UTAH DEPARTMENT OF HEALTH

Utah State Medicaid Health Information Technology Plan

Version 2022 Final – 7.1
Submitted to CMS 05/04/2022

Table of Contents

Table of Contents....2
SMHP Revisions Table....4
SMHP Introduction....5
Plan Purpose....5
How the SMHP is Organized....5
SMHP Plan Scope....5
Detailed Activities for Implementation....5
Promoting Interoperability Program....5
HITECH Administrative Matching Funds....8
Ongoing Initiatives....9
SMHP Plan Background....10
State HIE/HIT Governance Structure....10
Current State HIE & HIT Initiatives....11
Current HIE/HIT Activities and Funding Sources....11
Utah Grant Funding Sources Table....12
Utah Health Resource and Services Administration Grants....13
Other Current Complementary Activities....13
Populations with Unique Needs....15
Utah Assumptions on Federal Dependencies....16
SMHP Plan Development....16
MITA Approach....16
SMHP Workgroup....20
Governance Review....20
Utah's "Historical" HIT Landscape....21
Governance Landscape....21
Provider Landscape....23
Adoption of Certified Electronic Record Technology....23
Medicaid Promoting Interoperability Payments....25
EHR Systems....25
Broadband Initiatives....27
Broadband Grants Received....27
Current Broadband Coverage....27
Broadband Challenges in Rural Areas....28
HIE Challenges....28
Public Health....29
Legislative Landscape....30
Utah Medicaid Operations & Systems Support Landscape....33
Appeals Process....36
Payment Offset....37
Audits....37
Recoupment process for payments....37
Other HITECH Funding Opportunities....38
HITECH Funds to Promote HIE connections with Medicaid Providers....40
Pediatric Patient Portal....40
Controlled Substance Medication Integration....41
Newborn Screening....42
Electronic Physician Orders for Life Sustaining Treatment (ePOLST)....42
Falls Prevention....43

Utah's "Programmatic" HIT Landscape 43
Governance Landscape 44
Provider Landscape 44
Legislative Landscape 44
Utah Medicaid Operations Landscape 44
Promoting Interoperability Program Activities Table 46
Core Administration Activities Table 47
Administration and Oversight 48
Sanctions & Licensing Verification 48
Hospital-Based Determination 49
Provider Attestation Overall Content Verification 49
AIU Verification 53
MU Verification 53
State Specific Changes to MU 53
Certified EHR Technology Verification 54
Collection of MU Data 54
Attestation Goals 54
Final Environmental Scan 56
Future Pursuits ..... **Error! Bookmark not defined.**
Decomissioning the SLR and Other Cloesout Activities 58
Interoperability and Patient Access Rule Implementation 58
Death Certification 59
Social Determinants of Health 59
Other Strategic Health IT Goals 60
Applicable Road Maps & Work Flow Diagrams 61
Attachments & References Not Hyperlinked 61

SMHP Revisions Table

This page is dedicated to providing a summary of the changes made to Utah State Medicaid HIT Plan (SMHP) document.

SMHP Section	Description of Change	Date Requested by State	Date Approved by CMS
1.0 Original	Submission to CMS	12/23/10	
1.1 Revised	CMS requested additional information on appeals process and hospital payments process	1/31/11	
2.0 Original	Submission to CMS	11/22/2013	
3.0 Original	Submission to CMS	11/01/2014	
4.0 Original	Submission to CMS	09/30/2016	12/13/2016
4.1 Addendum	Stage 3 2015-2017 modifications	02/13/2017	04/25/2017
5.0 Original	Submission to CMS	06/30/2019	08/05/2019
5.1 Revised	CMS requested additional information on HIT Landscape, provider correspondence, state systems, MITA, funding streams, and audit strategy	09/25/2019	11/05/2019
6.0 Original	Annual update submission to CMS	12/16/2020	
7.0 Original	Final update submission to CMS	3/31/2022	

SMHP Introduction

Plan Purpose

This document represents an update of Utah's State Medicaid Health Information Technology Plan (SMHP). The overall purpose of the plan is to improve interoperability across the continuum of care on behalf of Medicaid recipients. As a first step, the Utah Department of Health Division of Medicaid & Health Financing (DMHF) has assumed responsibility for administering an efficient Medicaid Promoting Interoperability (PI) Incentive Payment Program to eligible providers and hospitals, thereby encouraging the adoption of certified EHR technology to promote health care quality and the exchange of health care information. In follow up to the EHR deployment to hospitals and eligible providers, DMHF is moving towards the identification of other Medicaid providers who have historically been ineligible for the Medicaid EHR Incentive Payment Program.

The primary focus of our SMHP is to continue engagement with eligible Medicaid providers and facilities in order to improve coordination of care, electronic exchange of information across the continuum of care, and provide an electronic infrastructure for the development of HIT related population health applications through 2021. Utah is also committed to carefully and appropriately executing closeout activities for this program, as directed by the Centers for Medicare and Medicaid Services (CMS) in recent guidance.

How the SMHP is Organized

Various stakeholders from our community have provided input to this plan. The Utah Department of Health DMHF will continue to work with stakeholders, thereby enabling the pursuit of specific initiatives that encourage the adoption and meaningful use of certified EHR technology and electronic exchange across the continuum for the improvement of health care quality. This SMHP has been aligned with the recommended sections identified in the SMHP companion guide as of June 2015 SMHP Overview Template OMB Approval Number: 0938-1088. Guidance from the Final SMHP Template dated June 2020 has also been consulted.

SMHP Plan Scope

Detailed Activities for Implementation

Based on the requirements defined in the Federal Regulation 42 CFR Parts 412, outlining Medicare and Medicaid Program Electronic Health Record Incentive Programs and the letter received February 29, 2016 (SMD#16-003) regarding the availability of HITECH Administrative Matching funds, the State Medicaid HIT Plan is to provide CMS with details regarding the necessary activities, processes and timelines for the proposed aims.

Promoting Interoperability Program

Utah developed and maintained the necessary systems to collect the attestations for the first year's Adopt, Implement or Upgrade (AIU) payments. Utah began accepting meaningful use attestations in December 2012 for eligible hospitals and January 2013 for eligible professionals.

The key activities for Utah's Promoting Interoperability Program are as follows:

1. Continue to interface with CMS regarding payments made to eligible providers using their developed National Level Repository (NLR) system

2. Process payments on schedule and provide notification of approval/denial for incentive payments

3. Maintain a Web site for Provider Registration and FAQs

4. Develop communication materials about the EHR Incentive Program and/or EHR adoption/meaningful use

5. Conduct provider outreach activities

6. Staff a provider help-line and dedicated e-mail address/phone

7. Monitor and review current CMS policies, propose recommended changes or inclusion of new policies and procedures, and develop and update FAQs

8. Validate volume thresholds, payment calculations, meaningful use, quality measures, and provider credentials throughout the life cycle of the program

9. Analyze and report on program statistics regarding payments made, meaningful use and clinical quality measures

10. Provide financial oversight and monitoring of expenditures to combat fraud waste and abuse in the program

11. Provide financial oversight and monitoring of expenditures for Meaningful Use Public Health Reporting partnerships

12. Public Health Registry activities to support providers in meeting Promoting Interoperability Measures and the practical use of clinical registry data.

The EHR incentive program requested and received approval for funding to support meaningful use activities with public health partners within the Department of Health in 2013. Funding in the current IAPD approved September 16, 2020 supports the following meaningful use duties through calendar year 2021:

Utah Statewide Immunization Information System (USIIS)

- Work with UDOH IT resources to specify and test enhancements to USIIS processing rules, database structure and interface engine in order to meet Stage 3 requirements of bi-directional interfaces, to include response to queries for evaluated immunization history and forecast.
- Research, develop and unit test enhancements to USIIS data exchange infrastructure to meet Stage 3 requirements of bi-directional interfaces, to include:
    - Interface engine enhancements;
    - HL7 2.5.1 message processing: interpreting received QBP message profile Z34 and responding with RSP message profile Z32 – for all possible scenarios;
    - HL7 2.5.1 message processing: interpreting QBP message profile Z44 and responding with RSP message profile Z42 – for all possible scenarios;
    - Message exception and error handling; and
    - Database writing.
- Support CQMs CMS 117v8 and CMS147v9 with enhanced system patient matching and deduplication process, and develop provider portal to display metrics on patient population immunization status.
- Work with EHR vendors to develop, test and validate new EHR-USIIS HL7 2.5.1 immunization interfaces.
- Manage and track on-boarding eligible hospitals and providers with EHR-USIIS HL7 2.5.1 immunization interfaces.
- Work with eligible hospitals and providers during on-boarding EHR-USIIS interfaces to attain data quality compliant with Meaningful Use and to deploy their interfaces into Production.

- Support eligible hospitals and professionals in their Meaningful Use registration for the Immunization Public Health Measure and to provide notification of pass or fail.
- Run data quality reports and conduct data quality consulting for EHs and EPs registered for Medicaid incentive programs with EHR-USIIS HLT 2.5.1 interfaces.
- Ensure that development and deployment of interface infrastructure comply with state and department requirements with respect to software development, change management, and security processes.

Informatics and Public Health Reporting

- Work with EHR vendors and state Department of Technology Services (DTS) to create interfaces for the exchange of electronic data.
- Test and validate interfaces to ensure compliant ELR, syndromic surveillance, or case reporting message.
- Aggregate incoming Syndromic Surveillance feeds from eligible hospitals.
- Create Syndromic Surveillance export for BioSense.
- Provide requirements for cCDA parsing and case report process development.
- Act as ELR Coordinator to manage and support meaningful use attestations for eligible hospitals.
- Manage and track onboarding process.
- Perform data validation and quality assurance on data feeds from eligible hospitals and providers.
- Manage ELR and case report exception queue.
- Fix message errors in HL7 messages and case reports.
- De-duplicate and merge HL7 messages.
- Create and provide attestation memos.
- Follow up with participants who have registered intent to participate to keep work/progress moving forward.
- Implement and upgrade web-service and interfaces for EHs and EPs that have (or are in process of) setting up public health reporting interfaces by creating interfaces in the Mirth Interface Engine and setting up mappings for message structure and vocabulary.
- Coordinate regularly with UHIN as several EHs and EPs that report data are members of the cHIE (UHIN) and UHIN sends the data feed to UDOH on behalf of the EH and or EP.
- Maintain UDOH MU public health reporting website.
- Maintain and enhance MU registration system as needed.
    - Syndromic Surveillance specific activities, including: Create SyS export for the BioSense-Essence (CDC managed SyS system).
    - Coordinate with Syndromic Surveillance Epidemiologist in the Bureau of Epidemiology to manage the SyS data feed going to BioSense-Essence.
    - Act as SyS Coordinator to manage and support MU activities for EHs and EPs.
    - Develop analysis, visualization, and reporting infrastructure for usage of SyS data.
- Electronic Laboratory Reporting specific activities, including:
    - Import EHR local codes for each EH.
    - Create mappings from local codes to master codes.
    - Manage ELR messages processed into the Electronic Messaging Staging Area (EMSA) application: Identify and fix message errors, deduplicate and merge messages.
    - Ongoing management of local and master vocabulary and code lists and rules engine in EMSA.
    - Develop analysis, visualization, and reporting infrastructure for usage of ELR data.
- Electronic Case Reporting (eCR) specific activities, including:
    - Create data vocabulary mapping from eCR messages into EMSA and Utah's disease surveillance system.
    - Design, develop, and implement the capacity to accept and process electronic case reports for EHs and EPs as required by MU stage 3.

    - Upgrade EMSA (including eCR specific rules engine) to automatically process MU compliant case report messages.
    - Enhance data model to accept additional data elements contained in case reports.
    - Develop rules to accept and process MU compliant case report messages.
    - Develop data matching and de-duplication process to merge case reports with existing system data that are specific to case reporting.
    - Develop analysis, visualization, and reporting infrastructure for usage of eCR data.
    - Manage eCR messages in EMSA.
    - Identify and fix message errors in eCR messages.
    - De-duplication and merging of eCR messages.
    - Provide guidance with the processing of eCR messages when manual review of message is needed.
    - Ongoing management local and master vocabulary and code lists.
    - Ongoing management of eCR based rules engine in EMSA.
    - Develop mapping to disease surveillance system.
- Develop data matching and duplication process to merge case reports with ELR messages.
- Implement and upgrade web service and interfaces for eligible provider and hospital systems for ELR and Syndromic Surveillance.
- Create interfaces in the Mirth Interface Engine.
- Assist with on-boarding new facilities by mapping messages structure and vocabulary.

HITECH Administrative Matching Funds

In the past Utah has received two State Innovation Model (SIM) Design Grants from the Center for Medicare and Medicaid Innovation (CMMI.) In 2013, Utah was awarded its first State Innovations Model (SIM) Grant from CMMI to begin the process of putting the previous policy discussions into action. The Utah SIM Executive Policy Group, led by Lt. Governor Greg Bell, was the governing body of these Innovation efforts. This governing body collaborated with 120 community leaders (business, the health care delivery system, health work force education, Utah's mental health systems and government) to continue the work that began at the 2011 Summit. During that phase, three use cases were prioritized by the policy leaders to include behavioral health integration, obesity and diabetes reduction and advance care planning at the end of life.

In 2015, Utah was awarded a second SIM Model Design grant ($2 million) to develop a State Health Systems Innovation Plan. A draft of that plan was submitted to CMMI July 31, 2016. The plan is organized around the three prioritized cases identified above and focuses on six infrastructure issues, one of which is Health Information Technology. Recommendations and priority projects from the SIM work are being integrated into this SMHP as deemed appropriate.

The key activities for HITECH Administrative Matching Funds are as follows:

1. Identify list of potential HIT projects.
2. Prioritize according to SIM recommendations.
3. Identify Fair Share of Medicaid population impacted.
4. Identify list of Medicaid providers who were not eligible for MU incentive program.
5. Identify source of matching funds.
6. Develop cost analysis for individual projects.

7. Develop IAPD application for each of the projects.

8. Secure matching funds.

9. Submit IAPD for each of the projects.

We believe that appropriate business processes, staffing, and systems support are in place to ensure continued success with these key activities.

Ongoing Initiatives

As recognized by CMS, continued development of the SMHP is an iterative process and the Utah Department of Health DMHF is committed to updating the plan. Our plan is to continue with the successful administration of incentive payments for all stages of the program, and to support and encourage continued participation in the program in Utah's provider community. Additionally, we are seeking to integrate the SIM recommended HIT projects as they are identified and are consistent with the HITECH Administrative Funding opportunities.

The decision to pursue each of these initiatives is contingent upon continued coordination with our community partners and will be referenced in future iterations of Utah's SMHP & IAPD. Some of the ongoing initiatives and identified projects are listed below:

1. Require all providers receiving incentives to connect with public health databases in an effort to meet meaningful use (i.e. laboratories, immunization registry, etc.).

