providers in underserved areas and assists Medicaid providers that seek out their services in implementing EHR systems and achieving meaningful use. Many of these targeted providers are also be eligible for the Medicaid EHR Incentive Program.

For implementation assistance, NJ-HITEC provides project monitoring support for the EHR implementation process that may include individualized coaching, consultation, troubleshooting, and other activities to assist its participating providers in assessing and enhancing their organizational readiness for Health IT, assessing and remediating gaps in their IT infrastructure, configuring EHR software to meet practice needs, ensuring adequate software training for all staff, and tracking and adhering to implementation for achieving meaningful use. The services included in “implementation and project monitoring” provided to a participant provider are limited to those services that are normally and regularly included in assisting a provider move from “go-live” status to being a “meaningful user” of electronic health records as defined by ONC. Services beyond this scope are billed to the provider at a discounted NJ-HITEC member rate.

For meaningful use, NJ-HITEC assists its participating providers by reviewing the utilization of the EHRs within their practices and providing appropriate feedback and support to improve the utilization of features essential for meaningful use. NJ-HITEC



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works with participating providers in trying to understand and implement technology and process changes needed to attain meaningful use.

Medicaid Specialist Program: NJ-HITEC and New Jersey Medicaid partnered to fill a gap in meaningful use assistance services by running a program, supported by federal HITECH administrative funding, to provide their EHR selection guidance and meaningful use assistance services to specialist providers that may be eligible for the Medicaid EHR Incentive Program but do not qualify as primary care providers as described in NJ-HITEC's ONC grant agreement. The initial agreement for the Medicaid Specialist Program allowed up to 500 specialist providers to receive the full array of EHR and meaningful use assistance services available through NJ-HITEC. New Jersey Medicaid provides payment to NJ-HITEC as eligible providers reach each of three milestones: signing a participation agreement with NJ-HITEC, receiving a Year 1 Medicaid EHR Incentive Program payment (typically for adopting, implementing, or upgrading certified EHR technology), and receiving a Year 2 Medicaid EHR Incentive Program payment (typically for achieving 90 days of stage 1 meaningful use). Through March 31, 2014, NJ-HITEC had signed up all 500 specialist providers, including approximately 400 that have received Year 1 Medicaid EHR Incentive Program payments, and 90 that have received Year 1 Medicaid EHR Incentive Program payments for achieving 90 days of meaningful use.

Program funding for the Medicaid Specialist Program ended on September 30, 2014 and the providers and services have been transitioned into a new program, the Medicaid Provider Program.

Medicaid Provider Program: New Jersey Medicaid have strategized to to expand the services being provided to physician specialties and sub-specialists by the NJ-HITEC Medicaid Specialist Program to Medicaid primary care providers (PCP). HITECH administrative funding totaling \$4.9 million was requested and approved by CMS to extend and expand the consultative and meaningful use services being provided by NJ-HITEC to include additional Medicaid specialty providers that are excluded from federally-subsidized Regional Extension Center support services and PCPs who no longer are able to receive federally-subsidized Regional Extension Center support services due to the expiration of NJ-HITEC's grant agreement with the federal Office of the National Coordinator for Health Information Technology (ONC) in 2015. The program provides core funding for operational and administrative cost as well as direct funding for provider milestone achievement based on five distinct milestones.

- Milestone 1 – Up to 550 Medicaid Participating Provider (MPP) membership documentation



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- Milestone 2 – Up to 550 MPP's receipt of a Year 1 Medicaid EHR Incentive payment
- Milestone 3 – Up to 550 MPP's receipt of a Year 2 Medicaid EHR Incentive payment
- Milestone 4 – Up to 515 MPP's receipt of a Year 3 Medicaid EHR Incentive payment
- Milestone 5 – Up to 515 MPP's receipt of a Year 4 Medicaid EHR Incentive payment

Regional HIOs: New Jersey is building upon a “network of networks” approach to statewide health information exchange. The Department of Health continues to monitor implementation progress of each regional HIO and their provider membership. Additionally, efforts are underway to implement use cases that will lay the foundation for HIO-HIO health information exchange.

New Jersey Health Information Network (NJHIN): In order to facilitate statewide HIE among the regional HIOs, DOH is implementing a slim set of NJHIN shared services to connect these entities. Plans are taking shape to pilot shared services to facilitate the clinical exchange of patient information among HIOs. DOH has recently been awarded by the Office of the National Coordinator for Health Information Technology (ONC) with additional interoperability funding of \$4 million (\$3 million federal and \$1 million state match) to continue NJHIN development.

Public Health Participation in HIE: As a component of NJHIN planning, DOH will support efforts to test query/retrieve capabilities with the Immunization Registry. Lessons learned from this pilot will guide future design and implementation efforts to have the public health actively participate in the State's model of health information exchange.

Medicaid Provider On-boarding to the State HIE Infrastructure: This initiative is designed to promote provider use of the State's health information exchange infrastructure to improve the integration and coordination of care for patients throughout the State by focusing on providers that have already participated in the EHR Incentive Program and building on the technology and investments made to date by connecting these providers to New Jersey's HIE. This program will leverage the consultative experience of the State's Regional Extension Center, New Jersey Health Information Technology Extension Center (NJ-HITEC), in assisting Medicaid providers in attesting successfully for the New Jersey Medicaid EHR Incentive Program. Based on NJ-HITEC's previous experience assisting providers in achieving meaningful use, they are



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well-suited to assist Medicaid providers in connecting to a regional health information organization and in meeting meaningful use objectives that require Health Information Exchange capabilities.

NJ-HITEC will need to document that providers in this program meet the following milestones to receive direct payment:

- Milestone 1 – Medicaid Participating Provider’s successful connection to the HIE
- Milestone 2 – Medicaid Participating Provider’s successful utilization of the HIE connection in meeting meaningful use HIE objectives

Question A-10

Explain the SMA’s relationship to the State HIT Coordinator and how the activities planned under the ONC-funded HIE cooperative agreement and the Regional Extension Centers (and Local Extension Centers, if applicable) would help support the administration of the EHR Incentive Program.

New Jersey Medicaid is involved in activities being coordinated by the New Jersey HIT Coordinator’s office within the Department of Health. New Jersey Medicaid looks forward to continuing its active participation in these activities and providing support, advice and counsel to the New Jersey HIT Coordinator’s Office.

Given the Regional Extension Center (REC) Program’s core mission to assist physicians in adopting and meaningfully using EHR technology, New Jersey Medicaid looks to the New Jersey REC, NJ-HITEC, to counsel and assist Medicaid providers in adopting and implementing the EHR system that best fits their actice and informing the provider community of the Medicaid and Medicare EHR Incentive Payment Programs, including how to register for the program and how to attest to meaningfully using an ONC-certified EHR system. New Jersey Medicaid has no plans to include NJ-HITEC in the State’s EHR incentive program administrative process. Once providers apply for a New Jersey Medicaid EHR Incentive Program payment, New Jersey Medicaid, in coordination with its fiscal agent (Molina Health Care, Inc.), will be the entity responsible for ensuring that only eligible providers receive payments, distributing these payments quickly and accurately upon verified provider attestation, and establishing and implementing audit procedures. Bringing the Regional Extension Center into the administration process may set up a conflict of interest between their mission to promote EHR adoption and the fair and accurate oversight of the Medicaid EHR Incentive Program. There is an extensive discussion of New Jersey’s pre-payment and post-payment audit plans in



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Section D: New Jersey's Audit Strategy and in a separate EHR Incentive Program Audit Strategy, approved by CMS on June 24, 2013.

Question A-11

What other activities does the SMA currently have underway that will likely influence the direction of the EHR Incentive Program over the next five years?

New Jersey is implementing a new MMIS. An RFP was released in May 2013, and a contract awarded to Molina Medicaid Solutions in May 2015. The Replacement MMIS will be MITA 3.0 aligned and compliant with CMS Seven Conditions and Standards. The solution emphasizes modularity, configurability, and a Service Oriented Architecture (SOA).

The R-MMIS implementation is finishing up the Planning Phase (Phase 2) and is moving into Phase 3, Requirements Verification and Design. This phase focuses heavily on plans for data conversion, solution configuration, and testing. System implementation/deployment is targeted for 2nd calendar quarter of 2018.

Other activities New Jersey Medicaid currently has underway that may influence the direction of the EHR Incentive Program over the next 5 years include the following:

- **New Jersey FamilyCare – Integrated Eligibility System (NJFC -IES)** – A project to meet the requirements of the Affordable Care Act (ACA), consolidate and standardize application for medical coverage under Medicaid and replace many antiquated data systems currently in use. The New Jersey FamilyCare (NJFC) Integrated Eligibility System (IES) is the current New Jersey Medicaid Eligibility and Enrollment (E&E) strategy to meet the requirements of the Affordable Care Act (ACA), consolidate and standardize application for medical coverage under Medicaid, include MAGI rules, connectivity to federal data hub and replace many antiquated data systems currently in use.
- **ICD-10** – Adoption of the new standard for clinical diagnosis and procedure codes.
- **Universal Provider Credentialing** – A centralize provider data collection, perform primary source verification, and coordinate the credentialing and re-credentialing process for NJ FamilyCare providers as part of the new Medicaid Management Information System project . A single credentialing system will reduce the administrative burden on providers by using a common application and more efficient systems processes in



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managing the credentialing needs of the NJ FamilyCare program and its managed care partners.

- **National Core Indicators – Aging and Disabilities (NCI-AD)** - The NCI-AD is an initiative designed to support states' interest in assessing the performance of their programs and delivery systems and improving services for older adults, individuals with physical disabilities, and caregivers. The expected benefits to the State from participating in the NCI-AD program include the following:
 - Focus on performance of New Jersey's LTSS systems instead of specific services
 - Provide data on LTSS across various state programs (NJ FamilyCare, PACE, Older Americans Act).
 - Compare New Jersey's LTSS recipients on a National level
 - Focus on how individuals experience services and how they impact their quality of life (to go beyond services satisfaction).
- **Master Client Index (MCI)** – A project intended to resolve duplicate records within and link recipients between New Jersey's Medicaid program, Immunization Registry, and Blood Lead Screening Registry.
- **Document Imaging Management System:** A project intended to replace public assistance customers' paper documents with electronic records. All the documents related to Food Stamps, TANF, GA and Medicaid programs will be stored in this system.

Question A-12

Have there been any recent changes (of a significant degree) to State laws or regulations that might affect the implementation of the EHR Incentive Program? Please describe.

On September 4, 2014, CMS issued a final rule entitled "Medicare and Medicaid Programs; Modifications to the Medicare and Medicaid Electronic Health Record (EHR) Program for 2014 and Other Changes to the EHR Incentive Program; and Health Information Technology: Revisions to the Certified EHR Technology Definition and EHR Certification Changes Related to Standards" also known as the CEHRT Flexibility Rule. One of the main provisions of this rule is to allow eligible professionals and hospitals to attest for 2014 EHR Incentive Program payments using non-2014 specification certified electronic health record technology (CEHRT). New Jersey Medicaid implemented several changes to its Provider Incentive Payment (PIP) attestation application or the NJMMIS web-portal in order to allow its providers to attest using the CEHRT version



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options available through the flexibility rule. This web-portal utilizes business rules to show providers the appropriate screens for their attestation based on the program year, the provider's EHR Incentive Program payment year, and the stage of meaningful use included in the provider's previous attestations.

On October 6, 2015, CMS released the Final Rule for the Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 3 and Modifications to Meaningful Use in 2015 through 2017. The regulation was intended to simplify requirements and add new flexibilities for providers to make electronic health information available when and where it matters most and for health care providers and consumers to be able to readily, safely, and securely exchange that information. The Modifications to MU Rule was also intended to build progress toward program milestones, to reduce complexity, and to simplify providers' reporting. These modifications, intended to take effect for 2015-2017 attestations, would allow Eligible Professionals (EP) and Eligible Hospitals (EH) to focus more closely on the advanced use of certified EHR technology to support health information exchange and quality improvement. The Modifications to MU Rule program change most visible to providers will be in New Jersey's PIP attestation application. Given the variation of attestation options for calendar years 2015, 2016 and 2017, the New Jersey attestation application will be programmed to present the appropriate attestation screens or questionnaires based on attestation calendar year.

Question A-13

Are there any HIT/E activities that cross State borders? Is there significant crossing of State lines for accessing health care services by Medicaid beneficiaries? Please describe.

HIT/E activities that cross New Jersey's borders are currently very limited. Only one New Jersey entity, the privately funded Virtua Integrated Delivery Network, currently connects to other healthcare systems across state lines, and only in limited instances. Ultimately, it is the vision that NJHIN will serve as the gateway to the eHealth Exchange, the Sequoia Project, and serve as the conduit for broad multi-state HIE.

Based on data from the State's MMIS, New Jersey Medicaid beneficiaries are crossing state borders to access health care services. In the twelve months through April 30, 2014, approximately 9% of services by dollar value across the New Jersey Medicaid enterprise, representing \$961.7 million in combined fee-for-service claims and managed



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care encounters occurred outside of New Jersey. More than two thirds of this activity occurs in states bordering New Jersey (Pennsylvania, New York, and Delaware).

Question A-14

What is the current interoperability status of the State Immunization registry and Public Health Surveillance reporting database(s)?

In New Jersey, the State Immunization Registry and all Public Health Surveillance reporting systems are run by the Department of Health (DOH). DOH has implemented process and technology enhancements to allow for the immunization registry, ELR, syndromic surveillance, and cancer registries to be available for public health reporting by the State's healthcare providers to support them with the demonstration of meaningful use. All public health registries are capable of accepting MU Stage 1 and Stage 2 compliant formats (HL7 v2.x and HL7 CDA, as appropriate by registry) for maximum interoperability with certified EHR systems.

To continue to successfully support providers with public health reporting and the demonstration of meaningful use, DOH will require additional resources to process the backlog of 1,400 providers who have registered their intent to establish an HL7 interface with NJIIS (the State Immunization Registry). Many of these providers have also requested a real-time, bidirectional HL7 interface with NJIIS which will require additional NJIIS resources in order to provide the necessary technical assistance to eligible providers and eligible hospitals to onboard and attest to MU.

Additionally, per New Jersey Medicaid's request, DOH is participating in New Jersey Medicaid's MCI project. NJIIS has established a real-time web service with the New Jersey Medicaid MCI, allowing for de-duplication, data cleansing, and linking of patient data across departments. This service is live and in production, and provides the foundation for a public health registry such as NJIIS to participate in interoperable statewide health information exchange.

Question A-15

If the State was awarded an HIT-related grant, such as a Transformation Grant or a CHIPRA HIT grant, please include a brief description.