2. Continued Development and expansion of the Department of Health Master Patient Index (DOHMPI).

3. Initiate an independent evaluation of the EHR incentive program.

4. Implement a quality assurance program for Utah's fee for service providers.

5. Coordinate efforts of the State's Digital Health Services Commission who has assumed the role of the HIT Governance Consortium.

6. Collaborate with other neighboring states HIE's (i.e. ID, WY, NV, AZ, CO, MT etc.). Utah's cHIE has operational connections with HIEs in CO, OR, ID, NV, AZ, NE, OK, AR, MI, IN, IA, KY , ND, WV, MD, SC, LA, OH and AL. Utah cHIE is partially connected to systems in CA, WA, MT, TN, TX and WY.

7. Develop and support IAPD applications as determined to be appropriate through the application of HITECH.

8. Work with neighboring states including Idaho, Nevada, and Arizona on cross-state line interoperability criteria

SMHP Plan Background

State HIE/HIT Governance Structure

The Utah Department of Health DMHF has worked closely and collaboratively with HIT stakeholders throughout our State. They are an engaged group of stakeholders assisting DMHF to increase EHR adoption and utilization in Utah. Multiple entities compose this stakeholder group, each contributing to the task of improving healthcare in Utah through the use of EHRs.

Currently Dr. Navina Forsythe, PhD, MPA is the Director for the Center for Health Data and as the lead staff for the Governor-appointed Utah Digital Health Service Commission. The Digital Health Services Commission is a governor-appointed statutory policy advisory body. Its mission is to facilitate and promote the adoption and secure and efficient use and exchange of electronic health information as a means to reduce healthcare costs, enhance quality, increase access, and improve medical and public health services. The Digital Health Services Commission coordinates strategically with many partners to advance Health IT strategic goals and Objectives.

Utah Health Information Network (UHIN) is a non-profit group dedicated to the secure use of healthcare data and the creation of software solutions for the healthcare community. UHIN offers a full-service clearinghouse, operates Utah's clinical Health Information Exchange (cHIE), and provides analytics and business intelligence. UHIN is a source of healthcare education events and other training opportunities for the healthcare community. The Utah Department of Health and Utah State Medicaid have representatives that serve on the UHIN Board of Directors.

The Utah Partnership for Value-Driven Health Care is a regional health improvement collaborative comprised of multiple healthcare stakeholders including payers, purchasers, and providers. This partnership aims to advance higher value healthcare in Utah. Some current high-priority focuses of this group include advanced care planning, healthcare affordability, aligning quality metrics for medical professionals, and transparency. Several different workgroups work to address specific topics of importance within the Utah healthcare community.

The Utah PI Program gets significant collaborative support from coordination with other states who have also implemented the CNSI eMIPP state level registry. Michigan, Illinois, Washington and Utah regularly discuss technical issues and best practices. States share information on CMS interpretations of final rules and discuss implementation strategies for system or program changes. Since these states share the same core product, the work and cost of functionality upgrades or CMS-mandated updates to measures or other participation requirements can be shared among all states.

PI Program staff meets periodically with public health staff. Working closely with Utah's immunization registry, syndromic surveillance, electronic laboratory reporting, and clinical data repository group streamlines the process of confirming provider participation and progress towards public health reporting measures.

According to UHIN's website, the CHIE now has over 100 million clinical messages for over 7.24 million unique patients. Connections are in place to receive data from 95% of hospitals and 90% of large clinics in Utah. They also confirm 236,000 Clinical Summaries pulled from the HIE in July 2020 and 786,000 CHIE Alerts in that same month. (CHIE Alerts provide notifications when a patient is admitted to, or discharged from a hospital or emergency department.)

Utah's cHIE is a statewide entity. It is a 501c3 not-for-profit organization. The main business model is a full-service clearinghouse. UHIN became an HIE in 2009. The cHIE

established connections with HIE partners in Arizona and western Colorado to form a Patient-Centered Data Home. This allows providers from any of the three HIEs to get notifications and patient summaries when their patients have an encounter across state lines.

Current State HIE & HIT Initiatives

While many HIT initiatives in Utah are relatively mature, we realize a great deal of work remains to advance the statewide use of HIT and clinical health information exchange. The Utah Health IT Strategic Plan (2016-2020) details our strategic goals, objectives, current and planned efforts to promote a sustainable statewide HIE architecture for improved quality, efficiency, and reduced health care costs. This plan is being followed by all of the Digital Health Services Commission partners and stakeholders in order to provide consumers and their health care providers with credible, secure, and accurate health information at the lowest possible cost. A list of HIT initiatives coordinated across the Utah community and mapped to the Office of the National Coordinator (ONC) can be found in the Attachments section (USIM Grant and Strategic Plan.)

Utah's approach to HIT has been based on statewide cooperation and regional sharing, strong executive leadership, and legislative reforms. This history, along with a relatively high penetration of EHR and Hospital Information Management Systems (HIMS), has enabled a market-driven HIE. Based on information from the Health IT Dashboard, an estimated 85% of all outpatient primary care practices in Utah have adopted certified EHR systems. This is slightly above the national average of 80%.

Current HIE/HIT Activities and Funding Sources

The State of Utah has received more than $45 million dollars in state and federal funding to support our current HIE and HIT initiatives. When the initial SMHP was written in 2010, the following tables were representative of the funding received. This table has been made current as of 2020.

Utah Medicaid maintains separate coding strings to separate the different funding sources for regular MMIS funding and HITECH funding. All HITECH/HIE programs are assigned individual Units to identify the specific HITECH project and program code S9I* (followed by the federal fiscal year). Program code S9I* indicates the enhanced 90/10 match for HITECH. MMIS expenses are recorded using program codes that start with X** and then vary depending on the federal match they qualify to receive. These Units and their program codes are monitored for incorrect coding, as well as MMIS expenses that may have incorrectly received an invalid program code. The state's accounting system, FINET, is set up to require a valid Unit and matching program code when transactions are initiated. HITECH units only accept S9I* program codes, and MMIS units don't allow program codes starting with S9I*. Reports are generated regularly to identify any expenditure coding strings that aren't consistent with predetermined coding criteria.

Utah Grant Funding Sources Table

Grant #1: Beacon Community Grant awarded to HealthInsight – Utah's Regional Extension Center Funding Amount = $15,790,181	In 2010, Utah received a Beacon Community Grant from the ONC for HIT. The focus of this grant will be to improve adult diabetes care management in Salt Lake, Summit and Tooele Counties, by increasing availability, accuracy and transparency of quality reporting, connecting providers to the State's HIE and fostering better collaboration with community partners.
Grant #2: ARRA Regional Extension Center Technical Assistance awarded to HealthInsight – Utah & Nevada's Regional Extension Center Funding Amount = $6,917,783	In 2010, as the Regional Extension Center for Nevada and Utah, HealthInsight provides federally-subsidized technical assistance on a priority basis with physician office practices to offer hands-on, one-on-one customized assistance selecting and effectively using electronic health records to improve care.
Grant #3: State Health Information Exchange Cooperative Agreement Program awarded to the Utah Department of Health Funding Amount = $6,296,705	In 2010, the Utah Department of Health received this funding to build upon existing efforts to advance regional and state-level health information exchange while moving toward nationwide interoperability. The majority of this funding was sub-contracted to UHIN, the state's designated clinical health information exchange vendor.
Grant #4 CHIPRA Quality Demonstration Grant awarded to the Utah Department of Health Funding Amount = $10,277,360	In 2010, The Utah Department of Health received this funding to use HIT to coordinate care for children in Utah & Idaho through Medical Homes and share immunization data between both States' HIE's.
Grant #5 HRSA Public Health Clinical Information Exchange with Providers Funding Amount = $1,200,000	In 2009, UHIN, the University of Utah and the Utah Department of Health collectively applied for and received funding to develop Utah's Newborn Screening Clinical Health Information Exchange which will allow users to share test results of newborn hearing and blood screenings with a child's primary care medical home.
Grant #6 NIH – Statewide Master Patient Index (MPI) for Health Funding Amount = $2,000,000	In 2009, a research grant was issued to the University of Utah, Intermountain Health Care, Utah Department of Health and UHIN to develop and pilot a better framework for a statewide MPI to enhance the capacity of the cHIE and better support healthcare treatments, payments and public health uses.
Grant #7 Department of Agriculture Broadband Availability Survey Funding Amount = $300,000	In 2009, the Utah Department of Technology Services received funding to conduct a survey in places where broadband is unavailable and create opportunities for collaboration at a community level to use HIT and information exchange to achieve health care gains.
Grant #8 CMS Medicaid Meaningful Use Planning Grant Funding Amount = $400,000	In 2010, Utah Medicaid received a planning grant to develop the SMHP and IAPD to administer EHR incentive payments for the meaningful use of EHR's and clinical information exchange.
Grant #9 ONC – Health IT Workforce Development Funding Amount = $3,364,798	In 2010, Salt Lake Community College, with eight other states, received funding to develop and promote health information non-degree training opportunities for health IT professionals.
Grant #10 CMS/CMMI – State Innovation Model planning grant Funding Amount = $$942,4582	This Round 1 model design grant afforded Utah to gather policy leaders around the core infrastructure issues and examine the evidence. This effort resulted in the prioritization of three use cases (behavioral health integration, obesity and diabetes reduction, and advance care planning at end of life).
Grant #11 CMS/CMMI – State Innovation Model design grant Funding Amount = $2,000,000	A second round of funding for model design work has resulted in a set of specific recommendations addressing 6 infrastructure issues associated with the three prioritized use cases.
Grant #13 ONC – Community Health Information Exchange Funding Amount = $100,000	UDOH, UHIN and Intermountain developed the electronic exchange for the newborn hearing screening results and follow-up diagnostic reports between providers, HIE and public health program.

Utah Health Resource and Services Administration Grants

A number of Federally Qualified Health Centers (FQHCs) across the State received funding from HRSA in 2018. The funds are set aside for the United States Department of Health and Human Services (US DHHS) HRSA under the ARRA to expand healthcare services to low-income and uninsured individuals through its health center program. These grants will support ongoing and expanded EHR implementation projects in addition to HIT enhancement projects. The project goals include improved healthcare quality, efficiency, and patient safety achievements through the use of technology. No recent updates to this funding are available at the time of this submission.

HEALTH CENTER GRANTEE	EHR REPORTERS [1]	CLINICAL QUALITY IMPROVERS [2]	ADVANCING HEALTH INFORMATION TECHNOLOGY [3]
BEAR LAKE COMMUNITY HEALTH CENTER, INC.	$5,000	$0	$6,000
CARBON MEDICAL SERVICE ASSOCIATION, INC.	$5,000	$9,326	$4,000
COMMUNITY HEALTH CENTERS, INC.	$0	$52,001	$6,000
ENTERPRISE VALLEY MEDICAL CLINIC, INC.	$5,000	$18,284	$6,000
GREEN RIVER MEDICAL CENTER	$5,000	$0	$6,000
MIDTOWN COMMUNITY HEALTH CENTER	$5,000	$0	$6,000
MOUNTAINLANDS COMMUNITY HEALTH CENTER	$5,000	$19,309	$6,000
PAIUTE INDIAN TRIBE OF UTAH, THE	$5,000	$15,771	$5,000
SOUTHWEST UTAH COMMUNITY HEALTH CENTER	$5,000	$15,878	$6,000
UTAH NAVAJO HEALTH SYSTEM, INC.	$5,000	$17,437	$6,000
UTAH PARTNERS FOR HEALTH	$5,000	$22,569	$6,000
WASATCH HOMELESS HLTH CARE/4TH ST. CLINIC	$5,000	$10,604	$3,000
WAYNE COMMUNITY HEALTH CENTERS, INC.	$5,000	$13,186	$4,000

[1] EHR Reporters employed EHRs to report on all CQM data for all of the health center's patients

[2] Clinical Quality Improvers made at least a 10% improvement in one or more CQMs between 2016 and 2017

[3] Advancing HIT for Quality Awards recognize health centers that utilized HIT systems to increase access to care and advance quality of care.

Other Current Complementary Activities

The robust HIT infrastructure Utah has built will optimize our ability to access accurate information on health care quality indicators. This information supports transparency of quality and cost, which can be used for health payment reforms.

DMHF has funded the Center for Health Data and Informatics' Health Informatics Program (HIP) through an IAPD to develop the Department of Health Master Patient Index (DOHMPI). HIP has successfully completed the first use case to link the death records with the Medicaid eligibility records and send the death notification to Medicaid.

HIP is planning the DOHMPI next use cases such as death notification for Medicaid providers or identity validation for Medicaid newborns.

From 2010-2013 the State of Utah advanced statewide use of HIT and clinical health information exchange to improve health care quality and reform by using ARRA funds awarded through the Statewide Health Information Exchange Program (UHIN), HIT Regional Extension Center, and Beacon Community Program (Comagine.)

UHIN has issued over 4,000 health care providers a clinical health information exchange (cHIE) user name and password to exchange clinical health information for treatment purposes at the point of care. They have expanded cHIE services to include electronic prescribing, laboratory orders and results delivery, and medical history to support meaningful use. They have developed a sustainable governance and business model to operate the cHIE and have plans to integrate public health data exchange with clinicians thereby reducing the burden on providers, increasing timely and complete reporting for population health.

Comagine (previously HealthInsight), is a Medicare Quality Improvement Organization (QIO), functioned as the HIT Regional Extension Center (REC) for Utah, and serves as the Agency for Healthcare Research and Quality (AHRQ) Chartered Value Exchange for the state as well. They provided technical assistance, tools and resources to maximize the use of CEHRT. They also counseled participating providers regarding retention of appropriate records for future audit. HealthInsight provided on-site assistance to clinics and consulted on vendor selection and system implementation. They also provided assistance to current EHR users in workflow redesign, audit documentation and meaningful use. This arrangement through the ONC was from March 2010 to July 2016 and resulted in 852 Utah providers attesting for 90 days of meaningful use with either the Medicare or the Medicaid incentive program. An additional 150 providers received assistance with the adoption/implementation/upgrade step of the program but hadn't yet achieved meaningful use. Grant assistance for this support declined. However, HealthInsight remains an important resource for Utah EPs looking for assistance with the Security Risk Assessment. The organization offered different levels of support with this measure based on provider needs. HealthInsight staff guided EPs through HIPAA self-assessment or provided a full-support remote risk analysis. HealthInsight partnered with an award-winning privacy and security software solution called HIPAA One.

Utah Medicaid is a partner with the Utah All Payer Claims Database (APCD) managed by the Office of Health Care Statistics. The APCD became operational in 2013 and receives a monthly data feed amounting to approximately 50-65 million claims annually. The data is from the private sector as well as Medicaid and provides a detailed resource for medical researchers, public programs, and other authorized users. Utah's APCD is able to analyze episodes of care from statewide health insurance claims, allowing a view of the complete course of patient care from initial diagnosis through treatment and follow-up. Utah's APCD is a robust source of data and is capable of answering questions such as:

- What was the patient's diagnosis and treatment?
- When was the patient diagnosed and who made the diagnosis?
- Where did the patient receive treatment?
- How much did the patient's care cost?
- Did the patient receive treatment expected by the standard of care?
- What is a patient or cohort's risk profile?

All the contributing and necessary parties are aligned and have a common vision for how HIE and HIT are implemented throughout the state of Utah. Utah's Medicaid PI Program will continue to be built upon this solid foundation and the program manager and staff will help pursue initiatives that encourage the adoption of certified EHR technology and audit for its meaningful use.

Populations with Unique Needs

The Utah PI program has benefited populations with unique needs in several ways. When the CQM selections were expanded for program year 2014, providers had the option of reporting on several new measures that were more applicable to pediatric populations. This change gave Utah pediatricians incentive to focus on meeting these measures and allows clinics to focus on improving care for specific pediatric populations such as children with asthma and children being treated with attention deficit/hyperactivity disorder medication.

See section "HITECH Administrative Matching Funds to Promote HIE connections with Medicaid Providers" for details on the Pediatric Patient Portal project which is intended to provide specific technical resources to the families of children with complex medical conditions.

Utah Medicaid also has additional programs that focus specifically on the unique needs of Utah children.

Children's Health Insurance Program

The Children's Health Insurance Program (CHIP) is a state health insurance plan for children who do not have other insurance. It provides well-child exams, immunizations, doctor visits, hospital, emergency care, prescriptions, hearing and eye exams, mental health services and dental care. Preventative services (well-child visits, immunizations, and dental cleanings) do not require a co-pay.

Child Health Evaluation and Care (CHEC)

CHEC is Utah's Early and Periodic Screening, Diagnostic and Screening (EPSDT) program for children ages birth through twenty who qualify for Medicaid. It provides preventative medical and dental care for children enrolled in Medicaid. Medicaid ensures that each child has access to necessary check-ups. This program also encourages parents to establish a medical home for their child.

Benefits include preventative physicals, hearing and vision screenings, mental health care, as well as access to all necessary immunizations. If there are additional medical concerns, CHEC works with the doctor to ensure the child is given appropriate and necessary care. CHEC dental provides preventive care. This includes two dental examinations per year, x-rays, sealants, fluoride and necessary restoration work.

Baby Your Baby

Baby Your Baby (BYB) is temporary medical coverage for low-income, pregnant women who qualify. BYB covers pregnancy-related outpatient services provided by any Utah Medicaid Provider. It does not cover the delivery of the baby. The goal of this program is to reduce infant mortality by assisting Utah women to obtain early and frequent prenatal care.

Autism Related Services

Autism related services are available to Medicaid patient under the age of 21 who qualify for CHEC services. These services help develop, maintain or restore the functioning of a person with an autism spectrum disorder (ASD). A service called Applied Behavior Analysis (ABA) is available to assist with behavioral issues. In addition, there are other types of services such as speech, occupational and physical therapy that may also help a person with ASD.

Children's Medicaid Waiver Programs

Several waiver programs are operated under the Utah Home and Community Based Services which add specific benefits for pediatric populations:

Medically Complex Children's Waiver. This program provides medical assistance to children age 0-18 who are medically complex, and meet the following criteria: children who have 3 or more specialty physicians, children who have 3 or more organ systems involved in their disability, children who are not meeting age-appropriate milestones for their activities of daily living, and children with a disability designation from the Social Security Administration or from the State Medical Review Board.

Waiver for Technology Dependent Children. This program supports children and families and ensures the availability of services and supports for technology dependent children so that they can be cared for in their homes.

Utah Assumptions on Federal Dependencies

This section includes the assumptions where the path and timing of Federal initiatives and plans have dependencies based upon the role of CMS (e.g., the development and support of the R&A System), ONC or other federal organizations.

The Utah Department of Health (UDOH) is dependent upon federal CMS for the review and approval of all SMHPs and IAPDs submitted to request federal funding for the Utah Medicaid PI Program. UDOH relies on federal CMS to maintain the Registration and Attestation System as operational support for provider participation in the program. The agency is also dependent on funding used for contractual support of outreach and application development services.

UDOH is also dependent upon federal CMS and the ONC for the distribution and clarification of the Final Rule regarding the Utah PI Program and MU criteria. Finally UDOH is dependent upon the ONC for the certification requirements of EHR systems so that Utah providers can ascertain that they are utilizing CEHRT.

SMHP Plan Development

MITA Approach

Utah assumed a Medicaid Information Technology Architecture (MITA) approach to determine the "Historical" (formerly known as "As-Is") and the "Programmatic" (formerly known as "To-Be") HIT landscape and has created a roadmap for the administration/oversight of the HIT incentive program. The SMHP Overview Template was followed in great detail and was critical in assisting the planning team.

Critical Milestone	By
Initiated Internal Review of SMHP & IAPD	December 2, 2010
Submitted I-APD & SMHP to CMS – Version 1.0	December 31, 2010
Hired/Designated Program & DTS Staff	January 31, 2011
Created System Technical Requirements for Making Payments	February 28, 2011

Received I-APD & SMHP approval from CMS	February 28, 2011
Designed & Developed System for Making Payments	March 31, 2011
Completed Integration Testing	May 30, 2011
Completed Issue(s) Resolution	June 30, 2011
Conducted Provider Outreach, Trained & Implemented Regarding the Application Process	June 30, 2011
Hired/Designated Remaining Program Staff	July 31, 2011
Accepted Applications for EHR Incentive Payments from Providers	September 1, 2011
Made First Set of EHR Incentive Payments to Providers for AIU	November 18, 2011
Made First Set of EHR Incentive Payments to Hospitals	December 16, 2011
Developed System Definitions & Requirements for Meaningful Use Stage 1	January 1, 2012
Submitted Revised IAPD – Version 2	July 1, 2012
Created System Technical Requirements for Meaningful Use Stage 1	May 15, 2012
Designed & Developed System for Making Payments for Meaningful Use Stage 1	December 7, 2012
Completed Integration Testing	November 15, 2012
Completed Issue(s) Resolution	November 28, 2012
Submitted & Received a SMHP Amendment for Meaningful Use Stage 2 Rule Changes for 2013 (in attachments section)	January 23, 2013
Made first MU incentive payments to hospitals	February 1, 2013
Made first MU incentive payments to providers	March 8, 2013
Submitted audit strategy and approved (in attachments section)	May 30, 2013
Submit Revised I-APD – Version 2.0	September 16, 2014
Submit Revised SMHP Version 3.0	November 1, 2014
Create System Technical Requirements for Meaningful Use Stage 2 for 2014 Implementation	August 7, 2014
Submit updated audit strategy Version 3.2	9/30/2014
Design & Develop System for Making Payments for Meaningful Use Stage 2	April 1, 2015
Make Stage 2 MU incentive payments to providers	April 1, 2015
Make Stage 2 MU incentive payments to hospitals	April 1, 2015
Submit revised IAPD Version 3.0	November 6, 2015
Replace current Oracle Solution with CNSI's HIT Incentive Product eMIPP	July 1, 2016
Launch approved screens for 2015 Modified Stage 2 requirements – EH	July 1, 2016
Launch approved screens for 2015 Modified Stage 2 requirements – EP	July 1, 2016
Plan and develop IAPD projects according to Medicaid criteria, SIM priorities and matching funds opportunity	September - December 2016
Submit updated SMHP version 4.0	September 2016
Request for Proposal through state purchasing process to solicit a program auditor	December 2017 – March 2018
Launch approved changes to SLR mandated by OPPS final rule dated 10/14/16	March 2018
Submit series of IAPD amendments staged according to priorities	January 2017-2021
Operationalize IAPD initiatives	January 2017-2021
Submit serious of IAPD amendments staged according to priorities	January 2017-2021

Request for Proposal through state purchasing process to solicit a program auditor	December 2017 – March 2018
Launch approved changes to SLR mandated by OPPS final rule dated 10/14/16	March 2018
Submit revised IAPD	August 21, 2018
Develop and Submit Audit Strategy	March 2019-July 2019
Implement SLR changes mandated by 2019 IPPS rule	June 27, 2019
Submit revised SMHP Version 5.0	June 30, 2019
Submit Audit Strategy Version 4.0 for CMS review	July 30, 2019
Submit IAPD-U	August 7, 2019
Make Stage 3 Meaningful Use Payments	February 2020
Submit HIE Project update IAPD	November 2019
PFS and IPPs Updates to eMIPP	June 29, 2020
Submit IAPDU	July 30, 2020
Submit updated SMHP Version 6.0	December 2020
Submit updated Audit Strategy	December 2020
Submit final SMHP Version 7.0	March, 31 2022
Submit final Audit Strategy	March 31, 2022

Utah Medicaid completed a full Medicaid Information Technology Architecture State self-assessment (MITA Framework 2.0) in December 2008. This was an important evaluation to take place at the beginning of discussions regarding replacement of the legacy MMIS. The Division determined that the replacement MMIS must meet the following general objectives:

- The MMIS must align with Federal and State laws, regulations, and guidelines.
- The MMIS must "work" from a functional perspective and must adhere to the requirements defined by the Division.
- The MMIS must be flexible, adaptable, and responsive (timeliness and ease of change).
- The MMIS must be supported by an adequate (appropriate) change control environment.
- The architecture for the MMIS must support a rules-based environment.
- The MMIS must support the elimination, reduction, or automation of manual processes.
- The architecture for the MMIS must allow for the integration of software/systems that support business needs.
- The MMIS must provide accurate, meaningful, and timely reporting.
- The MMIS must be implemented in a timely manner consistent with a robust, well-maintained project plan.
- The MMIS must support evidenced-based outcome functionality.

Based on these requirements a number of functional objectives were identified. These functional objectives are guiding principles for the functionality required of the CNSI PRISM MMIS.

Functional objectives:

Utah's Objectives	MITA Goals						
		(4) Provide timely, accurate, usable and accessible data	(3) Promote an enterprise view	(2) Promote flexibility, adaptability, and	(1) Develop integrated systems	(5) Provide performance metrics	(6) Coordination
	Number of Objectives matching Goal	*16*	*12*	*8*	*5*	*5*	*1*
	1. Accurate, reliable payment	■	■	■	■		
	2. Relate Aid Codes to Rate Cells	■		■			
	3. Policy & procedures access	■				■	
	4. Plastic Medicaid ID Cards	■	■				
	5. Real-time eligibility verification	■	■				
	6. Tools and functionality for PI	■	■				
	7. Correct tracking of benefit usage	■					
	8. Better access to resources and data	■					
	9. Flexibility in HCBS Waiver data ID	■					
	10. Greater rigor in data integrity	■					
	11. Improved data tracking	■					
	12. Improved (DSS)	■					
	13. Integration & access to data	■					
	14. Flexible access to summarized data	■					
	15. Payment tracking of all history	■					
	16. Standardization of data and reports	■					
	17. Multiple benefit programs		■	■	■		
	18. Match expenses to Managed Care		■	■	■		
	19. Automate Special Payments		■	■			
	20. Better State Plan update process		■		■		
	21. Multiple reimbursement methods		■				
	22. Mirror commercial insurance		■		■		
	23. Track Provider calls and responses		■			■	
	24. Robust training & communication					■	
	25. Contract requirements tracking					■	
	26. Better sub-systems interaction			■			
	27. Establishment of a PMO team					■	
	28. Flexibility in changes			■			
	29. Evidence based						■
	30. More consistent Prior Approval		■				

On February 2, 2012 The Utah Department of Health received approval from CMS for both the IAPD securing enhanced federal funding and the Request for Proposal (RFP) for the core system replacement. In August 2012 the Department named CNSI as the successful bidder.

The Department named the new MMIS "PRISM" (Provider Reimbursement Information System for Medicaid). Requirements validation and design are ongoing for this enormous project, and progress has been made in a series of releases.

The completed major releases as of 8/30/2020 are summarized below:

March 2014 Release 1 – New Medicaid website and Eligibility Lookup Tool

August 2014 Release 2 – HealthBeat Data Analytics Dashboard Tool

July 2016 Release 3 – Provider Enrollment and Electronic Medicaid Incentive Payment Program (eMIPP)

June 2020 Release C1 provided enhancements to the Provider Enrollment system and migrated the existing functionality including eMIPP to a cloud-based environment.

By 2023, full functionality including claims processing will be live in the PRISM cloud product. At this time the state will pursue full certification of the MMIS, and a full MITA State Self-Assessment will be completed.

SMHP Workgroup

In the planning process, the Utah Department of Health DMHF sought out and incorporated input for the following stakeholder organizations:

1. Association of Utah Community Health Centers (AUCH) is the primary care association for Utah whose members include Bureau of Primary Health Care (BPHC) grantees and other providers who strive to meet the needs of the medically underserved.

2. HealthInsight, now Comagine, is a Medicare Quality Improvement Organization (QIO) and HIT Regional Extension Center (REC) for Utah and serves as the Agency for Healthcare Research and Quality (AHRQ) Chartered Value Exchange for the State as well. They host our State's HIT Task Force meetings, where grant and project managers from the State HIE program, statewide clinical health information exchange (cHIE), Beacon Community, Medicaid HIT Incentives and CHIPRA Quality Improvement Project meet monthly to coordinate overlapping issues and project interdependency.

3. *Utah Health Information Network* (UHIN) is our statewide Health Information Exchange infrastructure (HIE). A list of participating healthcare entities in UHIN's Clinical Health Information Exchange (cHIE) can be found in the Attachments section of this SMHP along with a recent cHIE update that lists UHIN's accomplishments, plans, risks and financial status.

4. Utah Hospital Association (UHA) represents member hospitals and all ten healthcare systems operating in the State of Utah.

5. *Utah Department of Health Office of Public Health Informatics*, whose mission is to coordinate and support Utah's e-health initiatives and to facilitate development of systematic applications of information, statistics, and computer technology for Utah's public health surveillance, health service and learning.

6. *Utah Department of Technology Services*, which is Utah's consolidated IT resources organization that provides technical support to our MMIS and other business operations.

Governance Review

The SMHP was reviewed by key Utah Department of Health and DMHF management prior to submission to CMS.

Utah's "Historical" HIT Landscape

Governance Landscape

The Utah Department of Health is the single State agency for the Medicaid and CHIP programs. The Division of Medicaid and Health Financing serves as the Medicaid and CHIP administrative agency within the Department of Health. All of Utah's state-level public health agencies also co-reside within Utah Department of Health.