The only explicitly HIT-related grant that New Jersey received was a 2007 Medicaid Transformation Grant awarded under Section 6081 of the Deficit Reduction Act of 2005. This project was initially known as the New Jersey Electronic Medical Information for



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Children (E-MedIC) project, but is currently a component of the Master Client Index (MCI) project. The MCI project intends to resolve duplicate records within and link recipients between New Jersey's Medicaid program, Immunization Registry, and Blood Lead Screening Registry. This system is being used in development stage to eliminate duplicates in participants databases. Initial production operation of this system is expected in the second half of 2014.

In February 2015, Rutgers Center for State Health Policy (CSHP) received a one year, \$3 million State Innovation Model (SIM) design award on behalf of the State of New Jersey. This cooperative agreement is funded by the Center for Medicare and Medicaid Innovation (CMMI) from February 1, 2015 through January 31, 2016. The goals of the SIM are to design payment and service delivery models to reduce Medicare, Medicaid, and CHIP program expenditures while preserving or enhancing quality of care. Specific activities in the NJ SIM are targeted at 1) improving birth outcomes through smoking cessation efforts, particularly among pregnant women; 2) advancing behavioral and physical health integration strategies; and 3) addressing Medicaid cost/value, especially for high-cost patients.

Section B: New Jersey's "To-Be" HIT Landscape

Question B-1

Looking forward to the next five years, what specific HIT/E goals and objectives does the SMA expect to achieve? Be as specific as possible; e.g., the percentage of eligible providers adopting and meaningfully using certified EHR technology, the extent of access to HIE, etc.

New Jersey Medicaid's strategic HIT/E goals are described below. All of these goals will work in concert to make health information as widely available as possible, thereby improving the quality of healthcare for Medicaid recipients and beneficiaries. Progress on each goal will be defined through measurable baseline data and benchmarks.

Implement and Facilitate New Jersey Medicaid's "Comprehensive Waiver" -

The New Jersey Comprehensive Waiver enables the design of a New Jersey-specific plan for service provision with a set of innovative strategies. The key components of the Waiver are Managed Long Term Services and Supports (MLTSS), Qualified Income Trusts (QIT), integrated/coordinated behavioral health care services, the Delivery System



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Reform Incentive Payment (DSRIP) Program and a Supports program for adults with developmental disabilities. The Waiver was approved by CMS in October 2012 and is effective through June 2017.

In preparation for the sunset of the New Jersey 1115 Comprehensive Waiver in 2017, DMAHS held more than twenty-five internal stakeholder meetings that included staff from the Division of Mental Health and Addiction Services (DMHAS), Department of Children and Families (DCF), Division of Developmental Disabilities (DDD), the Department of Health (DOH) and the Medicaid Fraud Division (MFD). The purpose of these internal stakeholder meetings was to solicit ideas from subject matter experts in preparation of applying for renewal of the Waiver. More than two hundred suggestions were proposed in the key domains of: promoting integrated delivery systems; access to care; modifying Medicaid benefits and reimbursement rates; performance measurement and benchmarking; streamlining Medicaid oversight and infrastructure; and enhancing monitoring through data analytics. The Waiver renewal was submitted to CMS on September 2016 and is currently waiting for approval.

The Section 1115 waiver requires several technology goals required to support its implementation, including improvements in the Medicaid eligibility system through the implementation of New Jersey FamilyCare – Integrated Eligibility System (NJFC -IES)-, which will streamline the eligibility process, enable rules engine based eligibility logic throughout the State, and further New Jersey’s MITA maturity.

As New Jersey Medicaid demonstrates new care models, it is committed to using data to measure their effectiveness. To that end, New Jersey Medicaid is implementing ICD10 codes to enable more granular diagnosis and is also committed to using data repositories/datamarts and data warehouse systems to provide data on quality clinical outcomes and cost effectiveness.

Additionally, New Jersey Medicaid intends to streamline its internal program administration by deploying collaboration tools such as Microsoft SharePoint to enable efficient collaboration and workflows and has started using this new collaboration paradigm in the construction of this SMHP.

New Jersey Medicaid is committed to significantly reducing the time required to process applications for long-term care benefits by using preadmission screening to allow individuals to become eligible for these services under 42 CFR 435.210 well before the regular SSI eligibility determination is completed. New Jersey Medicaid will also



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automate the redetermination process by leveraging data available from the Internal Revenue Service, State Division of Taxation, New Jersey's child support program and any other available sources of income, residency, and eligibility information.

New Jersey Medicaid is taking actions specifically designed to provide integrated health care services, promote competition, support health homes for members, and pilot the Accountable Care Organization treatment model.

New Jersey Medicaid will continue its transition of patients into managed care in order to provide better oversight of client health care across all available Medicaid services. To improve the overall efficacy of the program, New Jersey Medicaid will use the outcomes and cost information captured within its data warehouse to improve the quality of health care provided to its clients in a cost effective manner. Finally, New Jersey Medicaid will partner with health care providers, managed care organizations, and program beneficiaries to implement a reward and responsibility program to encourage healthy lifestyle choices.

Achieve Broad Adoption of EHR and Meaningful Use - It is imperative for Medicaid providers across the State to adopt EHR technology and achieve meaningful use. The availability of health information enables providers to improve the quality of care being provided to their patients. New Jersey Medicaid intends to develop and track measurable objectives to meet this goal, including the percentage of practitioners with EHR access, the percentage of practitioners participating in a regional Health Information Exchange, and the percentage of practitioners meeting Meaningful Use Criteria. New Jersey Medicaid anticipates setting baseline benchmarks for these measures using a survey being conducted by the New Jersey Board of Medical Examiners as part of their biennial provider license renewal process. This survey will ask every provider in the State if they have adopted an EHR system and, for providers that have not adopted, when they expect to adopt. Since this information will be mandatory for providers to complete to maintain New Jersey licensure, it should give the most comprehensive statewide look at EHR penetration to date. New Jersey Medicaid will attempt to gather as much detailed information as possible from the this survey, and will utilize the CMS National Level Registry and other sources to improve our knowledge of provider EHR implementation plans. New Jersey Medicaid will include updates on statewide EHR adoption progress as additional information is made available.

Improve Healthcare Outcomes through HIT – New Jersey Medicaid will begin an aggressive quality improvement campaign that will leverage the increased use of health information technology and data exchange mentioned above to identify opportunities



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for improving processes across its entire program. These opportunities will include initiating quality improvement projects with providers, piloting ACOs, and other quality-based payment reform initiatives. Successful implementation of these pilot initiatives will result in improved quality of care for all beneficiaries

Leverage Exchange of Health Information - New Jersey Medicaid will participate extensively in statewide efforts to establish and develop a technically robust, extendable, and interoperable health information network. With the establishment of the New Jersey Health Information Network (NJHIN), New Jersey will create a focal point for health information exchange in the State, leveraging existing regional HIO initiatives with the goal of making as much clinical data as possible available to providers and other stakeholders, within the constraints of all current and future privacy and security legislation and regulation. The initial data to be exchanged includes patient medication histories that will be made available when patients present themselves to an emergency department. Additional use cases defined by the New Jersey's HIT Steering Committee include the exchange of immunization data, lab results, Emergency Department discharge summaries, and transition of care referral information. As further statewide use cases are defined they will be included in updates to this document.

Improve Efficiencies and Reduce Cost - As a result of achieving the goals discussed above, New Jersey Medicaid and its providers should begin to realize both clinical and cost efficiencies. Once all patient data is available in an electronic format, the State expects enhanced claims transaction efficiency, reduced administrative costs, and improved health outcomes.

Keep Up With Health Information Technology Innovations – New Jersey Medicaid will continue to evaluate advances in health technology and incorporate updates into our plan. We will continue to monitor telehealth, secure messaging and other technologies and incorporate those technologies that can improve the quality and efficiency of health care provided by the Medicaid program.

Question B-2

What will the SMA's IT system architecture (potentially including the MMIS) look like in five years to support achieving the SMA's long term goals and objectives? Internet portals? Enterprise Service Bus? Master Patient Index? Record Locator Service?



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New Jersey's long term vision is to enable Medicaid to use information technology to empower individuals, improve the health of Medicaid beneficiaries, support programmatic changes related to its Medicaid Comprehensive Waiver and implement the expansion of coverage mandated by the Affordable Care Act. The State of New Jersey is under intense budget pressure so it is imperative that all IT improvements support administrative flexibility and simplification. New Jersey Medicaid believes this will drive better health outcomes and optimize the cost of health care for both the State and the federal government.

To enable this vision of improving health outcomes and optimizing cost, New Jersey Medicaid is implementing a flexible, service oriented architecture that will allow us to achieve MITA maturity.



Figure B.1: New Jersey Medicaid’s IT Architecture Vision

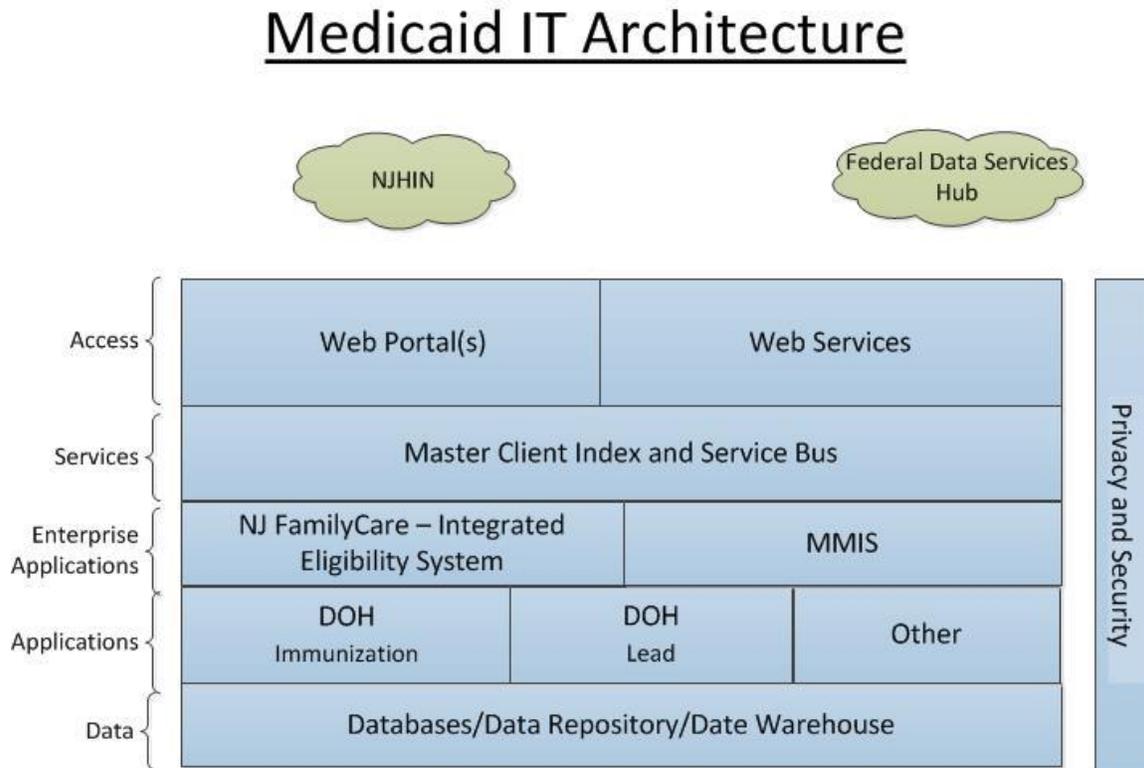


Figure B.1 represents the vision for New Jersey Medicaid’s IT architecture. New Jersey Medicaid will develop a data architecture where data elements are mapped to a single source of truth. All application databases will retrieve their information from the same source systems, transactions will be stored in data repositories for transactional processing, and datamarts/data warehouse(s) will be utilized for research, quality, and financial analysis.

Applications will use a master client index to link clients across all services Medicaid provides and will utilize a record locator service. Communication between applications and application modules will use standards-based communication protocols across an enterprise service bus.



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New Jersey FamilyCare – Integrated Eligibility System (NJ FamilyCare – IES) currently provides the tools required to support the ACA Medicaid eligibility requirements for MAGI and connectivity to the federal data hub.

Over the next 5 years New Jersey Medicaid anticipates the following system improvements and implementations:

- Implementation of the New Jersey FamilyCare – Integrated Eligibility System (NJFC -IES)- (NJ FamilyCare- IES) for Medicaid and other program eligibility including additional modules Age, Blind, Disabled program (ABD) and Presumptive Eligibility (PE), expected in 2017.
- Implementation of ICD-10 codes within the federally mandated time frame.
- New Jersey awarded the Replacement MMIS contract to Molina Medicaid Solutions in May 2015. DDI is currently underway, with a targeted go- live in second quarter of 2018. The solution is aligned with MITA 3.0 and complies with with the CMS Seven Conditions and Standards.
- MCI was implemented. As of May, 2015 all member demographic data and identifiers from MMIS, Immunization and Lead registries are contained in the MCI Client Registry and kept updated continuously near real time. Medicaid starts utilizing the MCI within the MMIS for Identity Management to examine all incoming eligibility records to determine if the eligibility record is for a new member or if it belongs to an existing member. Configuring and automating the data exchange between MMIS and the DOH Blood Lead Registry utilizing the MCI to extract Blood Lead lab readings for all Medicaid children 6 years and younger in May 2017.
- Scheduled to complete in Fall 2018, the integration of the MCI with the new Replacement Medicaid Management Information System’s Health PAS and the MedCompass Care Management systems. MCI is being used with Health PAS for Identity Management of all members. The MCI’s integration with the MedCompass system is to support the accurate data exchange between Medicaid RMMIS and the Lead Registry and Immunization Registry as specified in the RMMIS requirements for Care Management.

Question B-3

How will Medicaid providers interface with the SMA IT system as it relates to the EHR Incentive Program (registration, reporting of MU data, etc.)?



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The State of New Jersey is using its existing NJMMIS web portal to support the electronic submission of Medicaid EHR Incentive Program attestations. The NJMMIS includes a web portal that currently supports a single sign-on process that presents all functionality for which the signing-on provider is approved, including the Medicaid EHR Incentive Program Attestation Application. Providers that believe they are eligible for an incentive payment will have the following functionality available to them:

- Access to web-based application user manuals
- Workbooks that describe the information needed to successfully complete a Medicaid EHR Incentive Program attestation
- Access to all other written communications related to the Medicaid EHR incentive program
- Ability to attest for Medicaid EHR Incentive Program payments, including the receipt of a near real-time acceptance decision and the collection of banking information to support the electronic transfer of incentive payments to the provider.
- The ability to submit the meaningful use measures and clinical quality measures required to receive Medicaid EHR Incentive Program payments.

There are many providers who are enrolled with the New Jersey Medicaid Program as a “servicing-only” provider. For the purposes of the incentive program these “servicing-only” providers include health care professionals that are practicing exclusively within a group practice environment where they are providing direct treatment to New Jersey Medicaid beneficiaries but the payment for that treatment is being made to the group practice. These “servicing-only” providers currently are not issued a logon id and initial password for access to the NJMMIS web site.