The Utah Department of Health has the statutory responsibility to adopt standards for the electronic exchange of clinical health information between healthcare providers and third party payers that are for treatment, payment, healthcare operations, or public health reporting, as provided for in 45 C.F.R. Parts 160, 162, and 164, Health Insurance Reform: Security Standards. The Utah Digital Health Service Commission serves as an advisory board regarding statewide health IT and clinical Health Information Exchange (cHIE). Dr. Navina Forsythe PhD, MPA, Director for the Center for Health Data and Informatics and the lead staff for the Digital Health Service Commission, has been designated the State Health HIT Coordinator. Utah Medicaid participates in Utah Digital Health Services Commission meetings on an ad hoc basis as needed.

The governor of Utah selects 13 members for this commission, with representatives from the following areas:

(a) a physician who is involved in digital health service;
(b) a representative of a health care system or a licensed health care facility as that term is defined in Section 26-21-2;
(c) a representative of rural Utah, which may be a person nominated by an advisory committee on rural health issues created pursuant to Section 26-1-20;
(d) a member of the public who is not involved with digital health service;
(e) a nurse who is involved in digital health service; and
(f) eight members who fall into one or more of the following categories:
(i) individuals who use digital health service in a public or private institution;
(ii) individuals who use digital health service in serving medically underserved populations;
(iii) nonphysician health care providers involved in digital health service;
(iv) information technology professionals involved in digital health service;
(v) representatives of the health insurance industry;
(vi) telehealth digital health service consumer advocates; and
(vii) individuals who use digital health service in serving mental or behavioral health populations.

Historically, the information technology professional involved in digital health service ((iv) above) is a representative from the Utah Health Information Network which operates Utah's health information exchange.

The State Health IT Coordinator and the Director for the State Innovation Model Design Grant were given an opportunity to contribute to the SMHP. The Commission and SIM grant has worked with the following partners and organizations.

Representing	*Organization Names*
Government:	Utah Department of Health, including Utah Medicaid Program, Utah Department of Technology Services, Utah Department of Insurance, State Office of Education, Veterans Administration Salt Lake Medical Center, Utah Association of Local Health Officers,
Private:	Utah Health Information Network

Clinical/Hospital:	Intermountain Healthcare, University of Utah Health Sciences Center, HCA/MountainStar Hospitals, Central Utah Clinic, Utah Hospitals and Health Systems Association, Utah Medical Associations, ARUP Laboratories
Insurers:	Deseret Mutual Benefits Administrators, Public Employee Health Plans, Regence Blue Cross Blue Shield, SelectHealth, Molina Health Plans
Communities:	Utah Chartered Value Exchange at HealthInsight, Association for Utah Community Health, Utah Association for Home Health Care/Utah Hospice and Palliative Care Organizations, Utah Pharmacists Association, Utah Health Care Association, Utah Telehealth Network and Utah Indian Health Advisory Board
Education & Research:	University of Utah

Utah Medicaid was one of the founding organizations for UHIN and has participated in UHIN's governance since its founding in 1993. UHIN as previously mentioned is the State's designated HIE Vendor. They have a statewide geographic scope to support Utah Medicaid in the HIT incentive project. UHIN is governed by a Board of Directors. Emma Chacon, Medicaid Operations Director and Heather Borski, Deputy Director of the Utah Department of Health both sit on the UHIN board and also serve on the UHIN Board Executive Committee. The UHIN Board also has oversight over UHIN's administration of the cHIE.

UHIN is central to the State's HIT & HIE initiatives and activities, including the exchange of billing and clinical information. The Utah MMIS receives claim data from providers via UHIN and provides Medicaid recipient data through UHIN for exchange with participating providers. At this time, UHIN is in production for laboratory results delivery and initiating a pilot for the query function. The Department of Health, Center for Health Data and Informatics routinely convenes with UHIN and receives monthly updates. In addition, a UHIN representative serves as one member of the Utah Digital Health Service Commission in the capacity of an information technology professional involved in digital health service.

In 2012, as the result of HB 141, all of Utah's Medicaid and CHIP lives were opted in to the state's HIE. As of 12/31/2015 there were 446,641 CHIP and Medicaid lives enrolled in the cHIE. An additional 2,651 members have requested to be opted out of the cHIE.

The USIIS Program supports the Health Information Technology Plan by working with eligible providers (EPs) and eligible hospitals (EHs) in their efforts toward submitting immunization data to USIIS, the Utah Statewide Immunization Information System. USIIS supported Meaningful Use from its inception, providing documentation/instructions, online registration, secure methods for submitting data and status notices used by EPs, EHs and the Medicaid Program for attestation purposes. The USIIS Program also worked with Electronic Health Record system vendors used by Utah EPs and EHs to develop, test and approve for release HL7 interfaces that comply with MU stages and goals. Advances attained during this time include implementing 40 new interfaces for EHR systems used by Utah EPs and EHs and implementing three additional secure transport methods—including submission via the Utah clinical health information exchange (cHIE). The USIIS Program has assisted over 1,200 EPs and EHs through all stages of Meaningful Use, and has on-boarded 236 EPs and 32 EHs for Stage 2/Modified Stage 2. Furthermore, the USIIS Program has developed data quality reports and a

process to periodically provide data quality assessments and guidance to EPs and EHs as they continue to submit immunization data to USIIS.

Our public health partners, including Electronic Laboratory Reporting, Syndromic Surveillance, Immunization Reporting, and Cancer Registry Reporting developed a joint website dedicated to Public Health Reporting for Meaningful Use. Electronic case reporting is now an option on this site as well. This is a starting point for eligible professionals and eligible hospitals to obtain information, technical specifications, deadlines, and to register to conduct testing or exchange with these agencies. One registration form is used for all areas. This process is in collaboration with Promoting Interoperability Program within the Division of Medicaid and Health Finance.

In order to support ongoing efforts towards public health reporting and Meaningful Use, the Promoting Interoperability program has entered into Memoranda of Understanding with these public health partners, which will allow HIT funding to pay for our public health partners' staff time that is dedicated specifically to Meaningful Use. This is detailed in Utah's most recent IAPD. The registration process is for Utah Eligible Professionals and Eligible Hospitals intending to apply for the Medicaid and/or Medicare EHR Meaningful Use incentive programs for all meaningful use stages. The registration process is managed online and can be accessed with the following link http://health.utah.gov/meaningfuluse/

Provider Landscape

Adoption of Certified Electronic Record Technology

This table shows how Utah compares to the national average on measures of health information technology adoption and utilization. Data was obtained from the Office of the National Coordinator. Data below is from 2017 and is the most current dataset available through the ONC. While Utah appears to be performing especially well regarding hospital adoption of HIT, office physician adoption of HIT is slightly below the national average.

(https://dashboard.healthit.gov/apps/health-information-technology-data-summaries.php)

Utah Health IT Summary

Domain	Setting	Measure	Recent Year	Natl Avg	Utah	Compare
EHR Adoptions	Hospitals	Adopted Certified EHRs	2017	96%	97%	↑
	Physicians	Adopted Any EHRs	2017	86%	94%	↑
	Physicians	Adopted Certified EHRs	2017	80%	85%	↑
Certified IT Vendors	Hospitals	Reported Certified Health IT Vendor(2014)	2017	96%	95%	↓
	Professionals	Reported Certified Health IT Vendor(2014)	2017	81%	71%	↓
Electronic Prescribing		No recent data				
Exchange & Interoperability	Hospitals	Electronically Send from Outside Health Providers	2017	88%	91%	↑
	Hospitals	Electronically Receive from Outside Health Providers	2017	74%	82%	↑
	Hospitals	Electronically Find from Outside Health Providers	2017	61%	84%	↑
	Hospitals	Electronically Integrate from Outside Health Providers	2017	53%	79%	↑
	Hospitals	All Domains Electronically from Outside Health Providers	2017	41%	75%	↑
	Physicians	Electronically Send from Outside Health Providers	2017	36%	25%	↓
	Physicians	Electronically Receive from Outside Health Providers	2017	38%	31%	↓
	Physicians	Electronically Find from Outside Health Providers	2017	53%	49%	↓
	Physicians	Electronically Integrate from Outside Health Providers	2017	28%	22%	↓
	Physicians	Electronically Send or Receive from Any Health Provider	2017	46%	43%	↓
	Physicians	Electronically Send from Any Health Provider	2017	36%	25%	↓
	Physicians	Electronically Receive from Any Health Provider	2017	38%	31%	↓
HITECH Programs		No recent data				
Patient Engagement	Hospitals	Provided Electronic Capabilities to Patients-API Access	2017	38%	54%	↑
	Physicians	Provided Electronic Capabilities to Patients-Secure Messaging	2017	68%	65%	↓
Public Health Reporting		No recent data				

Medicaid Promoting Interoperability Payments

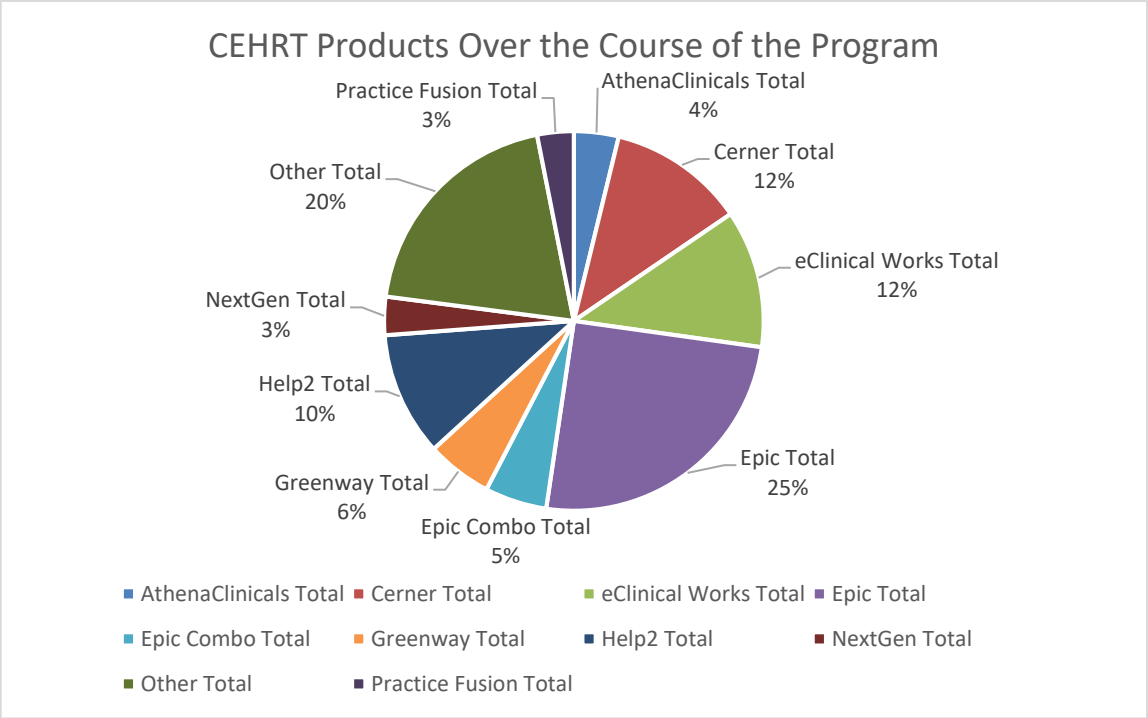
The following Utah providers and hospitals have received Medicaid PI payments for either adopting, implementing or upgrading to certified EHR technology or for achieving meaningful use

EP by Program Year			EH by Program Year		
Year	Total	Payment Total	Year	Total	Payment Total
2011	141	$ 2,769,594.00	2011	9	$ 6,311,660.00
2012	320	$ 5,720,518.00	2012	17	$ 10,674,127.00
2013	578	$ 8,944,857.00	2013	39	$ 21,508,546.00
2014	567	$ 6,614,451.00	2014	41	$ 16,847,952.00
2015	374	$ 4,087,091.00	2015	14	$ 3,096,693.56
2016	319	$ 4,000,673.00	2016	15	$ 1,010,126.00
2017	229	$ 1,906,828.00	2017	11	$ 618,096.00
2018	284	$ 2,382,837.00	2018	1	$ 6,925.00
2019	155	$ 1,283,504.00	2019	1	$ 6,925.00
2020	147	$ 1,229,669.00	2020	--	--
2021	106	$ 889,668.00	2021	--	--

Utah has paid year one incentives to over 1100 unique EPs. Of these providers, 699 unique EPs have received at least one meaningful use payment. As of 12/31/2021, 218 EPs have received their sixth and final payment for participating in the program. For eligible hospitals, 44 year one payments have been made and 43 hospitals from that group have demonstrated meaningful use. Twenty-five of these hospitals have completed all four years of the incentive program.

EHR Systems

The chart below depicts the utilization of EHR Systems in use in the State of Utah. The information was derived from attestations. Across the life of the program EPs have used a wide range of certified EHRs, however as the meaningful use stages have progressed, the bulk of program participants are tied to larger healthcare clinics and systems so we see much less variety in the CEHRTs being used to attest. The CEHRT utilization for program year 2019 shows this clearly. The two largest health systems in Utah, University of Utah Healthcare and Intermountain Healthcare, use Epic and Cerner systems, respectively.



Attesting providers reported using over 40 different EHR products over the course of the program, including some smaller, home-grown products. The majority of providers attesting for later stages Modified Stage 2 and Stage 3 used Epic, Cerner, Athena Clinicals or eClinical Works.

Utah has made incentive payments to 44 unique eligible hospitals. Of these facilities, 23 belong to one large health system and use the Cerner product. The state's other large health system uses the Epic product. Smaller facilities have attested using Meditech, Medhost, and Chart Access EHRs.

There are 12 Federally Qualified Health Centers (FQHC) in Utah, encompassing 29 different clinic locations. All of these FQHCs have adopted certified EHRs and all have attested for incentive payments. Approximately 180 FQHC providers have received over 420 incentive payments. The program has seen a good return rate for these providers with many providers receiving 4, 5, or 6 years of payments. FQHC dentists have really benefited from the administrative support from their clinics' participation in the incentive program. FQHC dentists represent the bulk of the Utah's dental meaningful users.

Utah's Veterans Affairs Medical Center (VAMC) in Salt Lake City is a formal organizational member of the UHIN and the cHIE project. The VAMC successfully completed a project in partnership with UHIN that allows patient summaries to be exchanged bi-directionally. The process is working well but does require two separate consents from the patient in order for data to be exchanged. They have also been working on projects for direct connection of home health information as well as the sharing of care plans.