In order for New Jersey to process incentive payments for these providers, they will be issued unique logon IDs and passwords to the MMIS Provider Portal and be given access to the EHR Incentive Program Attestation Application through the portal. All providers will receive their incentive payments along with their regular weekly Medicaid payments. All providers should be familiar enough with the existing Medicaid provider payment and remittance reporting process that only minimal training of the provider community will be required to educate it on how incentive payments will be uniquely identified on their weekly remittance advice. Providers exclusively servicing Medicaid Managed Care clients will have to enroll with New Jersey Medicaid in order to receive their Medicaid EHR Incentive Program payments.



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Providers will also have the ability to contact call center customer service representatives to obtain assistance regarding the incentive program by calling the existing MMIS toll-free call center lines. The initial menu that allows providers to specify the reason for their call has been expanded to include an option for the incentive program. Inquiries received from providers selecting this option will be automatically routed to call center representatives with specialized incentive program training and knowledge.

Question B-4

Given what is known about HIE governance structures currently in place, what should be in place by 5 years from now in order to achieve the SMA's HIT/E goals and objectives? While we do not expect the SMA to know the specific organizations will be involved, etc., we would appreciate a discussion of this in the context of what is missing today that would need to be in place five years from now to ensure EHR adoption and meaningful use of EHR technologies.

There are several factors that need to come together across the State of New Jersey over the next five years to enable New Jersey Medicaid to meet its HIT and HIE goals. First, the Department of Health needs to successfully stand up the statewide New Jersey Health Information Network (NJHIN) and continue to promote and support the regional health information exchanges. Only with a robust statewide network supported by the regional HIOs can New Jersey Medicaid achieve its vision of sharing the maximum amount of clinical information with the maximum number of health care professionals and institutions to achieve higher quality, cost effective care within the established legal and data privacy framework. The establishment of NJHIN will be a pivotal step for New Jersey Medicaid's goals since it will allow for a single point of data transfer between New Jersey Medicaid's IT systems and the rest of the State's health care community, allowing Medicaid data to be worked into provider EHR systems and allow them to meaningfully use EHRs by having a patient's complete clinical history at their fingertips. Eventually, the single connection to NJHIN may allow state residents to look at their entire clinical history through a patient health record.

In order to facilitate statewide HIE among the regional HIOs, DOH is implementing a slim set of NJHIN shared services to connect these entities. Plans are taking shape to pilot shared services to facilitate the clinical exchange of patient information among HIOs. DOH has recently been awarded by the Office of the National Coordinator for Health



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Information Technology (ONC) with additional interoperability funding of \$4 million (\$3 million federal and \$1 million state match) to continue NJHIN development.

New Jersey Medicaid also intends to eventually establish a Medicaid MMIS State node to the NJHIN. As part of the State's ongoing efforts toward its HIT goals, an HIE IAPD was submitted to and approved by CMS. This HIE IAPD is intended to support Medicaid activities contributing to EHR and meaningful use adoption of measures utilizing both regional and statewide health information exchange infrastructure and supports the establishment of NJHIN. These activities include milestone based on-boarding of Medicaid providers to the State HIE infrastructure, personnel support for public health registry on-boarding of Medicaid providers to the New Jersey Immunization Information System (NJIS), the establishment of an NJIS interface to NJHIN and the establishment of a Medicaid Management Information System (MMIS) prescription drug information interface to NJHIN.

The State will also be presenting proposals for additional HIE IAPD funding based on the guidance provided by CMS under the State Medicaid Director's (SMD) Letter #16-003, "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers". The initiatives to be proposed include Medicaid Provider On-Boarding to the State HIE Infrastructure, Health Information Exchange Infrastructure and Architecture Enhancements and Public Health Systems Enhancements.

Question B-5

What specific steps is the SMA planning to take in the next 12 months to encourage provider adoption of certified EHR technology?

Over the next 12 months, New Jersey Medicaid intends to encourage provider adoption of certified EHR technology in three primary ways:

First, continued operation of the Medicaid EHR Incentive Payment program will give providers a means of receiving financial reimbursement for adopting, implementing, upgrading, or meaningfully using certified EHR technology.

Second, as CY2016 is the final year to participate in the Medicaid EHR Incentive Program, a provider outreach strategy is being developed that will include the following:



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- A letter from the New Jersey Medicaid Director to providers encouraging Medicaid provider participation
- Inclusion of EHR adoption and HIE quality measures in the Managed Care Organization (MCO) contract
- Collaboration with Regional Extension Center
- Engagement of state medical associations and societies
- Engagement of correctional facilities whose providers recently became eligible for the program
- Active campaign calling utilizing attestation application registration data
- Addition of State flexibility to allow the option for new eligible professionals (EPs) intending to attest for their first Medicaid EHR Incentive Program payment, to use a continuous 90-day period in the 12-months preceding the attestation to establish their Medicaid patient volume. New participating providers may select this option in place of the current preceding calendar year reporting period.

Information will continue to be disseminated to providers on both the Medicaid and Medicare EHR Incentive Payment programs and the benefits of adopting EHRs. This information will be developed by New Jersey Medicaid in collaboration with New Jersey Regional Extension Center (NJ-HITEC) and is expected to be distributed through the New Jersey HIT website (<http://www.nj.gov/health/njhitec/>), New Jersey Medicaid's website (<http://www.state.nj.us/humanservices/dmahs/home/index.html>) and NJ-HITEC's website (<http://www.njhitec.org/>).

Third, Medicaid providers will be explicitly referred to NJ-HITEC to receive its assistance and guidance in implementing EHRs, choosing the EHR product that best suits their needs, and developing a plan to achieve the meaningful use of their EHR systems.

Fourth, NJ-HITEC's Medicaid Provider Program is designed to provide free direct assistance to additional Medicaid specialists as well as primary care providers. Continuing the success of the Medicaid Specialist Program which assisted more than 500 New Jersey Medicaid specialist providers, the Medicaid Provider Program aims to continue Medicaid provider meaningful use support to these specialty providers as well as primary care providers that no longer receive support services from the Office of the National Coordinator for HIT Regional Extension Center program. It is expected that NJ-HITEC's assistance will result in a significant increase in the number of Medicaid EHR Incentive Program participating providers that will achieve meaningful use over the next twelve months.

Finally, New Jersey Medicaid is looking into including an EHR and HIE adoption quality measure in its managed care contract. A clause pertaining to this measure is being included based on the final rule released on April 25, 2016 by CMS on Medicaid managed



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care organization (MCO) regulations that supports both electronic health record systems and health information exchange. This rule also allowed states to specify in contracts with managed care providers that the organizations must participate in "broad-based provider HIE projects," as well as other programs that could bolster care quality.

Question B-6

If the State has FQHCs with HRSA HIT/EHR funding, how will those resources and experiences be leveraged by the SMA to encourage EHR adoption?

KeyCare, LLC, a consortium of New Jersey FQHCs, through Southern Jersey Family Medical Centers (SJFMC) received \$3 million in HRSA HIT/EHR funding to implement and adopt HIT systems and was the only New Jersey FQHC to receive these funds. These funds have been used to enhance the EHR capabilities across the FQHCs belonging to KeyCare and begin innovation projects in the FQHC members that have mature EHR systems. New Jersey Medicaid will defer a response on the second part of this question as it considers strategies to leverage the FQHC experiences to encourage EHR adoption amongst Medicaid providers.

Over the next 12 months, New Jersey will further investigate how the EHR developments and enhancement supported with these HRSA funds can be used by Medicaid providers still seeking a comprehensive EHR solution.

Question B-7

How will the SMA assess and/or provide technical assistance to Medicaid providers around adoption and meaningful use of certified EHR technology?

Given the limited resources available to New Jersey Medicaid to provide technical assistance on achieving meaningful use, it does not anticipate being directly involved in providing assistance to Medicaid providers in adopting and meaningfully using certified EHR technology. These providers will instead be encouraged to register with NJ-HITEC to receive these services through their ONC grant agreement, which supports technical assistance, planning, consulting and other services related to meaningful use for 5,000 primary care providers that meet certain geographic, practice size, and specialty criteria.



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As of July 27, 2012, NJ-HITEC has reached its 5,000 primary care provider goal; additional providers wishing to utilize NJ-HITEC's unique meaningful use expertise will be charged a fee.

To assist providers not eligible for NJ-HITEC's ONC funded slots, New Jersey Medicaid has entered into an agreement with NJ-HITEC to supply up to 500 Medicaid specialist providers with their full array of EHR assistance services, including counseling and guidance in adopting, implementing, upgrading, and meaningfully using an EHR system. The funding for this agreement assumes 500 providers will receive NJ-HITEC's services over three years, with New Jersey Medicaid paying NJ-HITEC a total of \$5,000 total for each verified Medicaid specialist provider that achieves 90 days of meaningful use. The \$5,000 per provider amount is distributed in three equal installments, based on the following milestones:

- Milestone 1 - Signing of an NJ-HITEC participation agreement and verification by New Jersey Medicaid that the provider is a Medicaid specialist provider
- Milestone 2 - Reception of a Year 1 Medicaid EHR incentive Program payment, generally received for successfully attesting to the adoption, implementation, or upgrade of certified EHR technology and meeting the necessary Medicaid EHR Incentive Program Medicaid patient volume requirements
- Milestone 3 - Reception of a Year 2 Medicaid EHR Incentive Program payment, generally received for meeting stage 1 meaningful use requirements for 90 days and meeting the necessary Medicaid EHR Incentive Program Medicaid patient volume requirements

Program funding for the Medicaid Specialist Program ended on September 30, 2014 and the providers and services were transitioned into a new program, the Medicaid Provider Program. New Jersey Medicaid expanded the services being provided to physician specialties and sub-specialists by the NJ-HITEC Medicaid Specialist Program to Medicaid primary care providers (PCP). HITECH administrative funding totaling \$4.9 million was requested and approved by CMS to extend and expand the consultative and meaningful use services being provided by NJ-HITEC to include additional Medicaid specialty providers that are excluded from federally-subsidized Regional Extension Center support services and PCPs who no longer are able to receive federally-subsidized Regional Extension Center support services due to the expiration of NJ-HITEC's grant agreement with the federal office of the National Coordinator for Health Information Technology (ONC) in 2015. The program provides core funding for operational and administrative cost as well as direct funding for provider milestone achievement based on five distinct milestones as follows.



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- Milestone 1 – Up to 550 Medicaid Participating Provider (MPP) membership documentation
- Milestone 2 – Up to 550 MPP’s receipt of a Year 1 Medicaid EHR Incentive payment
- Milestone 3 – Up to 550 MPP’s receipt of a Year 2 Medicaid EHR Incentive payment
- Milestone 4 – Up to 515 MPP’s receipt of a Year 3 Medicaid EHR Incentive payment
- Milestone 5 – Up to 515 MPP’s receipt of a Year 4 Medicaid EHR Incentive payment

New Jersey Medicaid will also be periodically disseminating materials updating providers on the progress of the Medicaid EHR Incentive Program and encouraging them to reach out to NJ-HITEC for support and assistance in adopting, implementing, and meaningfully using EHR technology.

Finally, in order to better administer New Jersey’s Medicaid EHR Incentive Payment Program, the State’s fiscal agent (Molina HealthCare, Inc.) is supplying one dedicated Provider Services call center representatives to assist providers in completing the registration and attestation processes required to begin receiving EHR incentive payments. Additional Provider Services call center representatives are available to assist the dedicated representative during periods of high call volume.

Question B-8

How will the SMA assure that populations with unique needs, such as children, are appropriately addressed by the EHR Incentive Program?

NJ-HITEC’s Medicaid Specialist Program (described in the response to question B-7) which was transitioned into the Medicaid Provider Program provides a pathway for several populations with unique needs to be addressed by the Medicaid EHR Incentive Program. Through September 2014, Medicaid Specialist Program participants included over 200 psychiatrists and smaller numbers of providers from other specialties (including dentists, cardiologists, surgeons, urologists, and others). The Medicaid Specialist Program has enabled these providers that serve populations with unique needs to receive the same EHR implementation and meaningful use assistance available to primary care providers and should result in increased Medicaid EHR Incentive



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Program participation, an increase in EHR adoption in New Jersey, and quicker facilitation of health information exchange across the state and the nation. Overall, as of September 2016, there are 1,721 attestations from 797 unique pediatric providers in New Jersey's Medicaid EHR Incentive Payment Program.

Question B-9

If the State included in a description of a HIT-related grant award (or awards) in Section A, to the extent known, how will that grant, or grants, be leveraged for implementing the EHR Incentive Program, e.g. actual grant products, knowledge/lessons learned, stakeholder relationships, governance structures, legal/consent policies and agreements, etc.?

The Medicaid Transformation Grant discussed in the response to question A-15 was used by New Jersey Medicaid to develop and implement the statewide Master Client Index; therefore, this grant is not available to be leveraged for implementing the EHR Incentive Program. The scope of this project does not align with the implementation or operations of the New Jersey Medicaid EHR Incentive Program, and therefore will be unable to be leveraged for this purpose.

Question B-10

Does the SMA anticipate the need for new or State legislation or changes to existing State laws in order to implement the EHR Incentive Program and/or facilitate a successful EHR Incentive Program (e.g. State laws that may restrict the exchange of certain kinds of health information)? Please describe.

New Jersey Medicaid does not anticipate needing new state legislation or changing existing state statutes to implement or continue operations of the Medicaid EHR Incentive Program.



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Question B-11

Please include other issues that the SMA believes need to be addressed, institutions that will need to be present and interoperability arrangements that will need to exist in the next five years to achieve its goals.

Over the next five years, the key issues that need to be addressed to effectively implement health information exchange in New Jersey revolve around the successful standing up and implementation of the statewide New Jersey Health Information Network (NJHIN). The Department of Health is currently developing a plan to ensure the financial sustainability of NJHIN that includes the fair assignment of costs across all HIE beneficiaries. The Department of Health is also establishing the NJHIN governance structure and the policies and procedures needed to ensure that all HIE activities comply with state and federal laws and exchange data in a secure way that does not jeopardize patient privacy. These policies and procedures will be formalized in trust agreements modeled after the federal Data Use and Reciprocal Support Agreement (DURSA), and will be signed by Medicaid and any HIO participating in the exchange of health data. In addition, standards for the secure transmission of clinical data must also be set at the national level through the establishment of the Nationwide Health Information Network (NwHIN). Interstate legal agreements for the exchange of health information that meet all federal and state privacy and security requirements must be developed and executed to facilitate the establishment of this network.

As part of these activities, New Jersey Medicaid, through its MMIS, will act as a source of clinical and other data for the regional HIOs and NJHIN and will provide information on Medicaid beneficiaries to CMS, other state agencies, hospitals, provider offices, and other New Jersey Health Care Payers (Medicare, managed care organizations, and commercial insurers) in order to facilitate the establishment of the most complete electronic health record for as many New Jersey residents as possible.



Section C: Activities Necessary to Administer and Oversee the EHR Incentive Payment Program

Question C-1

How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?