Tribal participation in the Promoting Interoperability program remains very limited. Utah Navajo Health Systems, the Paiute Indian Tribe of Utah and the Goshute Tribe of Utah all had EPs who began participation in the PI program. However, participation from this group has dwindled and the program does not expect to have any tribal healthcare groups achieve Stage 3 meaningful use. Utah paid one tribal hospital as well, Blue Mountain Hospital, which received 3 years of incentive payments.

Broadband Initiatives

Widespread broadband Internet capabilities are essential for the success of HIE implementation. The sections below describe a number of initiatives supporting the expansion of Internet access across the State of Utah, enabling the healthcare community's ability to participate in HIE.

Broadband Grants Received

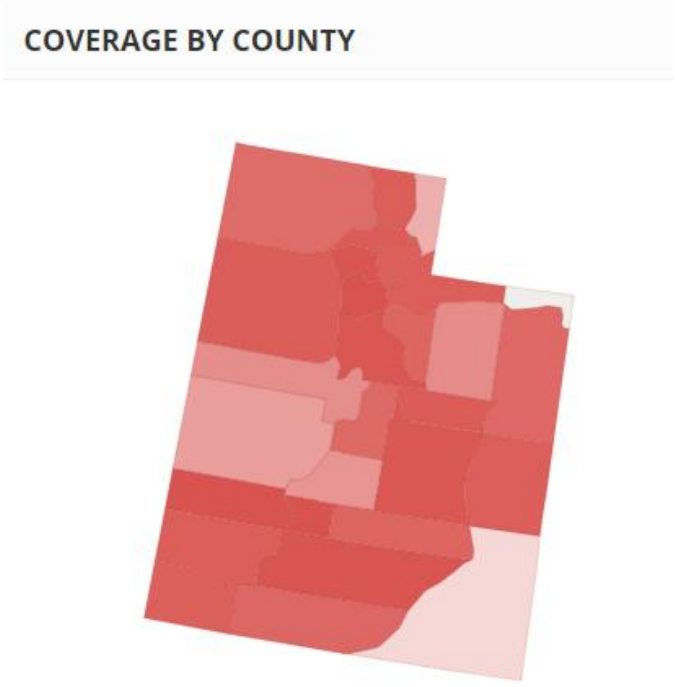
- Since 2010, The State of Utah Broadband Project has been awarded $5,196,025 in federal grants for Utah's Broadband Initiative.
- Another $31,048,683, accounting for 0.9% of all federal infrastructure grants, was awarded to broadband infrastructure projects in Utah.
- Since 2011, access to a wired connection of at least 10mbps has improved from 90.2% to 97.1% of Utahns.

Current Broadband Coverage

According to BROADBANDNOW, 100% of Utahns have access to mobile broadband service and 97.9% have access to fixed wireless service. There are now 139 broadband providers in Utah. However, there are still geographic areas, where access to broadband is more limited. Current gap statistics include:

- 108,000 people in Utah are without access to a wired connection capable of 25mbps download speeds.
- The population of Daggett County, Utah does not have any wired internet providers available, and only 4% of county residents have access to 25mbps download speeds.
- The population of San Juan County also has limited access to sufficient download speeds, with only 25% of the county residents able to obtain 25mbps service.
- Another 45,000 people in Utah do not have any wired internet providers available where they live.

A broadband speed of 25mbps or faster is accessible to 96.1% of Utahns, while 93.6% have access to broadband of 100mbps or faster. Additionally, a broadband speed of 1 gigabit is accessible to 30.2% of Utahns, wireline service is accessible to 98.5%, fiber-optic is accessible to 32.9%, cable is accessible to 90.7% and DSL is accessible to 96.3%. Utah is rated as the 29th most connected state and averages 69.5mbps state-wide. More information and statistics can be found at https://broadbandnow.com/Utah.



Utah's Broadband: Stats & Figures BROADBANDNOW. Last updated September 1, 2020.

Broadband Challenges in Rural Areas

Given the infusion of broadband infrastructure and connectivity funding in recent years, access to broadband internet is not a significant challenge to HIT or HIE in most rural areas. There are pockets in rural Utah where broadband internet access is less affordable due to limited connectivity options (fiber, wireless, or cable) and lack of competition due to limited Internet Service Providers (ISP) in the territory. 11 of 29 counties in Utah have only two ISPs, and one rural county has only one ISP.

HIE Challenges

Utah has a state-designated health information exchange called the Clinical Health Information Exchange (cHIE.) The CHIE provides a patient-centric record that can be accessed by disparate providers. cHIE services such as Admission/Discharge/Transfer alerts and Direct Secure Messaging are designed to help Utah healthcare providers achieve interoperability. Though the count of Utah healthcare locations connected to the cHIE continues to increase, a large proportion of locations do not invest financially in the advanced features of the HIE, or they lack awareness of the availability and benefits of HIEs. Healthcare organizations like long term care and behavioral health have had limited opportunities for connectivity subsidies and that makes affordability among certain health care sectors more challenging.

Internet access and acceptable speeds are not major issues affecting the Utah HIE; however, the data being exchanged today is mostly summary only. Internet bandwidth may become a greater challenge as bidirectional exchange increases, or as larger files such as imaging results become more common.

Without a mandate or legislative requirement, creating a business case for HIE continues to be an issue. Larger health systems have historically been resistant to share data outside of their networks and affiliations. Additionally, larger EHRs like Epic and Cerner,

associated with Utah's two largest health systems, have the ability to function like an HIE now and that can reduce the need/demand for a broader based or statewide HIE.

Public Health

As part of demonstrating meaningful use, EPs and EHs must make connections with two public health registries. In Utah several of these registries are housed within the Department of Health in the Division of Disease Control and Prevention (DCP). The Utah PI program has financially supported efforts by these public health partners to interface with participating providers. The Utah Statewide Immunization Information System (USIIS), Syndromic Surveillance Reporting, Electronic Laboratory Reporting (ELR) and Electronic Case Reporting. These public health entities maintain a meaningful use registration site for tracking registration, onboarding activities and active engagement. Funding for certain activities performed by public health staff that support the PI program have been budgeted into the current IAPD. Some activities that are funded to support PI public health reporting are:

- testing, validating and maintaining interfaces;
- working with EHR vendors to create and validate compliant HLT messages;
- data validation and quality assurance;
- tracking onboarding processes and progress;
- providing memos to confirm Active Engagement status for participating providers;
- maintaining a public health Meaningful Use website with a central registration for all supported state registries;
- infrastructure enhancements to support new requirements for additional stages of Meaningful Use such as bi-directional interfaces.

Utah is pleased with the results of these activities. Close partnerships with these registries allow program staff to confirm compliance with these measures as part of pre-payment verifications. The active engagement memos are uploaded to support the meaningful use attestations. Other public health data achievements that have been supported as part of meaningful use are:

- USIIS has developed interfaces with 63 distinct EHR systems.
- Facility participation in immunization record reporting increased 57% from 2012-2016.
- Immunization records processed into USIIS via EHR interface have increased 429% from 2012-2016 and an additional 260% from 2016 to 2021.Adult immunization records in USIIS have increased 126% from 2012-2016.
- USIIS processes over 250,000 immunization history queries (an increase of over 400% from 2016) on a weekly basis as part of a bi-directional interface that was mandated for Stage 3 Meaningful Use. This peaked to over 300,000 queries per week during COVID. Approximately 35% of those queries included an immunization forecast.
- Utah was the first state to implement Docket mobile phone app for consumer access to immunization records. This application also supports the Smart Health Card QR code standard, supporting COVID travel and immunization record sharing.
- Reliability of EHR-USIIS connections has been increased by improving error handling and automating many processes that had previously required manual interventions.
- 36 hospital laboratories have been onboarded for electronic lab reporting and all emergency departments in Utah have been onboarded for Syndromic Surveillance.
- The percent of ELR messages added to the communicable disease surveillance system has increased from 65% to 99%. This has allowed the program to reduce

manual data entry personnel by 2 full-time employees. Without ELR it would have been impossible for us to collected the detailed level of information on COVID testing, which has driven much of our intervention efforts and policies. Syndromic surveillance can now track several diseases and injuries that they were previously unable to track due to the low volume of data, including influenza, COVID-19, opioid overdoses, firearm-related injuries and non-fatal suicide attempts.

- Collection of negative lab test data allows insight into screening rates and improves identification of false positive lab results.
- Surveillance data obtained electronically is timelier. For instance, DCP is now able to monitor Influenza-Like-Illness data for influenza surveillance during the influenza season and will allow for a larger component of monitoring COVID-19 activity as the state moves into the "Steady State" COVID response.
- Syndromic surveillance data related to opioid overdose can now be collected in nearly real time which improves public health response to opioid events.
- Electronic case reporting partnerships with Utah's largest hospital system are actively collecting incidents of several disease conditions: Chlamydia, Gonorrhea, Pertussis, Salmonella, and Zika virus and reports these results to jurisdictions as well as notifying the initial reporter.

Legislative Landscape

Utah health policymakers acknowledge that health information technology (HIT) and health information exchange (HIE) are two driving forces to transform health systems. To ensure that health care reform leads to better health care, the Utah legislature passed the following legislation to improve efficiency and quality of health care and reduce cost since 2005. It was important to include bills since 2005 because of the continual impact they have. To reinforce the importance of legislative bills as it pertains to HIT and HIE, the following table is being provided:

Bill No. & Sponsor	Bill Title	Year Passed
S.B. 132 Christensen, A.	Health Care Consumer's Report	2005
H.B. 137 Daw, B.	Pain Medication Management and Education	2007
H.B. 6 Menlove, R.	Controlled Substance Database Amendments	2007
H.B. 9 Morley, M.	Health Care Cost and Quality Data	2007
H.B. 133 Clark, D.	Health System Reform	2008
H.B. 326 Curtis, G.	CHIP Open-Enrollment	2008
H.B. 119 Daw, B.	Controlled Substance Database Amendments	2008
H.B. 24 Menlove, R.	Amendments to Utah Digital Health Service Commission Act	2008
H.B. 47 Menlove, R.	Standards for Electronic Exchange of Clinical Health Information	2008
H.B. 188 Clark, D.	Health System Reform – Insurance Market	2009
H.B. 106 Daw, B.	Controlled Substance Database Amendments	2009
H.B. 331 Dunnigan, J.	Health Reform--Health Insurance Coverage in State Contracts	2009
H.B. 128 Menlove, R.	Electronic Prescribing Act	2009
H.B. 165 Newbold, M.	Health Reform--Administrative Simplification	2009
H.B. 294 Clark, D.	Health System Reform Amendments	2010
H.B. 186 Menlove, R.	Controlled Substance Database Revisions	2010
H.B. 52 Newbold, M.	Health Reform - Uniform Electronic Standards - Insurance Information	2010
H.B. 18 Daw, B.	Health Reform – Cost Containment	2011
H.B. 19 Dunnigan, J.	Insurance Law Related Amendments	2011
H.B. 128 Dunnigan, J.	Health Reform Amendments	2011
H.B. 0404 Ipson, D.	State Health Insurance Amendments	2011
H.B. 0046 Menlove, R.	Electronic Personal Medical Records	2012

Bill No. & Sponsor	Bill Title	Year Passed
H.B. 0450 Dee, B.	Health Insurance Amendments	2012
H.B. 0475 Ray, P.	Medicaid Amendments	2012
S.B. 0085 Christensen, A.	Medicaid Cost Control Amendments	2012
H.B. 25 Barlow, S	Patient Identity Validation	2012
H.B. 42 Valentine, J.	Repeal of Health Insurance Mandate Review	2013
H.B. 364 McCay, D.	Nullification of Federal Health Care Law	2013
H.C.R. 10 Adams, J.	Concurrent Resolution on the Patient Protection and Affordable Care Act and State Health Care Reform	2013
S.B. 213 Knudson, P.	Employer Association Health Plan Amendments	2013
S.B. 242 Hillyard, L.	Health Insurance Market Amendments	2013
S.B. 142 Weiler, T.	Small Employer Health Insurance Amendment	2014
H.B. 141 Dunnigan, J.	Health Reform Amendments	2014
S.B. 71 Harper, W.	Informed Consent Amendments	2014
S.B. 251 Shiozawa, B.	Amendments to Medicaid and Health Care	2014
S.B. 272 Davis, G.	Expansion of Medicaid Program	2014
H.B. 114 Ward	Controlled Substance Reporting	2016
H.B. 239 McKell	Access to Opioid Prescription Information via Practitioner Data Management Systems	2016
H.B. 149 Daw	Death Reporting and Investigation Information Regarding Controlled Substances	2016
H.B. 310 Thurston	Utah Statewide Immunization Information System Program	2017
S.B. 150 Eliason	Utah Statewide Stroke and Cardiac Registry	2018
H.B. 461 Christensen	Patient Access to Medical Records Amendments	2018
H. B. 158 Daw	Controlled Substance Database Revisions	2018
H.B. 77 Daw	Health Information Exchange Amendments	2019

H.B. 313 Ballard	Telehealth Parity Amendments	2020
S.B. 138 Vickers	Pharmacy Benefit Manager Revisions	2020
H.B. 15 Ward	Controlled Substance Amendments	2021
H.B. 85 Hall	Controlled Substance Database Access	2021
H.B. 19 Elias	DNA Specimen Analysis Amendments	2022
H.B. 21 Handy	School and Child Care Center Water Testing Requirements	2022

The Utah legislature has shown its support of HIT initiatives in Utah. We feel that our Medicaid program and our HIT/HIE partners have received all the needed legislation to continue and move forward with our EHR Incentive Payment Program into the future. Additional supportive legislation is likely to be considered in the next session.

Utah Medicaid Operations & Systems Support Landscape

Utah Medicaid is committed to educating providers, promoting the EHR incentive program and working with UHIN and HealthInsight to meet the goal of an increase in numbers of medical professionals using certified EHR technology.

Utah Medicaid Bureau of Medicaid Operations has a provider training program. This program has been used to help educate providers on the Medicaid PI Program. Additionally, Medicaid has a web site that Medicaid providers can use to find the right entity for questions about EHR, cHIE and the Medicaid PI Program. The PI program maintains a dedicated page of the Medicaid website. The page includes information on registration and enrollment, auditing, eligibility, payment process, public health reporting measures, training, and other helpful material including a provider user guide and frequently asked questions. This site also links to the current version of the SMHP.

The Utah Medicaid PI Program is staffed by a Health Program Manager, with a Health Program Specialist who processes the provider and hospital attestations. Oversight is provided to this group from the Assistant Bureau Director for the Bureau of Managed Health Care. Program staff is readily available to answer the Provider Hotline, and interact with providers on a daily basis answering questions or addressing technical issues with the attestation site. This Hotline number also appears on every screen that providers/hospitals encounter when they are completing an attestation.