New Jersey's EHR Incentive Program Attestation Application confirms provider eligibility against the NJMMIS Provider Master Database which contains a record for each health care provider enrolled in the New Jersey Medicaid Program. This database allows New Jersey to determine the enrolling provider's eligibility for the New Jersey Medicaid Program (which includes the requirement for the provider to be appropriately licensed), status as a federally excluded provider, and will include any "on review" limitations that may be in place for the provider. The NJMMIS tracks periods of eligibility and ineligibility for each enrolled provider. Each period of time is defined by a begin date, an end date and a cancel reason. The value of the cancel reason defines if the period of time defined by the begin date and end date defines a period of eligibility or a period of ineligibility. Periods of time defined with a cancel reason code of either "00" or "01" define periods of active Medicaid eligibility. Cancel reason codes that define periods of Medicaid ineligibility include but are not limited to the following:

- 10 – Provider is Federally Excluded
- 03 – Cancelled Due to Inactivity
- 30 – Eligibility Suspended – Disciplinary Action
- 32 – Eligibility Suspended – License Revoked

When the enrolling provider identifies the service period for which they are attesting to meaningful use, the incentive payment administrative solution will check to confirm that the provider was Medicaid-eligible for the full attestation period specified, that the provider has not been designated as federally excluded for any of the attestation period, and that the provider was not under review for any of the attestation period.

If Medicaid providers not currently included in the NJMMIS Provider Master Database (including managed care providers with no Medicaid fee-for-service business) wish to



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pursue an incentive payment, they are required to enroll in the New Jersey Medicaid Program and receive a unique NJMMIS logon ID and password.

Question C-2

How will the SMA verify whether EPs are hospital-based or not?

The current provider enrollment application process for EPs calls for the provider to specify their practice type. Practice Types supported by the NJMMIS include the following:

- Individual
- Partnership
- Corporation
- Hospital-based Physician
- HMO
- Group Practice (Private)
- Facility Practice (such as a teaching Hospital)
- Independent Clinic
- Other

The “Hospital-Based Physician” value allows for the unique identification of those EPs that are hospital-based. The Attestation Application also determines from fee for service claims and encounter claims housed within the NJMMIS the percentage of services that were provided within a hospital setting as compared to a community-based setting based on the place of service indicated on the claim. If 90% or more of a provider’s claims in the NJMMIS are determined to be hospital-based, the provider will not be able to proceed through the remainder of the attestation process.

Question C-3

How will the SMA verify the overall content of provider attestations?

New Jersey Medicaid will use both pre-payment and post-payment processes to verify the overall content of provider attestations. The below table shows how New Jersey is verifying 12 different EHR Incentive Program eligibility criteria; eleven of these measures were included in a July 2011 federal Office of Inspector General (OIG) report entitled “Early Review of States’ Planned Medicaid Electronic Health Record Incentive Program



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Oversight”; the final measure in the table, verification of the “practicing predominantly in an FQHC” eligibility requirement for using the needy individual patient volume measure, was not included in the federal OIG’s initial program review.

Table C.1: New Jersey Attestation Verification Procedures

<u>Verification Criteria</u>	<u>Eligible Professionals</u>	<u>Eligible Hospitals</u>
Practitioner must be one of the permissible practitioner types	<i>Pre-payment verification via the NJMMIS</i> . The registration information received by the EHR Incentive Program Attestation Application from the National Level Repository is compared against the provider information on file with New Jersey Medicaid via the NJ MMIS. If the provider type included in the NLR registration does not match the information in NJ MMIS, the provider’s registration is rejected and the provider is instructed to update either their NLR registration or their NJ MMIS provider profile.	
Practitioners and hospitals must be licensed to practice in the State	<i>Pre-payment verification via the NJMMIS</i> . The registration information received from the National Level Repository is compared against the provider license information on file with New Jersey Medicaid via the NJ MMIS. If the provider is found to not be licensed in New Jersey, they are unable to move forward with their attestation. New Jersey Medicaid is working with the New Jersey Division of Consumer Affairs to establish a real-time connection to their provider licensing database to improve upon the current verification procedures.	
Practitioners and hospitals must not be excluded, sanctioned, or otherwise deemed ineligible to receive payments from the State	<i>Pre-payment verification via the NJMMIS and Decision Support System</i> . Eligibility data is exported from the NJMMIS mainframe Provider Master Database on a weekly basis and this data is imported into the NJMMIS Decision Support System (DSS) which then serves as the source of provider eligibility data for the EHR Incentive Program Attestation Application. When the Attestation Application needs to confirm eligibility for a provider, it invokes a web service that requests the DSS application to return all periods of provider eligibility on file for the New Jersey Medicaid provider number. The DSS then returns to the associated begin date of eligibility and end date of eligibility. Only periods of Medicaid eligibility are returned to the PIP application; if a provider’s attestation information does not fall within a period of Medicaid eligibility, the provider is considered ineligible for New Jersey Medicaid EHR Incentive Program payments and their attestation will be denied.	
Practitioners must have a least a 30% Medicaid patient volume (or 20% for pediatricians) if they are not practicing predominantly in an FQHC or RHC	<i>Pre-Payment verification of Medicaid encounter volume via NJMMIS and post-payment review of overall encounters</i> . The overall Medicaid encounter counts included in provider attestations are verified against data available in NJMMIS for the patient volume attestation period before an incentive payment is approved for distribution. If the provider’s encounter count does not fall within a certain percentage of the encounter count returned from NJMMIS, the provider’s attestation is placed into a pending status and additional supporting information is requested from the provider. Since New Jersey does not have an all payer claims database, New Jersey Medicaid is unable to verify providers’ overall encounter counts; this is handled through the post-payment review process.	<i>Not applicable.</i>
Practitioners must have at least a 30% needy individual patient volume if they are practicing predominantly in an FQHC	<i>Post-payment verification only</i> since the “Needy Individual” patient volume measure includes encounters beyond those able to be verified by NJMMIS and New Jersey does not have an all-payer claims database.	<i>Not applicable.</i>



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Table C.1 (Continued): New Jersey Attestation Verification Procedures

<u>Verification Criteria</u>	<u>Eligible Professionals</u>	<u>Eligible Hospitals</u>
Practitioners must have conducted 50% of their encounters in an FQHC or RHC to qualify as practicing predominantly in an FQHC or RHC	<i>Post-payment verification only</i> since New Jersey does not have an all-payer claims database to perform a pre-payment verification of this information.	<i>Not applicable.</i>
Hospitals must have at least 10% Medicaid patient volume (acute care hospitals only)	<i>Not applicable.</i>	<i>Pre-Payment verification of Medicaid encounter volume via NJMMIS and post-payment review of overall encounters</i> . The overall Medicaid encounter counts included in hospital attestations are verified against data available in NJMMIS for the patient volume attestation period before an incentive payment is approved for distribution. If a hospital's encounter count does not fall within a certain percentage of the encounter count returned from NJMMIS, the hospital's attestation is placed into a pending status and additional supporting information is requested from the provider. Verification of overall encounter counts are done in the post-payment review process since New Jersey has not finalized an interface with the State's all hospital information database to perform pre-payment verifications of overall hospital patient volumes. New Jersey Medicaid is working towards establishing this interface.
Practitioners must not be hospital-based	<i>Pre-Payment for Medicaid encounters only and post-payment for all encounters</i> . The New Jersey EHR Incentive Program Attestation Application determines the percentage of a provider's services performed in a hospital-based setting based on fee for service claims and managed care encounter claims housed within the NJMMIS. If 90% or more of a provider's Medicaid claims in the NJMMIS are determined to be hospital-based, the provider will not be able to proceed through the remainder of the attestation process. Verification of hospital-based status for total claims is done as part of the post-payment review process.	<i>Not applicable.</i>
If a practitioner is a physician assistant, he or she must practice in an FQHC or RHC led by a physician assistant	<i>Not Applicable</i> to New Jersey since physicians assistants are not eligible for reimbursement from New Jersey Medicaid.	<i>Not applicable.</i>
Hospitals must have an average length of stay of 25 days or less (acute care hospitals only)	<i>Not applicable.</i>	<i>Post-payment verification only</i> . While New Jersey does have an all hospital information database, New Jersey Medicaid is not currently able to access the required information from this database to perform pre-payment verification of this information. New Jersey Medicaid is working towards establishing this interface. The current post-payment review process includes review of the admit and discharge dates of hospital encounters to verify the average is less than 25 days.



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Table C.1 (Continued): New Jersey Attestation Verification Procedures

Verification Criteria	Eligible Professionals	Eligible Hospitals
Practitioners and hospitals must adopt, implement, or upgrade EHR technology	Post-payment verification only . Providers and hospitals are strongly encouraged to upload contracts or agreements with their EHR vendor showing the commitment to adopt, implement, or upgrade EHR technology. The post-payment review process includes a review of the progress providers have made in adopting, implementing or upgrading their EHR systems. If the provider or hospital has attested to implementing or upgrading, the post payment review includes a demonstration of the provider or hospital's EHR system.	
Practitioners and hospitals must have certified EHR technology	Pre-payment verification since The EHR Incentive Program Attestation Application includes a real-time web service to the Certified Health IT Project List to verify the CHPL certification ID as it is entered into the attestation application. If the CHPL certification ID is not able to be verified the professional or hospital will not be able to proceed further with their attestation.	
Providers must render 50% of their total encounters in a location with certified EHR technology	Post-payment verification only. New Jersey's online attestation application has been upgraded to allow provider working in multiple locations to enter the number of total encounters conducted at each individual location. Since New Jersey does not have an all-payer claims database, the New Jersey Medicaid EHR Incentive Program cannot verify these encounter counts prior to payment. The information entered into the attestation application provider a base that can be used in post-payment review.	Not Applicable

In addition to the criteria discussed above, New Jersey's EHR Incentive Program Attestation Application includes the capability to capture and store within a local database all the provider attestation data and history of registration data, including the capture, validation and storage of all defined meaningful use clinical measurements. For Year 2 payments, the application will not only require the reporting of all mandated clinical measurements, but will also compare these clinical measurements against the minimum thresholds providers are required to meet to demonstrate meaningful use. In addition, New Jersey Medicaid has contracted with Mercadien P.C. Certified Public Accountants of Hamilton, New Jersey to conduct post-payment verifications of provider attestation information. Mercadien P.C. Certified Public Accountants p uses both random sampling and risk-based criteria when determining which provider attestation data will be reviewed. These reviews may include data uploaded into the NJMMIS and EHR Incentive Program Attestation Application, and onsite reviews.

Question C-4

How will the SMA communicate to its providers regarding their eligibility, payments, etc?



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There are several outlets available for New Jersey Medicaid to communicate with providers regarding all aspects of the New Jersey Medicaid EHR Incentive Program: the Program's statewide public website (<http://www.state.nj.us/health/njhit/ehr/incentive-program/>), New Jersey Medicaid's MMIS website (www.njmmis.com), the New Jersey Medicaid EHR Incentive Program Attestation Application, dedicated fiscal agent provider services staff, and a generic state e-mail address (mahs.ehrincentives@dhs.state.nj.us). Below are descriptions of each of these entity's roles in ensuring timely, accurate assistance through the entire registration and attestation process.

Statewide Public Website (<http://www.state.nj.us/health/njhit/ehr/incentive-program/>): This website is intended to supply providers with the high level detail needed to determine if they are eligible to attest for New Jersey Medicaid EHR Incentive Program payments. The front page of the site includes a section for "Program News" which provides updates regarding eligibility processes and procedures and regular updates on the number of providers receiving New Jersey Medicaid EHR Incentive Program payments and the total amount of these payments. The front page also has links to user guides for the National Level Repository, the New Jersey EHR Incentive Program Attestation Application, worksheets to assist providers in preparing to attest, and CMS and New Jersey frequently asked questions on the Incentive Program. On the left hand side of this screen there are choices to get additional information on the eligible professional (EP) or eligible hospital (EH) portion of the Program.

The eligible professional section of the website includes information on the following topics:

- *What is Certified EHR Technology?* – Defines a certified EHR based on ONC descriptions and includes links to ONC's certified HIT Product List (CHPL) and to the current eligible professional meaningful use criteria.
- *Am I Eligible?* – Overview of the provider types eligible for a New Jersey Medicaid EHR Incentive Program payment and the Medicaid patient volume requirements needed to receive payments (30% for most professionals, 20% for pediatricians).
- *Calculating Patient Volume* – Provides the definition of an encounter for EHR Incentive Program purposes (for New Jersey, this is a unique patient, date of service, place of service combination), examples of how to count encounters, the definition of a Medicaid patient encounter (including clear language stating that only Title XIX "Traditional Medicaid" encounters can be included in Medicaid patient encounter counts), the definition of "Needy Individual" patient encounters and the types of providers that are eligible to use this patient volume measure, how to calculate a patient volume percentage based on all of the



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various encounter definitions, scenarios where a group patient volume may be used to establish Incentive Program eligibility, and some additional patient volume considerations (including the statement that all attestation information is subject to audit).

- *Meaningful Use Requirements for Eligible Professionals* – Discusses the definitions of adoption, implementation, and upgrading of certified EHR technology needed to receive an initial New Jersey Medicaid EHR Incentive Program payment, a brief overview of meaningful use (with another link to the eligible professional meaningful use criteria on the CMS website), and the requirement that 50% of a provider's encounters occur at locations with certified EHR technology in order to be eligible for an EHR incentive payment.
- *Payment Schedule* – Provides the annual Medicaid EHR Incentive Program payment schedule for full payments, states that pediatricians are eligible for 2/3 payments if their Medicaid patient volume is between 20% and 30%, and provides the timing of provider payments once attestations are submitted.
- *Registration* – Provides an overview of the CMS National Level Repository registration process, the information needed to complete this process, and the information needed to complete New Jersey specific registration criteria (Medicaid provider ID, registration of electronic banking details, etc.)
- *Attestations* – Overview of the attestation process, including the criteria eligible professionals are attesting to meet (provider type, patient volume, certified EHR technology requirements, etc.), acceptable formats for attaching information to an attestation (not mandatory but strongly encouraged for contracts that show the adoption, implementation, or upgrading of certified EHR technology, and the definition of adopting, implementing, or upgrading certified EHR technology.
- *Audit Process* – Descriptions of the attestation information checked before an EHR Incentive Program payment is distributed, information that will be checked in post-payment review, and the process for correcting overpayments.
- *Appeals Process* – Overview of the process to appeal any decision made at any point during the EHR Incentive Program, including (but not limited to) eligibility determinations and payment calculations.