In 2013, the State of Utah selected a new MMIS replacement vendor. The vendor is CNSI and the Utah MMIS replacement system is called PRISM (Provider Reimbursement Information System for Medicaid). CNSI has customized a software solution package outside of PRISM titled the Electronic Medicaid Incentive Payment Product (eMIPP.) The decision to use CNSI's eMIPP product was based on the fact that it is a pre-built, "off-the-shelf" solution that would integrate simply with the PRISM infrastructure. We feel confident that this solution has improved the user experience for incentive program participants, and streamlined reporting and payments.

Currently the states of Michigan, Washington, Illinois and Maryland use eMIPP to administer their Medicaid PI Program. Sharing this solution with other states offers an additional benefit. The cost of programming any changes resulting from future CMS final

rules can be split among these states. The State of Utah completed requirements gathering and system design for a Utah implementation of eMIPP. The State and CNSI determined it would be best to implement the eMIPP product at the same time as the Provider Enrollment module. Despite some development delays, eMIPP went live in July 2016. The previous Oracle solution has been retired, however, the requirements documentation used to build it have been retained and used as a resource as needed.

Although eMIPP was implemented in July 2016, Utah continued to make PI payments to EPs and EHs from our legacy system. At this time we anticipate that Medicaid claims and payments will be live in the PRISM cloud based solution in January 2023. If this milestone is achieved prior to the completion of post-payment audits, then PI payments resulting from audit or appeals processes will be processed through these new mechanisms.

Program staff works closely with state DTS and participates in the testing process. The DTS resources needed for maintenance, development, testing and implementation of the eMIPP payments are in place and funding is outlined in the most recent IAPD.

The following technical work is supported by CNSI and is considered integral for an administration of the EHR Incentive Payment Program.

CNSI scope of work for the eMIPP product includes:

- Maintaining a two-way Interface between eMIPP and the NLR so that new provider records and updates can be received from the NLR, and payment requests, payment records, audits and appeals can be communicated to the CMS NLR.
- Developing and testing user interface screens used by eMIPP providers and state personnel.
- Maintaining and updating all meaningful use requirements to conform with CMS regulatory changes and program updates.

Cost estimates for state technology solutions supporting the payment process may be found in the State's current HIT IAPD. Any work that CNSI performs is being paid for by the MMIS replacement IAPD that Utah has in place.

All of the 2013 changes to Stage 1 Meaningful Use that were outlined in the Stage 2 legislation were implemented on schedule. The state also successfully programmed screens and implemented the required changes for 2014, including the CEHRT Flexibility Rule. The changes were approved by CMS at the time of implementation.

Utah's PI program was delayed in implementing the changes outlined in the CMS Stage 3 Rule dated October 2015. The rule change was announced late in the program year and required significant programming changes to implement. The State of Utah was preparing to adopt a new MMIS system which included a new state level system. The decision was made to delay implementation of the Stage 3 changes until the new MMIS system went live July 1, 2016. The State of Utah accepted 2015 attestations from 7/1/16-10/31/16.

At the time of eMIPP go-live 7/1/2016, the Modified Stage 2 Meaningful Use modifications were completed and approved by CMS for program year 2015. This incorporated all Stage 3 modifications for program years 2015-2017.

The system updates necessary to facilitate the 2017 changes mandated by the Outpatient Prospective Payment Program rule and the Medicare Quality Payment Program rules went live in eMIPP in March of 2018. This necessitated an extension of the tail period for 2017 attestations until 6/30/2018. The 2017 changes involved the following updates:

- Providers can select Stage 3 as an option when they are entering their meaningful use details.
- The meaningful use reporting period was changed to 90 days for all providers.
- Modifications were made to some of the measure calculation time frames to ensure that the actions included in the numerator must occur within the EHR reporting period.
- As the definition of Meaningful EHR User has been updated by CMS, language in the attestation release acknowledged by providers at the time of submission has been updated to include additional statements.

The system updates necessary to facilitate the CQM alignment changes outlined in 2019 through the Physician Fee Schedule final rule were implemented September 27, 2019. Additional minor changes for the 2021 reporting period were implemented June 29, 2020 which accommodate the possibility that the attestation may be submitted prior to the completion of the Security and Risk Assessment. Due to updates to the broader MMIS that were being implemented and tested at the same time, the PI program requested and administered an extended tail period ending June 30, 2020.

Since July of 2016, providers attest through the new eMIPP system. The provider will access the CMS National Level Registry (NLR) and register for the program. They receive an invitation to attest in eMIPP when this record is received by the state. (Returning providers receive notifications to enter eMIPP for attestation based on yearly deadlines applicable to the provider's stage of participation.) The provider proceeds to the PRISM provider portal and logs into eMIPP where the provider will be able to apply and submit eligibility information, attestations and complete other required forms. Proof of purchase, adoption or upgrade along with the provider's MU report cards will be requested upon attestation and will be retained by the program manager as part of the initial file created and housed in Utah Medicaid's eMIPP module.

The state user in the EHR reviewer role has access to these attestations and will review all supporting documentation and perform prepayment verifications. eMIPP does an automated check of the ONC national registry of certified EHR technology to confirm the certification number reported in attestation. The eMIPP system has established business rules based on the meaningful use measure specifications to do automated analysis on numerators and denominators submitted with the attestation. The system does frequent sanction checks against local and national databases to identify any providers who should not be allowed to participate or who may require additional review.

If additional information is needed to support patient volume or meaningful use, the reviewer will request this information. The reviewer also has the functionality to reject the provider attestation so that the provider can make corrections. Once the file is determined to be complete and eligible the EHR reviewer recommends the provider for payment. The approval of the payments is handled in the EHR approval role which is currently assigned to an assistant bureau director in the DMHF.

Upon approval in eMIPP, the D16 duplicate payment check interface will check CMS for permission to pay. This interface runs daily. If the record passes the duplicate payment check then an interface sends all information necessary for the payment request to the legacy MMIS system. This interface will also run on a daily basis, however checks are only issued in the legacy MMIS once per week on Fridays. The program is mindful that payments must be made within 45 days of notification to CMS. The program uses the existing Special Payments functionality in the legacy system to accomplish these payments. On Tuesday of the following week MMIS will send the status of the payment and the warrant number back to the eMIPP system. Upon receipt of this information

eMIPP will process the D18 to notify CMS that payment was issued. The D18 interface also runs daily.

Incentive payments for eligible providers who have a minimum of 29.5% (rounded to 30%) patient encounters paid by Medicaid, will then be eligible to receive an incentive payment of $21,250 in his/her first year payment and $8,500 in subsequent years.

For pediatricians who apply and are considered eligible they would receive up to the maximum allowable amounts of $14,167 in the first payment year and $5,667 in subsequent years. If the pediatrician is not hospital based and can demonstrate that they meet the minimum 30% threshold, they will qualify to receive the full incentive of $21,250 in his/her first year payment and $8,500 in subsequent years.

Hospitals incentive payments are calculated by program staff using the prescribed formula provided by CMS. Hospitals meeting Medicare meaningful use may be deemed eligible for Medicaid incentive payments. Eligible hospitals will receive a total gross payment over the course of four years. Their payment will consist of the $2,000,000 base plus a per discharge amount based on the Medicaid share of patients seen. Hospitals will receive fifty percent of the payment in the first year and forty percent in the second year, and five percent the last two years. In addition to requesting discharge data from the 12-month period that ends in the Federal fiscal year before the hospital's fiscal year, hospitals will have to include in their registration their full, legal business name, national provider identifier (NPI), business address/phone, tax payer identification number (TIN) and CMS certification number and certified technology. All Utah hospitals have been informed of the 2016 deadline to make their initial application for payment.

Appeals Process

Utah Medicaid PI Program providers may choose to appeal denials based on:

- Incentive payment amounts
- Provider eligibility determinations
- Demonstration of adopting, implementing, and upgrading, and MU eligibility for incentives
- Adverse post-payment audits

The appeal process is initiated by the provider filing a written, signed request for appeal with the Department's Administrative Hearings unit within 30 calendar days after the date of the Department's Denial Notification. These administrative hearings are governed by the Utah Administrative Code, R410-14-5.

The request for appeal shall include: 1. A State Fair Hearing Request form 2. A copy of the Denial Notification issued by the Department 2. A brief statement of the issue on appeal 3. Documentation supporting the appeal request.

The hearing request and the subsequent scheduling of the hearing(s) will be tracked by PI Program Manager and the Administrative Hearing Unit's secretary until a recommended decision is made. A final decision letter is prepared by an administrative law judge who has reviewed the action, the issues, the findings of fact, the conclusions of law and has documented the disposition, and the reasons for the disposition in a Final Agency Order that is signed by the State Medicaid Director (or his/her designee.) The Director may affirm, reverse, modify or remand the Recommended Decision for further findings. This Final Agency Order will include details about subsequent appeal processes to be used if the petitioner disagrees with the Final Agency Order.

After the Final Agency Order is signed by the Director, the original is sent to the petitioner or his representative by certified mail with a return receipt and copies are sent to other interested parties. Appeals related to incentive payment amounts or audit findings that adjust or recoup payment amounts will be reported to the CMS NLR via E8 transactions which are triggered within eMIPP when appeals are started and finalized.

Payment Offset

The State of Utah does not use incentive payment money to offset any amounts that are owed back to Medicaid, due to the differences in funding sources. Instead, program staff check to ensure providers are not in credit balance with Medicaid. This check occurs at the beginning of attestation processing and again before requesting permission to pay. In the event that a provider who is eligible for an incentive payment is found to be in credit balance, staff will work with provider administrators to ensure that the credit balance is resolved prior to approving the payment. The great majority of providers will receive their full payment via mail within two weeks of having their attestation approved.

Audits

Each Provider that receives an EHR Incentive payment is eligible for an audit. For each stage of the incentive program, the program will audit a minimum of 10% of Eligible Professionals and 10% of Eligible Hospitals who have received EHR incentive payments. As of 2019, auditing has been outsourced to Myers & Stauffer, LC. All providers are notified at the time of attestation of the requirement to retain the necessary documentation for this payment and are advised that they may be required to furnish this information to the program or its representative in the event of an audit. As of December 31, 2021, Myers and Stauffer had audited 281 incentive payments and identified five instances where payment was made incorrectly. As of June 30, 2016, the OIG had audited 198 incentive payments and identified 12 instances where payment was made incorrectly. Meaningful use Audits for dually-eligible hospitals were delegated to CMS up through program year 2015. The state will take over the audits for dual eligible hospitals starting with the 2016 program year. The Utah Audit Strategy was submitted to CMS as a separate document. All audits, with or without negative findings, will be reported to CMS via automated E-7 interface transaction triggered by audit statuses from within the eMIPP state level registry.

Recoupment process for payments

When an overpayment or improper payment is identified due to audit findings the following procedures will be followed.

The audit finding letter will notify the provider of the amount that needs to be repaid and provide an address for returning a check to Utah Medicaid. Providers will have 30 days to appeal the audit findings, and 60 days to make payment or make payment arrangements with Medicaid. This letter will be simultaneously shared with the Bureau of Financial Services so that financial management has the date of the findings and can ensure repayment of federal funds within 365 days. This timeline will be observed regardless of any delays or difficulties with recovering the amount owed.

Once the check for the recouped amount is received by incentive program staff, this will be returned to HITECH funds. The recouped amount will be returned to CMS through the State's normal draw process and reported as an overpayment on Utah's next quarterly CMS-64 report. The payment adjustment will also be reported to the CMS NLR via D18 transaction.

The repayment and reporting process will also be followed in the event of provider self-reported refunds, where there is no audit finding.

Other HITECH Funding Opportunities

We are integrating the SIM recommended HIT projects as they are identified and are consistent with the HITECH Administrative Funding opportunities. In this process, Medicaid provider types have been identified across the continuum of care. The goal of HITECH 90/10 IAPD applications is to reach out to these providers around specific use cases. A current list of potential projects prioritized in the SIM process with brief descriptions is found in table below.

Project	Project Description	Medicaid Project Description	Providers Types	Matching Source
ePOLST	Connect all SNF to cHIE	Onboarding Medicaid Providers	Long Term Care Providers	SNF civil money penalties
ePOLST	Upload ePOLST from SNF to PH registry	Query Exchange	Long Term Care Providers	SNF civil money penalties
ePOLST	Connect all EMS agencies to cHIE	Onboarding Medicaid Providers	Emergency Medical Provider Service Providers	BEMS grant $$
ePOLST	Provide EMS Access to ePOLST at POC	Query Exchange	Emergency Medical Provider Service Providers	BEMS grant $$
ePOLST	Provide ED departments access ePOLST at POC	Query Exchange	Emergency Medical Provider Service Providers	BEMS grant $$
CSDB	Connect CSDB to CHIE	Onboarding Medicaid Providers	Pharmacies	CSDB general funds
CSDB	Provide Access to CSDB at POC	Query Exchange	Emergency Medical Provider Service Providers	CSDB general funds
Ped BH Summary	Connect all BH providers to cHIE	Onboarding Medicaid Providers	Behavioral Health Providers	BMI/Department of Pediatrics
Ped BH Summary	Upload PED BH Summary	Query Exchange	Behavioral Health Providers	BMI/Department of Pediatrics
Ped BH Summary	Provide access to PED BH Summary at POC	Query Exchange	Behavioral Health Providers	BMI/Department of Pediatrics
THsISU	Establish Governance and Service Provision	Health Information Services Provider	Community-Based Providers	Business Case/Providers
MPI	State MPI	Provider Directories	Community-Based Providers	General fund
Medicaid Expansion	Expansion of Medicaid coverage to correctional, homeless, MH/SUD	Onboarding Medicaid Providers	Correction Heath Providers	General fund
Trauma Registry	Electronic Health Record reporting to Registry	Public Health System development/connection	Community-Based Providers	BEMS funding
EMSC Registry	Electronic Health Record reporting to Registry	Public Health System development/connection	Community-Based Providers	BEMS funding

HITECH Funds to Promote HIE connections with Medicaid Providers

In the Medicaid Directors Letter dated February 29, 2016, CMS expanded the scope of expenditures that are eligible for the 90 percent matching rate. In response to this funding change, the State of Utah requested HIE funding for three projects which will help the state achieve the following goals:

- Connect more providers to Utah's HIE.
- Improve the data quality and availability of data in the HIE by facilitating improvements in the master person index and by minimizing manual processes in newborn screening.
- Enhance the interoperability of EHRs.
- Enhance coordination of care among providers of primary care, specialty care, behavioral health care, various therapies, and community-based services.
- Enable the health information exchange of controlled substance medications to EP EHR systems.
- Improve outcomes for newborns by expediting interventions for certain conditions.
- Improve outcomes for pediatric patients with complex medical conditions.
- Enhance provider clinical decision making.

Pediatric Patient Portal

The State has identified a slow progression of HIE utilization and adoption among providers who care for children with complex conditions, delaying its anticipated impact on the quality, costs, and outcomes of patient care in this population. To address the slow progression of HIE utilization, the State initially developed a Pediatric Patient Summary (PPS), a web-based platform where clinicians and parents can collaborate to maintain a succinct, accurate, and up-to-date compilation of relevant information about children and youth with special health care needs (CYSHCN). The State also operates its Medical Health Portal, which offers guidelines, information, tools and other resources for clinicians, their teams, and caregivers to improve the care of CYSHCN, and their families, along with directories of local service providers.

The project was approved by CMS on 8/30/2017. It will address the challenges to the use and value of the Clinical Health Information Exchange (cHIE) to the targeted providers by embedding the PPS into EHR systems as an app compliant with SMART and FHIR standards. In addition, the project will redesign, develop, and implement its organization, content, and content management, data structure, and utilities and to integrate access to its resources into the PPS.

The pediatric patient portal will support:

- The utility and value of Utah's Clinical Health Information Exchange (cHIE) for behavioral health providers, and other non-traditional users of HIE, particularly those who care for children and youth with chronic and complex conditions, including physical, occupational, and speech/language therapists, home health, public health, emergency medical services, substance abuse providers, and the parents/guardians/caregivers of those children
- Coordination of care among providers of primary care, specialty care, behavioral care, various therapies, and community-based services
- Clinical decision making, particularly in long-term management of chronic conditions

- Engaging and enrolling the range of providers of care for Medicaid-enrolled children and youth, particularly those not currently using HIE
- Engaging patients and/or their parents/guardians/caregivers in understanding their conditions, in self-care, and as partners in coordinating care and improving outcomes

This project offers unique benefits to clinicians and patient families:

- User-friendly, efficient presentation of a concise summary of essential information from different institutions about children with chronic and complex conditions;
- Features to support Care Team Management and collaborative Care Planning that enables engagement of parents/guardians and sharing through HIE, Direct, and pdf;
- Integrated access within the PPS to information from the MHP to support primary care, care coordination, specialty collaboration, patient/family education, shared decision-making, and access to relevant professional and community providers to address clinical and related needs as well as social determinants of health;
- Collaboration with UHIN, Medicaid, and other payers to enhance information available on potential clinical providers; may be translatable to other states' HIEs and Provider Directories;
- App integrated into and launchable seamlessly within Epic; piloted also in Cerner, and potential for other FHIR-compliant EHRs (will be explored for those popular with Community Health Centers);
- MHP currently collaborating with 6 states to present local service provider directories, some of which have already expressed interest in the PPS-MHP app for their state; the app may enhance interest of other states in collaborating.

Several agencies were able to work together successfully to develop an app with aggregated data from multiple sources that helps physicians treating children and youth with special health care needs. A family app was also developed to allow families of CYSCHN to also view the information. Some objectives were not met, such as the ability for families to enter, store, and share comments within the app. Some of these shortfalls came from miscommunications and understanding among the parties, such as the cHIE not having a patient-facing portal. All parties expect to maintain and expand the use of the PPS and Family PPS over the coming years.

Controlled Substance Medication Integration

The Controlled Substance Database (CSD) contains all dispensed controlled substance medications for all Utah patients, and the CSD is used by the State's Prescription Drug Monitoring Program (PDMP) and Medicaid to analyze controlled substance usage. The CSMI project will develop the infrastructure necessary to integrate with the CSD to enable health information exchange between the CSD and Medicaid Eligible Providers (EPs). This will most significantly, allow for enhanced care coordination of Medicaid eligible patients receiving controlled substance medications, such as opioids, while also enabling opportunities for EPs to meet medication reconciliation, health information exchange, and clinical decision support Meaningful Use (MU) objectives and related electronic clinical quality measures (eCQMs), as a part of the PI Program. This effort also supports expanded onboarding of non-traditional EPs, such as Medicaid pharmacists and prescribers. CMS approved this project on 2/20/2018

The four main areas of this project are:

- Develop master person linkage within the states Controlled Substance Database (CSD) as required for HIE to link medication records to Medicaid patients within EHR systems for care coordination, medication reconciliation and clinical decision support.
- Develop web API layer to support HIE between the CSD and external systems to extract and transform controlled substance medications to be consumable into Medicaid eligible EHR systems.
- Onboard new eligible providers and EHR systems to the clinical Health Information Exchange (cHIE) to support EPs meeting MU objectives and eCQMs.
- Develop enhanced analytics for use in clinical decision support and care coordination

The CSMI project moved forward the state's desire to better integrate EHRs and the PDMP to streamline medication management and prescribing workflows. The University of Utah's research helped inform which CSD and EHR changes would be most effective. Lastly, the DOPL was successful in expanding their CSD integrations with healthcare entities around the state. The project experienced legal challenges and unforeseen staffing issues due to COVID and turnover that prevented some objectives from being completed. DOPL and UDOH intend to further improve the PDMP.

Newborn Screening

Newborn Screening (NBS) saves lives through the early identification and timely clinical management of babies born with life threatening disorders. However, identification through screening, diagnostic testing, short-term clinical management, and long-term clinical management relies on inefficient system infrastructure that delays timely identification of babies at risk, compromises care, and results in significant cost burdens. This project focuses on improving NBS infrastructure to improve infants' health outcomes. CMS approved this project on 7/23/18.

This project will build on and expand the utility and features of the cHIE and Utah Department of Health Master Person Index (DOHMPI) to improve the NBS process. Features within the cHIE that will be improved and/or developed include the Patient Lookup Service, Order Receiving Service, Patient-Provider Relationship Manager, NBS Result Distribution Service, and Provider Repository.

This project has three main areas:

- Establish HIE for NBS related data between EHRs and the laboratory information management system (LIMS) at the Newborn Screening Program (NSP) by leveraging Utah's Clinical Health Information Exchange (CHIE).
- Develop HIE for genomic data from NSP LIMS to EHRs.
- Establish NBS long-term follow-up to enhance clinical decision making for NBS disorders.

Electronic Physician Orders for Life Sustaining Treatment (ePOLST)

Clinical health information exchange for end-of-life care is one of the Utah Health Information Technology Strategic goals. The ePOLST project (approved September 10, 2019) is focused on design, development, and implementation of a HIE-based application to enhance the utility, value, and use of HIE in the care and engagement of Medicaid-insured patients with serious illness or frailty. This application will enable long term and post-acute care Medicaid providers, and caregivers to access and share Physician Orders for Life Sustaining Treatment (POLST.) This project aims to share advanced directives using SMART on FHIR interoperability standards, which will further integrate data from provider EHRs into the cHIE.

The minimum project objectives were met and the ePOLST HITECH project has improved the infrastructure in Utah for coordinating care for patients with serious illness. Workflows have been modernized to make documentation and sharing of POLST easier for participating facilities. Utah plans to continue training and expanding the use of ePOLST in the state now that the systems have been updated and tested to support more streamlined workflows.

Falls Prevention

This project, approved September 10, 2019 is targeted to older adults 65 years and older who are dual eligible beneficiaries (Medicaid/Medicare) at high risk for future falls. An older adult who falls, calls 911 for assistance, and is not transported to the Emergency Department is at high risk for another fall. However, the records from non-transport EMS calls are not shared with insurance companies, healthcare providers, or care managers at Area Agencies on Aging. This represents a missed opportunity to prevent future falls, repeat EMS calls, and hospitalizations.

Since EMS non-transport calls are not billable, healthcare providers, insurers, and Area Agencies on Aging are not aware when their patients/ beneficiaries have fallen, but not suffered an injury. Agencies and healthcare providers are unable to initiate a preventative fall risk management program.

This project will integrate Bureau of Emergency Medical Services (BEMS) assessment data for non-transport fall calls for older adult who are 65 years and older to the Utah Clinical Health Information Exchange (cHIE). Within cHIE, BEMS data will be matched with electronic health record data using patient name and zip code of residence. Alerts of the fall can then be sent to Medicare Advantage plans, healthcare providers and case managers at Area Agencies on Aging that are currently providing care, or medical insurance, for the individual.

The Falls project provided an automated way for Falls event data to flow from an EMS vendor to the Department of Health to the state's cHIE. This allows the cHIE to inform providers of these Falls events of which they would have otherwise been unaware. UHIN also developed a home health hub that will be a convenient way to coordinate home health services among agencies and providers that does not require significant effort to setup by each participating entity.

Utah's "Programmatic" HIT Landscape

Utah Medicaid worked directly with our stakeholders to record the "Historical" landscape (formerly known as the "As Is" landscape) and develop the "Programmatic" landscape (formerly known as the "To-Be" landscape). As identified in our first iteration of the SMHP, we will continue to facilitate payments to eligible providers and hospitals. Medicaid will also continue to work with our established partners on current and future projects that bring us closer to our long-term HIT/HIE goals. These goals include: providing credible information to consumers so they make informed health care decisions, reviewing provider quality data, seeing all Utah clinicians meaningfully use HIT, and connecting to our State's HIE to report timely and accurate public health data to improve population health. We will also seek to increase interoperability across the continuum of care of Medicaid providers which may include but, is not limited to onboarding, provider directories, secure electronic messaging, query exchange, care plan exchange, encounter alerting, public health systems development, and the provision of health information services.

Governance Landscape

Utah has appropriate HIT governance and partnerships in place as noted in the above 'As-Is' section. The State's Digital Health Service Commission includes broad representatives. Medicaid is a member of the UDOH Meaningful Use Workgroup including all public health partners from Immunizations, Syndromic Surveillance and Lab Reporting and Cancer Registry.

Provider Landscape

In the later stages of the PI program, the focus has naturally shifted from outreach/onboarding. As described elsewhere in this document, several factors are contributing to a narrowed base of participating providers. No new providers have started year one of the program since program year 2016. Changing requirements and the difficulty (and costs) to continue to meet the meaningful use measures have made this program less accessible to smaller, independent providers and groups who may lack the administrative and technical support that is needed. The providers who remain in participation with the PI program are well experienced with this program. Supporting these types of attestations consists less of training and outreach and more of technical support.

Program staff have developed strong relationships with the provider community who receive these payments. We are focused on keeping them informed of updates and deadlines, and reinforcing their responsibility to submit accurate information and maintain proper documentation for the PI incentive payments.

Legislative Landscape

As noted in the 'As-Is' section, the Utah Medicaid Program and our HIT/HIE partners have received all the needed legislation to continue to move forward with our EHR Incentive Payment Program. As Utah continues to implement the EHR Incentive Program new legislation may be required to insure broader access to medical data for professionals, hospitals, public health programs and entities in order to make informed decisions that will improve the health care outcomes for the citizens of Utah.

Utah legislature has passed a bill to expand Medicaid coverage for adults and some of the most at risk populations. The increase of Medicaid recipients may have the effect of increasing the number of providers with sufficient Medicaid patient volumes to attest for Meaningful Use.

Utah Medicaid Operations Landscape

In order to continually and successfully initiate payments to eligible providers and hospitals, certain business processes and documents (i.e. attestation/registration forms) have been developed, staff hired and provider outreach and education about the program has occurred. The EHR Program Manager continually engages with stakeholders and other Utah Department of Health and Department of Technology Services (DTS) staff to produce deliverables and meet milestones so payments can continue to Utah eligible providers and hospitals.

The State of Utah compiled requirements and documentation for a Request For Proposal (RFP), with the intention of selecting a specialized audit vendor to support the Medicaid PI Program. The scope of work includes a comprehensive update (and maintenance) of the Utah Promoting Interoperability Audit Strategy, execution of post-payment audits, professional support in evaluating hospital payment calculations, and other subject matter expertise as required. The RFP was posted to the state procurement system on

12/26/17 and closed to respondents on 2/9/2018. After evaluating and scoring the various responses, the PI program awarded this contract to Myers & Stauffer, LC on 3/20/2018. CMS approved the program's request for funding these audit activities in the IAPD which was approved December 6, 2018.

The following table identifies the business processes that have been developed, tested, and documented by the designated program manager, program support staff, and DTS staff. The table has been updated to reflect ongoing updates in the CNSI MMIS for the following business processes:

Promoting Interoperability Program Activities Table

Specific Business Process or Requirement to Making PI Payments	Oracle Solution Status	CNSI eMIPP Status	Expected Outcomes or Products	Responsible Staff • Lead • Support
Interface with NLR & CMS regarding payments made to eligible providers	Sunset date 7/1/2016	Fully functional as 7/1/2016.	A developed system that interfaces with the National Level Repository (NLR)	**Lead** DTS/CNSI - Developers EHR Program Manager **Support** Medicaid Staff
Verify Medicaid patient volume for all applicants, provide notification of approval/denial for incentive payments	Sunset date 7/1/2016	Fully functional as of 7/1/2016	Attestation Form and NLR interfaces will be in EMIPP.	**Lead** DTS/CNSI - Developers EHR Program Manager **Support** Medicaid Staff
Process payments to providers and hospitals, query claims data base to verify that providers meet Medicaid patient volume	Fully functional as of 10/1/2011	These functions will stay in legacy until the claims subsystem is functional, target date currently March 2022 for payments to process from PRISM.	Payments made in timely manner to eligible providers, validation of patient volume	**Lead** DTS/CNSI - Developers EHR Program Manager **Support** Medicaid Staff
Create & maintain a Web site for Provider Enrollment & FAQs	7/1/16	Current site is fully operational as of 10/1/11 with continual updates throughout the life of the program. The links and web based trainings for eMIPP are available as of 7/1/16	Website is running with continuous updates	**Lead** EHR Program manager **Support** State DTS
Continue to develop communication materials about the EHR Incentive Program and/or EHR adoption/meaningful use	12/1/14	Ongoing	Communication strategy & plan that covers the new look and feel of EMIPP will begin a few months in advance of switching to EMIPP	**Lead** EHR Program Manager **Support** Medicaid staff
Conduct provider outreach activities for HITECH interoperability projects	Ongoing	Ongoing	Webinars, meetings, and/or presentations conducted	**Lead** EHR Program Manager **Support** HealthInsight

Core Administration Activities Table

Specific Business Process or Requirement to Making PI Payments	Expected Start Date	Continue or End Date	Expected Outcomes or Products	Responsible Staff • Lead • Support
Installed a provider help-line/dedicated e-mail address/phone	Ongoing	Ongoing	The EHR Program staff respond to calls, emails & correspondence regarding technical issues, program parameters, enrollment validation & disputes (not appeals)	**Lead** DTS - Developers EHR Program Manager **Support** Medicaid Staff
Monitor & review current CMS policies, propose recommended changes or inclusion of new policies & procedures, develop & update FAQ's for dispute resolutions, keep screens and business processes current	Ongoing	Ongoing	Effective business process models supported by stakeholders, plus technical system support changes as necessary & a consistently updated SMHP & IAPD	**Lead** EHR Program Manager **Support** CNSI
Validate volume thresholds, payment calculations, meaningful use, quality measures & provider credentials throughout the life cycle of the program.	3/1/15	Ongoing	Queries to calculate Medicaid patient volume are now run directly from the data warehouse. Reviewer initiates this process manually.	**Lead** DTS/CNSI - Developers EHR Program Manager **Support** Medicaid Staff
Review of administrative activities & expenses of Medicaid provider health information technology adoption & operations; financial oversight & monitoring of expenditures including provider enrollment procedures for combating fraud waste & abuse in the program	Ongoing	June 2016	Compliance with the following: 42 CFR § 495.364 42 CFR § 495.366 42 CFR § 495.368, §455.15, §455.21	**Lead** EHR Program Manager **Support** Utah's Office of Inspector General, Medicaid Staff & HealthInsight Staff
Collaboration with Public Health Partners and cross continuum interoperability	Ongoing	Ongoing	Public health reporting for syndromic surveillance, lab reporting and Immunizations	**Lead** EHR Program Manager **Support** Public Health Partners
Maintenance of State Audit Plan, execution of post-payment audits for PI incentive payments by professional audit staff	4/1/19	9/30/23	Compliance with the following: 42 CFR § 495.364 42 CFR § 495.366 42 CFR § 495.368, §455.15, §455.21	**Lead** Myers & Stauffer LC **Support** EHR program staff

Administration and Oversight

Sanctions & Licensing Verification

Once a provider has enrolled at the CMS web site the registrations are sent to the state by the next business day. Federal sanction verifications are completed on a registration before being sent to the State.