The eligible hospitals section of the website includes information on the following topics:

- *What is Certified EHR Technology?* – Defines a certified EHR based on ONC descriptions and includes links to ONC's certified HIT Product List (CHPL) and to the current eligible hospital meaningful use criteria.
- *Am I Eligible?* – Overview of the hospital types eligible for a New Jersey Medicaid EHR Incentive Program payment and the Medicaid patient volume requirements



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- needed to receive payments (10% of acute care and emergency department encounters only, except for children's hospitals).
- *Calculating Patient Volume* – Provides the definition of an encounter for EHR Incentive Program purposes (for New Jersey, acute care services rendered per inpatient discharge), examples of how to count encounters, the definition of a Medicaid patient encounter (including clear language stating the only Title XIX "Traditional Medicaid" encounters can be included in Medicaid patient encounter counts), and some additional patient volume considerations (including the statement that all attestation information is subject to audit).
 - *Meaningful Use Requirements* – Discusses the definitions of adoption, implementation, and upgrading of certified EHR technology needed to receive an initial New Jersey Medicaid EHR Incentive Program payment, a brief overview of meaningful use (with another link to the hospital meaningful use criteria on the CMS website).
 - *Incentive Payment Calculation* – Discusses the information needed for hospitals to calculate their overall Medicaid EHR Incentive Program payment, includes a link to CMS's guidance on Medicaid hospital incentive payment calculations, states that all information included in a hospital's attestation is subject to audit, and provides recommended sources for hospital payment calculation information.
 - *Payment Schedule* – Provides the distribution of a hospital's overall calculated EHR Incentive Program payment (50% year 1, 40% year 2, 10% year 3) and the timing from attestation submission to payment distribution.
 - *Reassignment of Incentive Payments* – States there are no other entities that can receive hospitals' New Jersey EHR Incentive Program payments (including RECs).
 - *Registration* – Provides an overview of the CMS National Level Repository registration process, the information needed to complete this process, and the information needed to complete New Jersey specific registration criteria (Medicaid provider ID, registration of electronic banking details, etc.)
 - *Attestations* – Overview of the attestation process, including the criteria eligible hospitals are attesting to meet (hospital type, patient volume, certified EHR technology requirements, etc.), acceptable formats for attaching information to an attestation (not mandatory but strongly encouraged for contracts that show the adoption, implementation, or upgrading of certified EHR technology, and the definition of adopting, implementing, or upgrading certified EHR technology.
 - *Audit Process* – Descriptions of the attestation information checked before an EHR Incentive Program payment is distributed, information that will be checked in post-payment review, and the process for correcting overpayments.



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- *Appeals Process* – Overview of the process to appeal any decision made at any point during the EHR Incentive Program, including (but not limited to) eligibility determinations and payment calculations.

New Jersey Medicaid MMIS Website (www.njmmis.com): Providers utilize this website to enter the secure provider portal that includes general information on the New Jersey Medicaid EHR Incentive Program and updates and a link to access the New Jersey Medicaid EHR Incentive Program Attestation Application. Single sign on capabilities allow the attesting provider to access the New Jersey Medicaid EHR Incentive Program Attestation Application using the same user ID and password the provider uses to access the secure area of the New Jersey Medicaid website.

New Jersey Medicaid EHR Incentive Program Attestation Application: This is the system that providers will use to enter their attestation information. Once an attestation is submitted, the Application sends e-mails to providers informing them of the following status updates:

- State receipt of a successful registration with the National Level Repository (NLR)
- Errors occurred when processing a provider's NLR registration
- Successful submission of a New Jersey Medicaid EHR Incentive Program attestation
- Acceptance of a New Jersey Medicaid EHR Incentive Program attestation
- Attestation failure and reasoning for the failure
- Distribution of a New Jersey Medicaid EHR Incentive Program payment

Fiscal Agent Provider Services Representatives: There is a dedicated EHR Incentive Program option on New Jersey Medicaid fiscal agent's Provider Services Call Center menu. Selecting this option will direct the provider to one of several fiscal agent representatives that are available during normal business hours to provide technical assistance and answer any other provider questions related to the New Jersey Medicaid EHR Incentive Program. These representatives have guided providers through the NLR registration and New Jersey Medicaid attestation processes, provided clarification on how Medicaid encounters are defined for the Medicaid EHR Incentive Program, and attempt to provide any other assistance requested or refer the provider to another section of the fiscal agent or pertinent party that can provide assistance (usually National Level Repository or New Jersey Medicaid staff).



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Generic State E-Mail Address (mahs.ehrincentives@dhs.state.nj.us): Providers that have issues that can't be adequately solved by any of the other available means of communication can send an e-mail to this address describing their issues and it is reviewed by New Jersey Medicaid EHR Incentive Program staff, with a response usually sent within 24-48 hours of initial submission. Issues sent to this e-mail address include requests for further consideration of attestation denials based on patient volume, requests from providers to receive their provider-specific "Traditional Medicaid" proxy percentage (used to approximate the number of Title XIX encounters a provider has seen, see the response to Question C-5 below for more information), and other technical program issues.

Question C-5

What methodology will the SMA use to calculate patient volume?

New Jersey Medicaid will use the patient encounter method prescribed in the Final Rule for calculating patient volume. The method is summarized as follows:

Per the final rule eligible providers will divide the *total Medicaid patient encounters* in any representative, continuous 90-day period within a calendar year, by the *total patient encounters* in the same 90-day period. A Medicaid patient encounter is defined as a distinct patient, date-of-service, and place-of-service combination where Medicaid fee-for-service, Medicaid managed care or a Medicaid demonstration project (under section 1115 of the Act) paid for part or all of the service (including part of their premiums, co-payments, and/or any cost-sharing). Updated regulations also gave states the option to use a patient volume calculation methodology that used a 90-day period in the 12 months prior to the date of attestation instead of a 90-day period in the calendar year prior to the attestation. Based on a time lag in receiving fee-for-service claims and encounter transactions from New Jersey Medicaid's managed care organization, it would be impossible for the New Jersey Medicaid EHR Incentive Program to perform pre-payment validations of eligible professionals' submitted Medicaid patient volume information if New Jersey allowed its eligible professionals to use a 90 day period in the 12 months immediately preceding the date of attestation. Given this concern, New Jersey is maintaining its policy of using a 90 day period in the calendar year immediately prior to the attestation year for its eligible professional patient volume calculation.



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As part of the State's effort to increase program participation in CY2016, New Jersey, with approval from CMS, is now allowing the option for new eligible professionals (EPs) intending to attest for their first Medicaid EHR Incentive Program payment, to use a continuous 90-day period in the 12-months preceding the attestation to establish their Medicaid patient volume. New participating providers may select this option in place of the current preceding calendar year reporting period method. This change was approved by CMS with the following provisions:

- In order to verify Medicaid volume eligibility, the State will conduct pre-payment inspections for all attestations that utilized the 12-month volume "look-back" period.
- If the 12-month volume look-back period falls under the preceding calendar year of attestation, the attestation will undergo the currently established volume reporting attestation process.
- The 12-month volume look-back period option will only be made available in calendar year 2016 and only for EPs attesting for their first Medicaid EHR Incentive Program payment.
- For practices with new EPs and other EPs that previously participated in the EHR Incentive Program, new EPs will attest utilizing a group proxy with a 12-month look-back volume reporting period and returning EPs will use group proxy with the previous calendar year volume reporting period.
- Returning EPs that reported a 90-day patient volume using the 12-month look-back period in CY2016 will be instructed to report a 90-day patient volume using the preceding calendar year in their subsequent attestation years.

Eligible Hospitals (EHs) will use the same calculation described above, except the valid calculation must be within a hospital's fiscal year, and some additional clarifications to the final federal rule have been issued by CMS based on issues included in other states hospital calculations. New Jersey Medicaid and its fiscal agent will work with CMS to ensure its calculation is based on the most current CMS guidance. Generally, an EH Medicaid encounter is defined as services rendered to an individual per inpatient discharge or in an emergency department where Medicaid or a Medicaid demonstration project under section 1115 paid for part or all of the service (including part of their premiums, co-payments, and/or any cost-sharing). Based on a time lag in receiving fee-for-service claims and encounter transactions from New Jersey Medicaid's managed care organization, it would be impossible for the New Jersey Medicaid EHR Incentive Program to perform pre-payment validations of eligible hospitals' submitted Medicaid patient volume information if New Jersey allowed its eligible hospitals to use a 90 day period in the 12 months immediately preceding the date of attestation. Given this



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concern, New Jersey is maintaining its policy of using a 90 day period in the federal fiscal year immediately prior to the attestation year for its patient volume calculation.

Since New Jersey has a large Medicaid managed care program that pays for both Title XIX Medicaid and Title XXI CHIP encounters, most New Jersey providers are unable to differentiate their Medicaid paid encounters between Title XIX "Traditional Medicaid" and Title XXI "CHIP" because the payments they receive from our managed care organizations for patients in both programs look exactly the same. However, the HITECH Act only allows providers to include Title XIX "Traditional Medicaid" patient encounters in meeting the 30% Medicaid patient volume threshold needed to be eligible for Medicaid EHR Incentive Program payments. While most providers are unable to divide their encounters between the two programs, the State's systems must do this differentiation for our reporting to CMS.

Since only the State has this information that is vital to completing an accurate EHR Incentive Program attestation, New Jersey Medicaid established a "Title XIX" proxy value. This value is calculated by taking the percentage of claims billed for each NPI for an entire calendar year and dividing them up between Title XIX and CHIP based on the program status code of the patient on the fee-for-service claim or managed care encounter claim. Every NPI that is included in the billing provider field for claims in NJMMIS has a calculated proxy value, so every group provider, individual provider, and hospital can receive their own unique non-CHIP percentage. At the outset of the program, providers had to request this value via an e-mail to mahs.ehrincentives@dhs.state.nj.us, which resulted in several providers attesting without using the proxy to take out their CHIP encounters. To solve this problem, effective June 1, 2012, the "Title XIX" proxy value is automated into the New Jersey Medicaid EHR Incentive Program Attestation Application work process. Providers are now instructed to enter their total patient encounter counts (both Medicaid and CHIP). Once a provider enters their patient encounter count into the Attestation Application, it will retrieve the applicable non-CHIP percentage via a web service and compute the Title XIX-only encounter count based on either the individual provider NPI, group practice NPI (if the provider elects to use a group practice proxy), or hospital NPI.

Effective April 1, 2015, New Jersey was approved by CMS to define a statewide Title XIX/CHIP Proxy percentage value, to be used to populate proxy values for EP's that have no Title XIX/CHIP Proxy percentage calculated by the New Jersey EHR Incentive Program attestation application. As described above, the portal utilized by EPs for EHR Incentive Program attestations, is currently programmed to populate the Title XIX/CHIP Proxy



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percentage for individual EPs based on the percentage of claims billed for a National Provider Identification (NPI) number associated with a group practice or the percentage of claims serviced for EPs opting to use their own individual patient volume. In all cases, the proxy calculation is based on an entire calendar year of activity. If a proxy value is available, the system automatically populates and excludes CHIP patients from the EP's overall Medicaid volume percentage calculation. However, there is a subset of EPs eligible for the New Jersey Medicaid EHR Incentive Program that do not have managed care encounters processed by the New Jersey MMIS and, therefore, do not have a pre-populated Title XIX Proxy percentage. The claims for these providers are generally processed through entities that enter into a subcontracting relationship with a New Jersey Medicaid managed care plan. Currently, for these EPs, the proxy percentage is manually calculated. The manual CHIP proxy calculation is a resource intensive process that is accomplished by identifying the coverage (Title XIX vs. CHIP) for every single Medicaid beneficiary in the EP's selected 90 day patient volume period.

As approved by CMS a statewide Title XIX/CHIP Proxy percentage value will be used to populate proxy values. The total number of claims for all NPI for an entire calendar year will be divided between Title XIX and XXI with the resulting percentage of Title XIX encounters being defined as the statewide CHIP proxy.

Providers practicing predominantly in an FQHC (New Jersey has no RHCs) will be evaluated according to their "needy individual" patient volume as defined in 1903(t)(3)(F). To calculate needy individual patient volume, an EP must divide the total needy individual patient encounters in any representative, continuous 90-day period within a calendar year by the total patient encounters in the same 90-day period. Since both Title XIX Medicaid and CHIP encounters are included in the regulatory definition of "needy individual", providers using this methodology for calculating patient volume will not be required to use the "Title XIX" proxy value as part of their attestation.

New Jersey does not plan to offer providers the option of calculating patient volume using the patient panel method described in the Final Rule but will request providers to include both fee-for-service claims and managed care encounters in their submitted patient volumes. New Jersey Medicaid receives regular managed care encounter information from its managed care organizations that will allow the State to verify the combined fee-for-service and managed care patient volumes submitted by the providers prior to approving their attestations. The patient encounter methodology will provide a better measure of the mix of patients actually receiving treatment from an individual provider or group practice than the patient panel methodology. Using the encounter methodology will also better ensure that Medicaid EHR incentive payments are sent to



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providers actively supplying medical services to the required percentage of Medicaid beneficiaries.

Providers will use the EHR Incentive Program Attestation Application within the NJMMIS Provider Portal to enter their patient volume data. Once this data is entered, the Attestation Application will use a web service to access the provider's complete NJMMIS adjudicated fee-for-service claim and managed care encounter data housed within the NJMMIS Decision Support System (DSS). The DSS will return an unduplicated count of patient claims and encounters for the 90 day attestation period. This unduplicated count will then be compared to the patient volumes reported by the provider. If the DSS calculation determines a provider is ineligible to receive an incentive payment, the provider is asked to send the detail supporting their patient volume measurement to the State for additional review. If the supporting detail reviewed by the State appears to be reasonable, is retrieved from an auditable data source, and confirms the patient volume counts entered into the Attestation Application, the attestation will be approved by the State and sent to CMS for final verification.

Question C-6

What data sources will the SMA use to verify patient volume for EPs and acute care hospitals?

New Jersey Medicaid is using the complete adjudicated fee-for-service claim and managed care encounter data housed within the NJMMIS DSS to verify the Medicaid patient volumes included in provider attestations. When providers input patient volume information for their attestation period, the EHR Incentive Program Attestation Application will access the data residing within the NJMMIS DSS to determine an unduplicated patient count. This count will then be returned to the attestation application where it is compared against the provider-reported patient volumes. If the Medicaid patient encounter count entered by the provider is within a certain range of the patient encounter counts returned by the NJMMIS DSS, the provider's Medicaid patient volume will be accepted and moved to other pre-payment verification processes.

Since New Jersey does not have an all payer claims database that could facilitate pre-payment verification of the overall patient encounters entered by providers, this verification will occur as part of the post-payment review process conducted by Mercadieu P.C. Certified Public Accountants. Every eligible hospital that receives EHR



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Incentive Program payments will be subject to post-payment reviews for each year of payment. Post-payment reviews for eligible professionals are based on both risk-based and random selection criteria to ensure the review of a representative cross-section of attestations. The post-payment review process is discussed in greater detail in Section D of this document.

Question C-7

How will the SMA verify that EPs at FQHC/RHCs meet the practices predominately requirement?

There are no rural health centers in New Jersey, so this response will only discuss FQHCs.

The New Jersey EHR Incentive Program Attestation Application requires providers to first attempt to meet the 30% Medicaid patient volume threshold before opening screens for providers to establish that they practice predominantly in an FQHC. Since most of New Jersey's FQHCs meet the 30% Medicaid patient volume threshold, there are very few providers that should have to attest using the needy individual patient methodology.

For those providers that will use the needy individual patient volume methodology, the New Jersey Medicaid EHR Incentive Program is unable to verify that providers meet the practicing predominantly requirements prior to distributing payments since New Jersey does not have an all-payer claims database. As part of the post-payment review process, the state's contracted audit entity (Mercadien P.C. Certified Public Accountants) will review the information used by the provider to establish that they practice predominantly in an FQHC and determine whether these providers were eligible to use the needy individual patient volume methodology in their attestations.

Question C-8

How will the SMA verify adopt, implement or upgrade of certified electronic health record technology by providers?

Two distinct methods will be used by New Jersey Medicaid to verify provider attestations to the adoption, implementation, or upgrading of certified EHR technology.



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As part of the attestation process, the New Jersey Medicaid EHR Incentive Program Attestation Application will prompt providers to indicate whether they have adopted, implemented or upgraded their EHR system to be eligible for their year 1 incentive payment. The application will then use the Certified HIT Product List (CHPL) web service to validate, in real time, that the provider's EHR system is certified by the Office of the National Coordinator (ONC). The application will not allow a provider to move further in the attestation process if their chosen system is not on the certified list. Based on the introduction of new certification numbers for EHR systems meeting ONC's 2014 Edition Certified EHR Technology (CEHRT) certification criteria, this real time check has been upgraded to allow the differentiation of 2014 ONC certification number from other certification numbers. For calendar year 2014 attestations and beyond for eligible professionals and federal fiscal year 2014 attestations and beyond for eligible hospitals, only attestations that include a 2014 ONC certification number will pass this real time check and be permitted to move to the next attestation step. The application will be updated to accept 2015 Edition CEHRT as per the regulations published in the Stage 3 and Modifications to Meaningful Use in 2015 Through 2017.

Providers are also strongly recommended to upload their EHR system agreements that show the adoption, implementation, or upgrade of their certified systems as part of the attestation process. These uploads are included as part of the post-payment review process. For providers that attest to the implementation or upgrade of their certified EHR systems, the post-payment review process also includes a brief demonstration that the EHR system is in active use (for implementation) or a demonstration of the upgrade capabilities included in the providers' attestation.

Question C-9

How will the SMA verify meaningful use of certified electronic health record technology for providers' second participation years?

New Jersey's EHR Incentive Program Attestation Application includes the capability to capture and store all provider attestation data, including all defined meaningful use clinical measurements. The solution will also require the reporting of all mandated clinical measurements needed for providers to receive their year 2 incentive payments and will compare the submitted clinical measurement data to the minimum thresholds providers need to meet to show meaningful use.



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The verification of meaningful use will occur via the post-payment review process conducted by the State's contracted audit entity (currently Mercadien P.C. Certified Public Accountants). This entity will only be performing meaningful use reviews for eligible professionals; CMS has indicated that their audit group will perform the meaningful use reviews for Medicaid-only and dual Medicaid and Medicare eligible hospitals. Since New Jersey only began distributing meaningful use payments in May 2012, no post-payment meaningful use reviews have been conducted to date.

The New Jersey Medicaid EHR Incentive Program has implemented the screens and checks necessary to accept attestations to Stage 2 meaningful use and Mercadien P.C. Certified Public Accountants are prepared to begin reviewing Stage 2 meaningful use attestations.

Question C-10

Will the SMA be proposing any changes to the MU definition as permissible per rule-making? If so, please provide details on the expected benefit to the Medicaid population as well as how the SMA assessed the issue of additional provider reporting and financial burden.

New Jersey Medicaid will not request any modifications to the federal requirements for the demonstration of meaningful use through the period ending September 30, 2015.

Question C-11

How will the SMA verify providers' use of certified electronic health record technology?

The EHR Incentive Program Attestation Application uses the Certified Health IT Product List (CHPL) web service to validate that the EHR system selected by each provider has received ONC certification and will not let the provider move forward in the attestation process if the provider does not have a CHPL certification number. Since the initial requirements to receive an incentive payment only mandates that providers attest to their adoption, implementation, or upgrade of certified EHR systems, New Jersey Medicaid will verify their attestations through the post-payment audit process. The details of this portion of the post-payment review process are discussed in further detail in section D of this document. See the response to Question C-8 for additional detail for



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the verification of provider use of EHR technology that meets ONC's 2014 and 2015 Edition certification requirements.

Question C-12

How will the SMA collect providers' meaningful use data, including the reporting of clinical quality measures? Does the State envision different approaches for the short-term and a different approach for the longer-term?

New Jersey has a single, web-based process for the collection of provider meaningful use data as part of its EHR Incentive Program Attestation Application. This Application will be used to collect provider meaningful use data over the life of the program and will be appropriately configured to present the attesting provider with the meaningful use criteria specific to their payment year, with additional requirements able to be added based on the promulgation of additional federal meaningful use regulations. The attestation application has been enhanced to require eligible professionals to upload Meaningful Use reports/dashboards as supporting documentation to complete the attestation process.

Question C-13

How will this data collection and analysis process align with the collection of other clinical quality measures data, such as CHIPRA?

New Jersey Medicaid will work to coordinate the data collection and analysis processes for all health quality information, including CHIPRA and any other information received.

Question C-14

What IT, fiscal and communication systems will be used to implement the EHR Incentive Program?

New Jersey Medicaid leveraged the incentive payment administrative solution originally deployed in West Virginia by its current fiscal agent, Molina Healthcare, Inc. to facilitate a rapid system development period and begin the distribution of Medicaid EHR Incentive Program payments as quickly as possible after its November 2011 launch of



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National Level Repository registrations. The New Jersey Medicaid EHR Incentive Program is also taking advantage of the current IT, fiscal and communication infrastructures in NJMMIS and within the State's IT infrastructure to implement and operate the Program.

Additionally, the NJMMIS Decision Support System that houses provider data will be used to confirm provider eligibility and NJMMIS adjudicated fee-for-service claim and managed care encounter data will be used to verify patient volume data submitted by the provider.

Finally, the NJMMIS fiscal applications will be used to apply the appropriate federal matching percentages for incentive payments and any administrative costs to ensure the appropriate state and federal financial reporting is completed for the incentive payments and Incentive Program-related administrative costs.

Question C-15

What IT systems changes are needed by the SMA to implement the EHR Incentive Program?

The current NJMMIS provider web portal has been enhanced to support real-time interface with providers and allow them to attest for New Jersey Medicaid EHR Incentive Program payments. The portal enhancements also allow NJMMIS to interface with the National Level Repository in order to transmit registration data, attestation data, incentive payment data, and verification that providers are only receiving EHR Incentive Program payments from New Jersey Medicaid. Finally, the portal enhancements will send the appropriate provider-level data to the NJMMIS fiscal applications to facilitate issuance of incentive payments to eligible providers that have passed all pre-payment verifications.

Changes were also made to the existing NJMMIS Management and Administrative Reporting Subsystem (MARS) in order for New Jersey to uniquely identify, summarize, and appropriately report EHR Incentive Program expenditures on a new line in the CMS-64 report.



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Question C-16

What is the SMA's IT timeframe for systems modifications?

All required design, development and testing was completed in time to begin the exchange of incentive program data with the National Level Repository (NLR) in August 2011, the launch of EHR Incentive Program registrations with the NLR in November 2011, and the initial distribution of EHR Incentive Program payments in February 2012.

Question C-17

When does the SMA anticipate being ready to test an interface with the CMS National Level Repository (NLR)?

New Jersey Medicaid started testing its interface with the NLR in August 2011 and the NLR began accepting registrations for the New Jersey Medicaid EHR Incentive Program in November 2011.

Question C-18

What is the SMA's plan for accepting the registration data for its Medicaid providers from the CMS NLR (e.g. mainframe to mainframe interface or another means)?

The New Jersey Medicaid EHR Incentive Program Attestation Application process was originally designed to leverage the existing CMS GenTrans mailbox that was previously being used for the electronic exchange of Medicare crossover claims data, MSIS data, and Medicaid eligibility data with CMS to accept and respond to NLR registration transaction data and payment inquiry requests and responses. However, technical issues in establishing the required data exchanges between New Jersey Medicaid and the NLR dictated that the State implement the use of TIBCO to facilitate the required data exchanges. The specific transactions that will be exchanged include State Registration, Registration Confirmation, Dually Eligible Attestation Data, Dually Eligible Hospital Cost Report Data, Request Duplicate Payment/Exclusion Check, and Response. Additional transaction types can be added on an as-needed basis.



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Question C-19

What kind of website will the SMA host for Medicaid providers for enrollment, program information, etc?

The main website being used to communicate general and detailed program information to providers is currently housed within the Office of the Health Information Technology Coordinator's website and is located at www.nj.gov/njhit/ehr. A detailed description of the information available on this site is included in the response to question C-4.

New Jersey Medicaid has also made enhancements to its existing web-based New Jersey Provider Portal to supply additional enrollment and general program assistance and guidance to Medicaid providers. The enhanced provider portal will allow enrolled providers to do the following:

- View general EHR Incentive Program information and announcements
- Electronically complete, sign, and submit an EHR Incentive Program attestation and upload supporting documentation
- View the status of submitted attestations
- Review eligibility determinations by payment year
- View program participation and payment history

Question C-20

Does the SMA anticipate modifications to the MMIS and if so, when does the SMA anticipate submitting an MMIS I-APD?

New Jersey Medicaid anticipates few, if any, modifications will be needed to the existing MMIS to administer and continue operating the EHR Incentive Program and therefore does not anticipate needing to submit an MMIS IAPD. If there are any changes needed to the existing MMIS system New Jersey, in consultation with its CMS Regional Office and CMS HITECH Coordinator, will determine whether these changes are operational changes that can be done at 75% federal financial participation (FFP) or if they are developmental changes that would require an MMIS IAPD to request 90% FFP.



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Question C-21

What kinds of call centers/help desks and other means will be established to address EP and hospital questions regarding the incentive program?

Molina has provided additional Provider Services Call Center support to handle telephone and written inquiries received from providers related to the New Jersey Medicaid EHR Incentive Payment Program. A full-time representative dedicated to the EHR Incentive Program started in October 2011, with additional backup available from other existing Provider Services Call Center representatives. In preparation for questions related to meaningful use, additional representatives were trained to answer provider inquiries related to the EHR Incentive Program. Molina also initially planned to add a dedicated provider trainer for the Incentive Program, but technical assistance from other sources (most notably NJ-HITEC, New Jersey's Regional Extension Centers) made this provider trainer unnecessary.

Question C-22

What will the SMA establish as a provider appeal process relative to: a) the incentive payments, b) provider eligibility determinations, and c) demonstration of efforts to adopt, implement or upgrade and meaningful use certified EHR technology?

New Jersey Medicaid will leverage its current provider appeals and fair hearing process for any provider complaints related to any facet of the EHR Incentive Program, including eligibility determinations, denials based on provider failure to demonstrate efforts to adopt, implement, or upgrade and meaningfully use certified EHR technology, and issues in processing the actual incentive payments. Through September 2016, no provider appeal has entered the formal fair hearing process; all Incentive Program appeals have been handled through informal phone and e-mail discussions between providers and New Jersey Medicaid EHR Incentive Program staff.

New Jersey Medicaid will clearly communicate the basis for denying an incentive payment request and will make every effort to review the provider's entire attestation to determine if the incentive payment denial was due to an oversight in entering data into the Attestation Application or was due to a legitimate failure to meet the Incentive Program's eligibility criteria.



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The appeals process will allow providers 20 days from a formal notice of agency action to request a hearing on their complaint. The hearings will be conducted by an Administrative Law Judge from the New Jersey Office of Administrative Law and conducted pursuant to this Office's regulatory procedures with prompt, definitive, and final administrative action to be taken within 90 days from the hearing date. Providers will receive a written final decision from the Department and will have the right to pursue additional judicial review of this decision.

The only exception to this process will be for hospital appeals of meaningful use post-payment review findings. Since New Jersey Medicaid is opting to have CMS or its audit contractor perform meaningful use reviews at all hospitals receiving New Jersey Medicaid EHR Incentive Program payments, any appeals on the findings of this audit will go through CMS's provider audit process.

Question C-23

What will be the process to assure that all Federal funding, both for the 100 percent incentive payments, as well as the 90 percent HIT Administrative match, are accounted for separately for the HITECH provisions and not reported in a commingled manner with the enhanced MMIS FFP?

A separate account has been established in the New Jersey Comprehensive Financial System (NJCFS) for tracking and paying the 100% federally funded EHR incentive payments. New reporting codes uniquely identifying the EHR Incentive Program administrative and development costs will be set up in the NJCFS state and federal accounts that currently handle all of New Jersey Medicaid's IT development. All financial transactions related to the EHR Incentive Payment Program will be sent to the appropriate NJCFS account through the regular, weekly NJMMIS/NJCFS interface process.

Specific project and activity codes have been created within these accounts and integrated with contractor time-keeping systems and reporting to avoid commingling of Incentive Program and other MMIS-related expenses. Controls have also been established to ensure tracking and reconciliation policies and procedures are followed.



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Question C-24

What is the SMA's anticipated frequency for making the EHR Incentive payments (e.g. monthly, semi-monthly, etc.)?

Once approved, incentive payments are processed in the regular New Jersey MMIS weekly claims payment cycle through the same process used for Medicaid provider claims payments. Given this weekly payment cycle, an Eligible Professional or Eligible Hospital that successfully completes their registration and attestation requirements could receive their EHR incentive payment in as little as 30 days after their successful attestation submission. Issues uncovered during review of the provider's eligibility and/or documentation could extend the time from registration and attestation to payment beyond 30 days. These issues could include the inability of NJMMIS to verify the provider's Medicaid patient volume or failure to meet other pre-payment verification processes. The receipt of a large number of simultaneous EHR Incentive Program payment requests (near hospital or professional annual attestation deadlines) into the NJMMIS may also extend the time from attestation to payment distribution beyond 30 days.

Question C-25

What will be the process to assure that Medicaid provider payments are paid directly to the provider (or an employer or facility to which the provider has assigned payments) without any deduction or rebate?

The attestation process requires that the provider be identified through their National Provider Identifier (NPI) and their related New Jersey Medicaid Provider Number. Both of these identifiers will be retained as part of the attestation process. The Attestation Application also allows the provider/user to specify another provider it is associated with in the NJMMIS in order to designate the incentive payment to be made to this second provider; this will be based on the payee NPI entered into the provider's NLR registration. If Medicaid providers not currently included in the NJMMIS Provider Master Database (including managed care providers with no Medicaid fee-for-service business) wish to pursue an incentive payment, they will be required to enroll in the New Jersey Medicaid Program and receive a unique NJMMIS logon ID and password.



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Question C-26

What will be the process to assure that Medicaid payments go to an entity promoting the adoption of certified EHR technology, as designated by the state and approved by the US DHHS Secretary, are made only if participation in such a payment arrangement is voluntary by the EP and that no more than 5 percent of such payments is retained for costs unrelated to EHR technology adoption?

New Jersey Medicaid does not currently anticipate making EHR Incentive Program payments to an entity promoting the adoption of certified EHR technology. New Jersey's regional extension center will assist providers in becoming eligible to receive incentive payments and also receives payments from New Jersey Medicaid to provide meaningful use and other EHR system technical assistance to a defined number of Medicaid specialist and primary care providers that do not fall into the areas covered by their existing ONC grant funding.

Question C-27

What will be the process to assure that there are fiscal arrangements with providers to disburse incentive payments through Medicaid managed care plans does not exceed 105 percent of the capitation rate per 42 CFR Part 438.6, as well as a methodology for verifying such information?

The New Jersey Medicaid EHR Incentive Program does not disperse incentive payments through Medicaid managed care plans. If Medicaid providers not currently included in the NJMMIS Provider Master Database (including managed care providers with no Medicaid fee-for-service business) wish to pursue an incentive payment, they will be required to enroll in the New Jersey Medicaid Program and receive a unique NJMMIS logon ID and password.

Question C-28

What will be the process to assure that all hospital calculations and EP payment incentives (including tracking EPs' 15% of the net average allowable costs of certified EHR technology) are made consistent with the Statute and regulation?



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The State can require the documentation of provider expenditures within the system to qualify for the maximum incentive payment for providers. Reports can be run to determine which providers have this documentation on file. The Medicaid and Medicare Extenders Act of 2010 and recent federal guidance indicate that it is no longer necessary for states to track EPs 15% contribution towards EHR systems.

For the hospital payment calculation, the State has strongly recommended that hospitals use data from their Medicare cost reports in completing their incentive payment calculation, though, per CMS guidance, this will not be mandated. If a hospital chooses to use a different data source, it will be stressed to hospitals that the data used to perform the payment calculation must be auditable and should be maintained in their systems in the event of a post-payment review. The most recent update to the CMS guidance on hospital Medicaid EHR Incentive Program payment calculations has been posted to the state’s EHR Incentive Program website (www.nj.gov/nihit/ehr). The series of tables below walks through a sample hospital payment calculation using sample data.

Hospitals will start by calculating their three year average discharge growth rate by using the discharge amounts from their most recent completed hospital fiscal year and the three years prior, calculating each individual year’s discharge growth, adding these individual year amounts and dividing by three.

Table C.2: Sample Hospital Discharge Growth Rate

	<u>Acute Discharges</u>	<u>Change</u>
Prior Hospital Fiscal Year 1	1,800	
Prior Hospital Fiscal Year 2	1,839	2.17%
Prior Hospital Fiscal Year 3	1,877	2.07%
Most Recent Completed Hospital Fiscal Year	1,918	2.18%
<i>3 Year Avg. Discharge Growth</i>		<i>2.14%</i>

Hospitals will use this data to determine the “discharge bonus” they receive as part of each of 4 theoretical years of incentive payments. This “discharge bonus” is added to each theoretical year’s base amount of \$2 million and then multiplied by each theoretical year’s transition factor (set in federal regulation) to arrive at each theoretical year’s hospital incentive payments. These individual calculations are then added together to arrive at a hospital’s “EHR Amount”



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Table C.3: Sample Hospital EHR Amount Calculation

	<u>Payment 1</u>	<u>Payment 2</u>	<u>Payment 3</u>	<u>Payment 4</u>
Base Amount (Set by Federal Rule)	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000
Acute Discharges	1,918	1,959	2,001	2,044
3 Year Avg Annual Discharge Growth		2.14%	2.14%	2.14%
Discharge Bonus Threshold	1,149	1,149	1,149	1,149
Discharges Hospital Receives Additional Payment For	769	810	852	895
Discharge Bonus Factor	\$200	\$200	\$200	\$200
Discharge Bonus Amount	\$153,800	\$162,000	\$170,400	\$179,000
Pre-Transition Factor Amount	\$2,153,800	\$2,162,000	\$2,170,400	\$2,179,000
<i>Transition Factor (Set by Federal Rule)</i>	<i>1.00</i>	<i>0.75</i>	<i>0.50</i>	<i>0.25</i>
Base Hospital EHR Amount	\$2,153,800	\$1,621,500	\$1,085,200	\$544,750
<i>Overall Hospital EHR Amount</i>	<i>\$5,405,250</i>			

The next step is to calculate the hospital's Medicaid share. This is done by adding Medicaid fee-for-service acute inpatient bed days to Medicaid managed care acute inpatient bed days to arrive at the hospital's Total Medicaid Inpatient Bed Days. This amount is then divided by the product of the hospital's overall acute inpatient bed days and the non-charity care portion of the hospital's overall charges to arrive at the Overall Hospital Medicaid Share.



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Table C.4: Sample Hospital Medicaid Share Calculation

Medicaid Fee-For-Service Inpatient Bed Days	5,000
Medicaid Managed Care Inpatient Bed Days	2,000
Total Medicaid Inpatient Days (Medicaid Share Numerator)	7,000
<i>Total Inpatient Bed Days</i>	
	21,000
Non-Charity Care Overall Charges	
	\$8,700,000
Total Overall Charges	
	\$10,000,000
<i>Non-Charity Care Factor</i>	
	0.87
Total Non-Charity Care Inpatient Bed Days (Medicaid Share Denominator)	18,270
<i>Overall Hospital Medicaid Share</i>	<i>0.38</i>

The final step to determine a hospital's total Medicaid EHR Incentive Payment is to multiply the Overall Hospital EHR Amount shown at the bottom of table C.2 with the Overall Hospital Medicaid Share shown at the bottom of table C.3.

Table C.5: Final Sample Hospital Incentive Payment Calculation



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<u>Item</u>	<u>Value</u>
Overall Hospital EHR Amount	\$5,405,250
Medicaid Share	0.38
Aggregate EHR Incentive Payment	\$2,053,995

New Jersey will distribute the “Aggregate EHR Incentive Payment” shown in Table C.4 to hospitals over three years, with 50% being distributed in year 1, 40% in year 2, and the final 10% in year 3.

Question C-29

What will be the role of existing SMA contractors in implementing the EHR Incentive Program – such as MMIS, PBM, fiscal agent, managed care contractors, etc.?

New Jersey Medicaid has extended the role of its current Medicaid fiscal agent (Molina Health Care, Inc.) to support the design, development, implementation and operation of its EHR Incentive Program Attestation Application and the operation of the New Jersey Medicaid EHR Incentive Program itself. Molina developed, tested and performs ongoing maintenance on the Attestation Application and is also supplying provider help desk support (through the addition of one dedicated and several part-time Provider Services Call Center Representatives). Molina is also providing the necessary support to electronically distribute incentive payments to providers through the NJMMIS.

New Jersey Medicaid’s managed care contractors will be encouraged to inform their providers that incentive payments are available through New Jersey Medicaid if they meet certain patient volume and technology criteria.

Question C-30

States should explicitly describe what their assumptions are, and where the path and timing of their plans have dependencies based upon:

- *The role of CMS (e.g. the development and support of the National Level Repository; provider outreach/help desk support)*



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- *The status/availability of certified EHR technology*
- *The role, approved plans and status of the Regional Extension Centers*
- *The role, approved plans and status of the HIE cooperative agreements*
- *State-specific readiness factors*

New Jersey Medicaid is dependent on several entities to ensure continued operations of its EHR Incentive Program:

CMS assistance is needed to review and approve this SMHP update and the subsequent Implementation Advance Planning Document update that will serve as New Jersey's request to receive 90% HITECH federal financial participation for the administration of the Medicaid EHR Incentive Program. New Jersey will also be relying on CMS to ensure the availability of the NLR to provide the ability to identify and prevent payments to providers that may have already registered for and/or received an incentive payment from Medicare or another state's Medicaid program and identify hospitals who have been deemed meaningful users under the Medicare EHR Incentive Program and who do not need further verification to receive a Medicaid EHR incentive payment. Finally, CMS written guidance and support personnel are needed to assist New Jersey Medicaid and other stakeholders with questions and issues related to NLR registration or general attestation questions that may arise.

EHR vendors are needed to continue developing their certified EHR systems in order to allow professionals and hospitals to achieve the meaningful use criteria required to maintain their incentive payments beyond year 1.

The Regional Extension Center is needed to educate the provider and hospital community about the benefits of EHRs, consult with interested practices falling within the scope of their ONC grant to select an appropriate EHR system, and provide technical guidance and other support to assist these practices in meaningfully using their EHR systems.



Section D: New Jersey's Audit Strategy

Question D-1

Describe the methods the SMA will employ to identify suspected fraud and abuse, including noting if contractors will be used. Please identify what audit elements will be addressed through pre-payment controls or other methods and which audit elements will be addressed post-payment.

For a full detailing of the pre- and post-payment audit processes being used by New Jersey Medicaid to ensure federal regulatory compliance when distributing incentive payments, please see Table C.1. and the State's separate EHR Incentive Program Audit Strategy originally approved by CMS in June 2013, and subsequently updated and approved in August 2016.

Some pre-payment reviews are done systematically by New Jersey Medicaid's fiscal agent (Molina HealthCare, Inc.) through the NJMMIS, associated decision support system, and systematic interfaces with the National Level Repository. This includes reviews of general provider eligibility criteria, Medicaid patient encounter counts, and EHR certification numbers. There are certain attestations that receive full pre-payment audits performed by the State's contracted audit vendor, Mercadien P.C. Certified Public Accountants ("Mercadien"). Generally, but not always, these full pre-payment audits are triggered when providers do not pass the NJMMIS automated pre-payment Medicaid patient volume check and are unable to provide sufficient documentation supporting the patient encounter counts included in their attestation. In a full pre-payment audit, Mercadien goes through their entire post-payment audit process, including assessment of risk, reviews of provider eligibility, patient volume, and the appropriate EHR technology criteria (adopt, implement, upgrade, or meaningful use).

The audit triggers for the EHR Incentive Program will be different than those used for overall Medicaid audit determinations since there are different eligibility and payment guidelines and measures being used by the EHR Incentive Program.

All formal attestation reviews are conducted by Mercadien (www.mercadien.com). A contract with Mercadien is in place and they have been conducting post-payment reviews of EHR Incentive Program attestations for eligible hospitals since February 2012 and for eligible professionals since March 2012. Post-payment reviews of meaningful



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use attestations for eligible professionals began in August 2012. For eligible hospitals, the state has chosen to have CMS or its audit contractor conduct the post-payment reviews for meaningful use in conjunction with its review of eligible hospital Medicare EHR Incentive Program attestations and the State (via Mercadien) will review the other criteria necessary to be eligible for a Medicaid EHR Incentive Program payment, including patient volume, licensing, sanction/exclusion status, average length of stay, etc. New Jersey Medicaid acknowledges that any hospital appeals related to hospital meaningful use reviews performed by CMS's audit contractor will be subject to CMS's appeals process.

The agreement with Mercadien includes post-payment review of every successful eligible hospital attestation and post-payment or full pre-payment reviews of up to 500 successful eligible professional attestations, which New Jersey Medicaid estimates will represent about 1 out of every 6 successful attestations. The eligible professional reviews include risk-based and random reviews. The main criteria for selection of the risk-based reviews is patient volume, since provider offices may be unaware of the specific Medicaid EHR Incentive Program regulatory definition of a patient encounter despite this information being available through several different sources. All eligible professionals that attest to Medicaid patient volumes within 5% of the applicable minimum regulatory threshold will be subject to post-payment review. For pediatricians, this includes attestations with 19.5-25% Medicaid patient volume; for all eligible professionals (including pediatricians), this includes attestations with 29.5-35% Medicaid patient volumes. In addition to these risk-based reviews, additional reviews in a given 12 month period will be randomly selected from the remaining successful attestations.

Question D-2

How will the SMA track the total dollar amount of overpayments identified by the State as a result of oversight activities conducted during the FFY?

The NJMMIS financial application supports extensive online query and tracking capabilities relative to the recovery of any overpayments due from the provider. The fact that any transactions created to recover New Jersey Medicaid EHR Incentive Program overpayments will be uniquely identifiable will permit State staff to specifically target and track the recovery of provider incentive overpayments. The recovery of overpayments from the provider will be managed through this NJMMIS application.



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Once the amount of an overpayment has been determined through the post-payment review process, the New Jersey Medicaid EHR Incentive Program Director initiates a financial transaction that is approved by the New Jersey Medicaid CFO and will be entered into the Financial Master File to indicate the amount of the overpayment that needs to be recovered from the provider. The attestation application was enhanced to allow the New Jersey Medicaid EHR Incentive Program Director or designee to process the payment adjustments directly from the attestation application. This new process will eliminate the manual step, and any potential data entry errors that may occur from generating a financial transaction manually and data entry into the Financial Master File.

The NJMMIS financial application includes extensive flexibility in defining the rules for the recovery of the overpayment. New Jersey Medicaid will have the option to:

- Recover without limitation the amount of the overpayment from future payments to the provider
- Set a dollar limit as to the amount of the weekly payment due to the provider that can be used to recover the overpayment
- Set a percentage of the amount of the weekly payment due to the provider that can be used to recover the overpayment
- Report a refund of the overpayment that is received from the provider.

Each recovery may need to be handled differently based on the amount that needs to be recovered and the size of the entity responsible for the recovery (large hospital vs. small hospital, large independent hospital-owned group practices or FQHCs vs. smaller, independent provider practices). Regardless of the customized nature of the recovery process, New Jersey will aggressively pursue all overpayments and attempt to complete recovery in the shortest possible timeframe.

Every audit performed, regardless of outcome, will be noted on the audited provider's attestation record in the EHR Incentive Program Attestation Application.

Question D-3

Describe the actions the SMA will take when fraud and abuse is detected.



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Any fraud or abuse detected as part of the Incentive Payment Program will be referred to the New Jersey's Attorney General's Office and the New Jersey Office of the State Comptroller's Medicaid Fraud Division. Suspected cases of fraud and abuse (e.g., unacceptable practices under State regulations or statute) will be handled similarly to all other current allegations of fraud and abuse, including, but not limited to, the conduct of investigations, issuance of warning letters, imposition of penalties or other sanctions, exclusions and terminations from the New Jersey Medicaid Program.

Question D-4

Is the SMA planning to leverage existing data sources to verify meaningful use (e.g. HIEs, pharmacy hubs, immunization registries, public health surveillance databases, etc.)? Please describe.

New Jersey Medicaid plans to leverage the State's public health databases to help verify meaningful use, including the New Jersey Department of Health immunization registry and syndromic surveillance and electronic lab reporting systems. They will be testing with providers and hospitals and we will therefore be able to leverage that process to verify the public health meaningful use categories.

New Jersey Medicaid also anticipates collaborating with NJHIN and the regional HIOs to assist in the verification of future meaningful use phases.

Finally, New Jersey may also use SureScripts data available through the Office of the National Coordinator to verify providers are meeting meaningful use measures related to E-prescribing.

Question D-5

Will the state be using sampling as part of audit strategy? If yes, what sampling methodology will be performed? (i.e. probe sampling; random sampling)

In performing the post-payment inspections, Mercadien determines sample sizes based on risk level (moderate or high) for each provider. The risk level is based on multiple factors including Medicaid volume percentages (Medicaid volumes within five percentage points of the minimum requirement are high risk) and other factors (EP



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understanding of and application controls over EHR system). Once the sample size is determined, Mercadien selects a random sample for testing. The selection of the test encounters is made using the random number function (“RAND”) in Microsoft Excel.

Question D-6

What methods will the SMA use to reduce provider burden and maintain integrity and efficacy of oversight process (e.g. above examples about leveraging existing data sources, piggy-backing on existing audit mechanisms/activities, etc)?

The burden on providers to supply information is mitigated by the pre-payment review activities New Jersey Medicaid undertakes that leverages the following existing data sources:

- NJMMIS to verify provider program eligibility and provider-attested Medicaid patient volume
- The CMS National Level Repository to verify that providers requesting a New Jersey incentive payment are not receiving incentive payments in any other state.
- The ONC Certified Health IT Product List to verify that the EHR system the provider attests it has adopted, implemented, or upgraded meets the ONC standards needed to be included on this list.
- The attestation application had been enhanced to require eligible professionals to upload Meaningful Use reports/dashboards as supporting documentation to complete the attestation process.

New Jersey Medicaid is also verifying provider attestation data through the post-payment audit process. This audit function is being performed by Mercadien. A further discussion of post-payment audit activities is included in the response to Question D-1 and detailed description of Mercadien’s audit processes are included in the New Jersey EHR Incentive Program Audit Strategy approved by CMS in June 2013. Finally, New Jersey is leveraging existing audit mechanisms and activities where possible.

Question D-7

Where are program integrity operations located within the State Medicaid Agency, and how will responsibility for EHR incentive payment oversight be allocated?



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The main entity responsible for Medicaid program integrity in New Jersey is the Medicaid Fraud Division located within the New Jersey Office of the State Comptroller. By statute the Medicaid Fraud Division “shall be devoted to Medicaid program integrity through means including, but not limited to: the detection, prevention, and investigation of fraud and abuse; the recovery of improperly expended Medicaid funds; enforcement; audit; quality review; compliance; referral of criminal prosecutions; investigation; and the oversight of information technology relating to Medicaid fraud and abuse.” (N.J.S.A. 30:4D-56). This office has limited resources and it is expected that it will not be heavily involved in the oversight of the EHR Incentive Program.

New Jersey Medicaid’s EHR Incentive Program Director will be the main party responsible for oversight of the EHR Incentive Payment Program. Additionally, Pre-payment eligibility screens included in the incentive payment administrative solution being implemented by the State’s fiscal agent and discussed in the response to Question D-1 will play a role in program oversight. Finally, post-payment reviews are being conducted by Mercadien, with bi-weekly meetings held between Mercadien and the New Jersey Medicaid EHR Incentive Program Director to discuss audit progress and any changes that are needed to audit procedures. A further discussion of post-payment audit activities is also included in the response to Question D-1 and in Table C-1.



Section E: New Jersey’s HIT Roadmap

Question E-1

Provide CMS with a graphical as well as narrative pathway that clearly shows where the SMA is starting from (As-Is) today, where it expects to be five years from now (To-Be), and how it plans to get there.

New Jersey Medicaid will seek to improve its operations over the next five years through several distinct IT activities. Activities undertaken will emphasize maintaining compliance with Medicaid regulations, improving the technology landscape upon which New Jersey Medicaid operates, and increasing the use of electronic health records and meaningful use among Medicaid providers, while also complying with CMS’s Seven Conditions and Standards for IT development and all other federal regulation and guidance related to IT system development. Building on the As-Is Landscape discussed in Section A of this SMHP, New Jersey Medicaid will undertake the activities shown in Table E.1 below and followed by additional discussion.

Table E.1: Medicaid IT Development Projects

<u>Development Project</u>	<u>Implementation Date</u>	<u>Purpose</u>
EHR Incentive Payment Program	November, 2011	Administer and distribute EHR incentive payments to eligible providers
Master Client Index	Data Remediation has been ongoing. Real time and batch integration of MMIS, Immunization Registry and lead Registry expected in 2014	To resolve source system duplicate records and link clients records across state social service IT systems
5010 and NCPDP Conversions	Completed	To meet federally mandated deadline to implement HIPAA and NCPDP code set and



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		standards changes
HIE Medication History Web Service	Second Quarter 2015	To share real-time medication histories with regional HIOs and NJHIN, once it is operational
NJ FamilyCare – Integrated Eligibility System (NJFC -IES)- Integrated Eligibility System	November 2014	Utilizing cloud-based technology, the NJFC -IES is the current New Jersey Medicaid Eligibility and Enrollment (E&E) strategy to meet the requirements of the Affordable Care Act (ACA), consolidate and standardize application for medical coverage under Medicaid, include MAGI rules, Age Blind and Disabled (ABD), Presumptive Eligibility (PE) and also connectivity to federal data hub which will replace many antiquated data systems currently in use.
ICD-9 to ICD-10 Conversion	October, 2015	To meet the federally mandated deadline to implement this diagnostic code conversion
New Medicaid Management Information System (MMIS)	Spring 2018	Replacement of a 20 year old legacy system designed according to Service Oriented Architecture principles to be modular, flexible, and reusable in order to advance New Jersey Medicaid's MITA maturity level
Document Imaging Management System (DIMS)	DDI is complete and we are now in the third year of Operations and Maintenance (1 year extension of the contract with IBM).	Replaces public assistance customers' paper documents with electronic records. All the documents related to SNAP, TANF, General Assistance, and Medicaid programs will be stored into this system.



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Health Information Exchange (HIE)		Medicaid provider on-boarding to the State HIE infrastructure to promote provider use of the State’s health information exchange infrastructure and improve the integration and coordination of care for patients throughout the State.
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New Jersey Medicaid will implement the Medicaid EHR Incentive Program to promote the adoption of meaningful use of electronic health records across the Medicaid provider community and facilitate health information exchange between Medicaid providers and the New Jersey health care system. This program is currently expected to launch in November 2011.

Additionally, New Jersey Medicaid is currently developing and enhancing a Master Client Index that will include data from several New Jersey health and social service program IT systems. The initial scope of this project is to resolve duplicate records and link recipients within New Jersey’s MMIS, Immunization Registry, and Blood Lead Screening Registry. In the future and as time and funding allow, additional New Jersey IT systems will be incorporated into the MCI to assist in facilitating health information exchange across State operated programs and potentially allowing for a single overview of a resident’s involvement in various State operated public health and social service programs. New Jersey Medicaid started development of new ESB services using MCI to support the accurate matching of lead outcomes, from the DOH Lead Registry program, with Medicaid child recipients with the goal of achieving more matches and earlier detection of lead burdened Medicaid children. Preliminary work has also started in exploring the use of MCI to accurately match Medicaid recipients with DOH New Jersey Birth and Death records for the purpose of the Performance Based contracting program to improve birth outcomes, to perform birth and citizenship verification and to receive information on the death of Medicaid beneficiaries.

New Jersey Medicaid completed a pilot is currently sending test Medicaid prescription drug utilization data to HIO in an on-demand, real-time environment utilizing a secure web service. New Jersey Medicaid and the HIO organizations in the state agreed that we would use the proposed New Jersey Health Information Network (NJHIN) to share clinical information with the HIOs. The NJHIN will come online and start sharing data by



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end of calendar year 2014. New Jersey Medicaid is working with the New Jersey HIT Steering Committee's technology subcommittee to implement communication standards for secure, HIPAA-compliant data exchange.

New Jersey Medicaid completed the work necessary for recent federally mandated code set and standards conversions, including converting from Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee (ASC) X12 version 4010A1 to ASC X12 version 5010 and from National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version D.0. These conversions were all completed before the applicable CMS deadlines. The NJMMIS has already been remediated in order to accommodate the last official CMS mandatory date of October 1, 2014 for ICD-10. NJMMIS work to change the mandatory date for ICD-10 to October 1, 2015 and to require the continued use of ICD-9 for services dates through September 30, 2015 was completed

Implementation of the New Jersey FamilyCare – Integrated Eligibility System (NJ FamilyCare – IES), an automated, rules-based eligibility system that will determine client eligibility and provide other services to county and state workers. The NJFC-IES is being implemented utilizing an agile and modular methodology. The module for online applications and worker portal along with some components of the Federal Data Services Hub (FDSH) are currently implemented. Additional modules including applications Age, Blind, Disabled program (ABD) and Presumptive Eligibility (PE) are currently under development and are targeted to go into production in the second half of calendar year 2017.

Finally, New Jersey is currently in DDI of a Replacement MMIS that is MITA aligned, modular, COTS-based, and configurable. It will replace a 20+ year old legacy system that limits flexibility and agility in today's dynamic health care environment.

New Jersey has nearly completed Phase 2 (Planning) of the SDLC, and is moving into Phase 3 (Requirements Verification and Design). New Jersey is operating with an approved I-APD, with an update pending..

Targeted go-live in currently set for the second calendar quarter of 2018.

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Question E-2

*What are the SMA’s expectations re provider EHR technology adoption over time?
 Annual benchmarks by provider type?*

New Jersey Medicaid expects adoption of EHR technology to expand over time, especially once the Medicaid EHR Incentive Payment Program becomes active in the second half of 2011. See table E.1 below for the year-by-year projected increase in EHR technology adoption by Medicaid providers anticipated to be eligible for Incentive Program awards.

Table E.2: Anticipated EHR Incentive Program Participation

<u>Year</u>	<u>Estimated Eligible Providers¹</u>	<u>Estimated Number of Incentive Program Participants</u>	<u>Estimated Incentive Program Participation Rate</u>
2011	3,088	1,210	39.2%
2012	3,088	1,504	48.7%
2013	3,088	1,900	61.5%
2014	3,088	2,382	77.1%
2015	3,088	2,631	85.2%

1 - Based on June 2010 Provider survey

Chart does not take into account the potential increase in eligible providers once all provisions of the Affordable Care Act are implemented in 2014.

New Jersey does not currently have annual benchmarks for EHR adoption by provider type; however the New Jersey Board of Medical Examiners is asking all providers in the state if they use EHRs or when they expect to begin using them. The results of this survey may be used as a tool to set annual benchmarks for EHR adoption in the future. Once these survey results are available and analyzed, this SMHP will be revised to include some preliminary EHR adoption benchmarks.

Question E-3

Describe the annual benchmarks for each of the SMA’s goals that will serve as clearly measurable indicators of progress along this scenario.

New Jersey Medicaid will implement annual benchmarks based on the work being done by the Consumer Advocacy and Quality Care Subcommittee of NJ’s HIT



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Commission. The subcommittee is developing quality measures for the approval of the commission based on approved statewide HIE use cases. These use cases and their respective quality measures are described below.

- 1. Medication History in an Emergency Department** – Quality measures for this use case include the percentage of New Jersey residents with emergency room visits to NJ acute care hospitals for whom a medication history was accessed from an HIO and the percentage of New Jersey residents with emergency room visits to acute care hospitals for whom an allergy history was accessed from the HIO.
- 2. Immunization Data** – Measures include the number of flu shots for New Jersey residents reported electronically to the State Immunization Registry and the number of pneumococcal immunizations for eligible New Jersey residents reported electronically to the State Immunization Registry.
- 3. Lab Results** – The primary measure for this use case will be the percentage of encounters where a lab history was accessed from the HIO.
- 4. Emergency Department Discharge Summary** – The primary measure for this use case will be the percentage of hospital discharges for which the patient's primary care physician, specialist, or other licensed health care professionals received a discharge summary from an acute care hospital.
- 5. Referral Information** – The primary measure for this use case will incorporate a quantification of communications between primary care physicians and specialists via "Direct" for secure exchange of health information.

New Jersey Medicaid will review these and other quality measures produced by the subcommittee and incorporate the measures that would support Medicaid's HIT goals.

The list includes some additional measures New Jersey Medicaid will review. This SMHP will be updated as these measures are refined, quantified, and finalized.

EHR Adoption - Percentage of practitioners with EHR access, the percentage of practitioners participating in a regional Health Information Exchange, and the percentage of practitioners meeting Meaningful Use Criteria



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Improve Health Outcomes - Adverse Drug Event Rate, average length of stay/mortality rate/readmission rate and cost per case, and the number of related acute hospitalizations for Health Program participants

Improve Efficiencies and Reduce Costs - Percentage of duplicate tests, Adverse Drug Event Rate, average length of stay/mortality rate/readmission rate and cost per case, and the number of related acute hospitalizations for Health Program participants

Question E-4

Discuss annual benchmarks for audit and oversight activities.

New Jersey has contracted with Mercadien P.C. Certified Public Accountants to perform post payment reviews of New Jersey Medicaid EHR Incentive Program attestations. This contracted entity will provide post-payment audits to validate that payments were made correctly and to verify registration, attestation and other information supplied by providers during the enrollment and eligibility process. It is expected that the contracted audit will utilize standard processes and techniques as part of the post-payment audit function. It is further expected that post-payment audit candidates will be identified using a variety of analytical tools and data mining techniques available to the contracted audit entity. Finally, it is anticipated that the number of audits performed will not increase each incentive payment year, but that the requirements of each audit conducted will be updated to the meaningful use criteria relevant to each given incentive payment year.

There will also be pre-payment audit activities that will be performed by the incentive payment administrative solution for all providers going through the registration and attestation process.

First, upon initial program enrollment NJMMIS will be checked to verify provider eligibility in New Jersey. This process will be repeated for each subsequent incentive payment year, and will include a verification of the provider's active license and any Medicaid sanctions the provider may be under.

Second, the NLR will be checked to determine if eligible providers have received an incentive payment from the Medicare EHR Incentive Program or if the provider is participating in another state's Medicaid EHR Incentive Program. The ONC's Certified



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Health IT Product List will also be checked to verify that a provider requesting an incentive payment has attested to adopting, implementing, or upgrading an ONC-certified system.

In addition, patient volumes submitted by providers will be verified via the NJMMIS Decision Support System and significant variances noted and investigated.

Finally, New Jersey Medicaid will work with its fiscal agent to develop methods that will enable verification of data submitted by providers related to year 1 meaningful use. For meaningful use in year 2 and beyond, provider clinical data attestations for meaningful use will be compared against the statutory and regulatory requirements for receiving Medicaid incentive payments.