In response to the B6 provider registration records received from CMS each day, eMIPP performs automated validation checks (provider type, sanctions, death match, provider/payee relationship, Medicaid enrollment) and notifies the provider via email to complete their attestation.

For eligible providers, eMIPP will transmit a D16 "intend to pay" transaction to CMS daily. Once eMIPP receives the daily response from CMS, the requested payment amount is validated, and a second sanctions check is performed.

To ensure that payments are not made to payees who are in credit balance status, review staff query a system report from finance that checks for any balances owed to Medicaid. The report is generated on a weekly basis. Confirmation of no credit balance is made at the start of prepayment review and on the day of attestation approval. This verification is stored in the eMIPP review comments. If a provider is found to be in credit balance, staff advises on how to investigate and correct the situation and does not recommend for payment until the balance is cleared. Medicaid does not offset or deduct the PI incentive payment in any way due to concerns about different funding sources. The entire payment is issued to the payee NPI that the provider has listed at the CMS national level registration.

The PRISM Provider Credentialing Service (PCS) is an automated process that looks for sanctions or other issues in the Medicaid provider profile. This automated check runs at the time of PRISM enrollment and usually on a monthly basis thereafter. The eMIPP reviewer triggers PCS manually when reviewing the attestation as an additional sanction check. PCS performs the following verifications:

- National Provider Identifier (NPI) and related taxonomies through the National Plan and Provider Enumeration System (NPPES);
- Drug Enforcement Agency number (DEA) numbers are assigned by the DEA to providers who write prescriptions;
- Clinical Laboratory Improvement Amendments (CLIA) certification numbers managed by the Centers for Medicare & Medicaid Services (CMS);
- In State and Out of State Professional Licenses;
- Social Security Number (SSN) assigned by the Social Security Administration;
- Federal Employer Identification Number (FEIN) assigned by the Unites States Internal Revenue Service;
- State and Federal Vital Statistics; specifically date of death;
- American Board of Medical Specialties (ABMS) Board Certifications;
- Sanctions (OIG, CMSMED, SAM, MCSIS, Other State Sanctions);
- Other sanctions includes SAM and MED.

Utah confirms an active license during the attestation review process and uploads the results to the eMIPP file. The reviewer also ensures that any disciplinary actions noted on the license are reflected the in the PRISM provider enrollment file.

In addition to these verifications, eMIPP reviewers verify pediatrician training, when appropriate, for pediatricians qualifying with a patient volume percentage below 30%, but greater than or equal to 20%. If possible, pediatric board certification is verified

using the American Board of Pediatrics. Pediatric residency training is sometimes confirmed using a physician faculty biography. Pediatricians may also qualify if the Medicaid enrolled provider serves a patient base that consists of 80 percent or greater of patients under the age of 18 (age of the patient at the time the service is rendered.)

An additional manual check is performed by sending provider name and NPI to Utah's Office of the Inspector General prior to payment. This prevents the program paying a provider with a fraud investigation not otherwise visible in the PRISM system.

Hospital-Based Determination

During Utah's pre-payment audit, a query of patient encounters determines if the Eligible Professional (EP) is considered as hospital-based. If 90% or more of patient encounters for the reporting period were performed in POS 21 and 23, then the provider is determined to be hospital-based and is not eligible to receive an incentive payment.

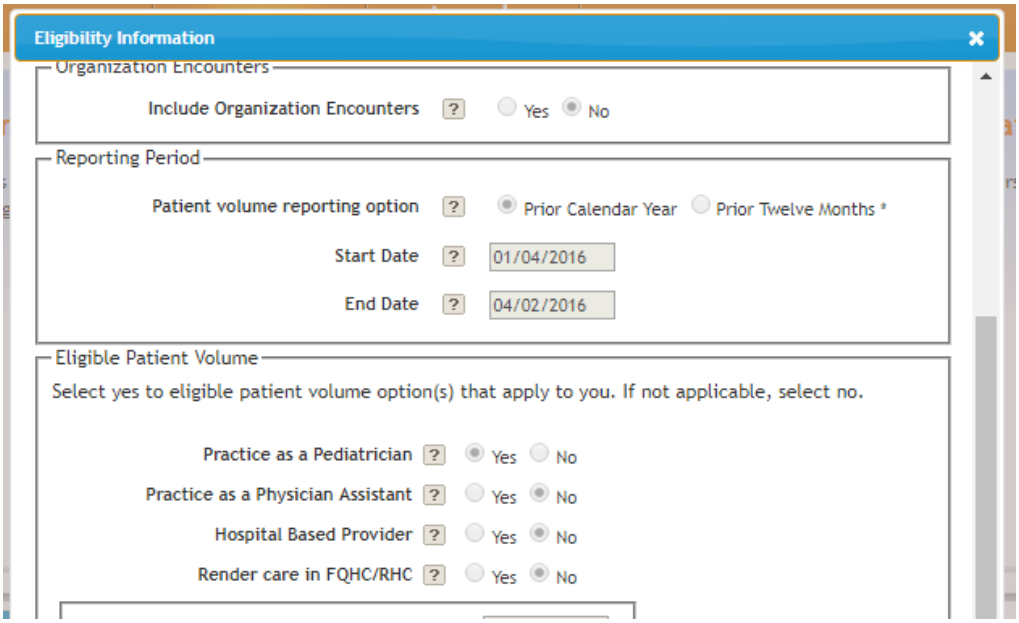
EPs are also required to answer an eligibility question, "Hospital-Based provider? (Y/N)". The eMIPP system advises providers at the time of attestation that "Hospital based eligible professionals must provide less than 90% of their services as inpatient hospital discharging physician or emergency room physician to be eligible for the incentive program. Hospital based is refined to exclude from the definition those EPs who are not furnishing professional services "through the use of the facilities and equipment, including qualified electronic health records, of the hospital."

Provider Attestation Overall Content Verification

Provider attestation content prepayment review is performed by incentive program staff. Reviewers follow a checklist developed for their process which consists of both manual and automated validations. Providers with incorrect or missing information are rejected with reviewer's comments noted.

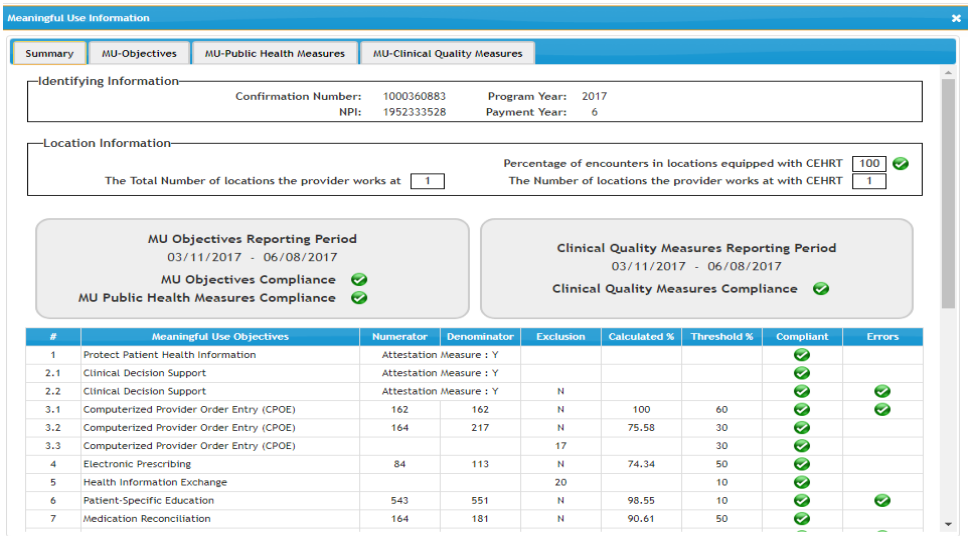
Eligibility Tab:

- Validate 90-day date range
- Did the provider include organizational encounters?
- Does the provider practice in an FQHC or RHC?
- Note the Medicaid encounters and total encounters



Meaningful Use Tab:

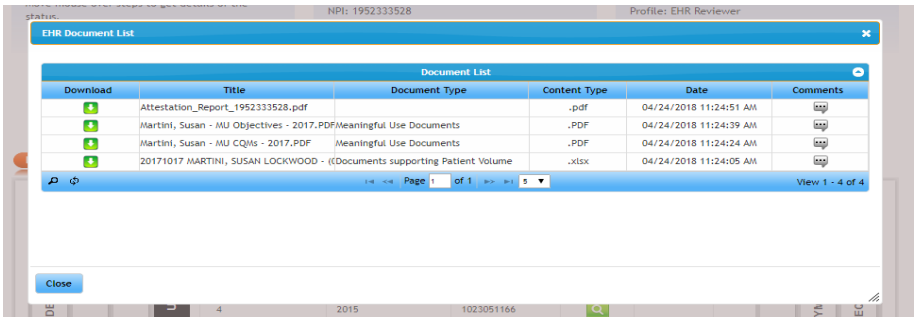
- Verify CEHRT questions in the location information section (compliance recognized by a green checkmark, a red checkmark designates non-compliance).
- Verify completion of MU Objectives Compliance, MU Public Health Measures Compliance and Clinical Quality Measures Compliance (compliance with meaningful use business rules recognized by a green checkmark, a red checkmark designates non-compliance).
- Compare all meaningful use measures and exclusions entered match provider's meaningful use reports from certified EHR technology.



#	Meaningful Use Objectives	Numerator	Denominator	Exclusion	Calculated %	Threshold %	Compliant	Errors
1	Protect Patient Health Information	Attestation Measure : Y					✓	
2.1	Clinical Decision Support	Attestation Measure : Y					✓	
2.2	Clinical Decision Support	Attestation Measure : Y		N			✓	✓
3.1	Computerized Provider Order Entry (CPOE)	162	162	N	100	60	✓	✓
3.2	Computerized Provider Order Entry (CPOE)	164	217	N	75.58	30	✓	
3.3	Computerized Provider Order Entry (CPOE)			17		30	✓	
4	Electronic Prescribing	84	113	N	74.34	50	✓	
5	Health Information Exchange			20		10	✓	
6	Patient-Specific Education	543	551	N	98.55	10	✓	✓
7	Medication Reconciliation	164	181	N	90.61	50	✓	

Upload Documents tab:

Providers may upload any documents they feel necessary for their attestation. State staff upload other supporting documentation collected or generated during the review process.



Review tab:

Verify that patient volume is at least 20-29% for pediatricians or 30% for all other providers.

Verifying encounter data:

- Run query on NPI for selected 90-day range through data warehouse.
- Compare individual or group totals as necessary.
- Obtain additional documentation if not within 5% of attested Medicaid encounter numerator.
- If the provider number is lower than DMHF's number, they need to make sure that they are counting every time that Medicaid is a valid insurance on a patient's account. It doesn't matter if Medicaid is primary, secondary, tertiary or even if Medicaid paid $0.00.
- If Medicaid encounters from other states are needed to reach the eligibility threshold, email a request to PI program counterpart in that state for a count of encounters.
- For providers who use global billing, or nurse practitioners who bill under a supervising physician, the Medicaid claims are not always a good match for the provider's attested Medicaid numerator. In these cases a partial audit of patient eligibility is performed to confirm that the Medicaid patient was eligible for Medicaid on the date of service.

Establishing Patient Volume Methodology

Methodology for Determining EP Patient Volume

All EPs (except EPs predominantly practicing in an FQHC/RHC) will calculate patient volume based on encounters with patients eligible for Utah Medicaid or other state's Medicaid program. The final rule allows for an EP practicing predominantly in a FQHC or RHC to also include their CHIP patients under the needy individual patient volume requirements.

Definition of an EP Medicaid Encounter

For purposes of calculating EP patient volume, a Medicaid encounter is defined as services rendered on any one day to an individual where the individual was enrolled in a Medicaid program (or a Medicaid demonstration project approved under section 1115 of the Act) at the time the service was provided. It also includes Medicaid Managed Care Organization encounters and encounters where Medicaid is the secondary payer.

Definition of an EP Needy Individual Encounter

For purposes of calculating patient volume for an EP practicing predominantly in a FQHC/RHC, a needy individual encounter is defined as services rendered on any one day to an individual where medical services were:

- Billed to Utah Medicaid;
- Furnished by the provider as uncompensated care (charity care); or
- Furnished at either no cost or reduced cost based on a sliding fee scale determined by the individual's ability to pay.

Calculating Eligible Professional Patient Volume

To calculate patient volume, providers must include a ratio where the numerator is the total number of Medicaid patient encounters (or needy individuals for FQHCs and RHCs) treated in any 90-day period in the previous year or the twelve months prior to the attestation date, and the denominator is all patient encounters over the same period.

The numerator must consist of all patient encounters for Medicaid eligible patients during the 90-day period; the denominator must consist of all patient encounters during the 90-day period.

To calculate Medicaid patient volume, EPs (except those practicing predominantly in a FQHC/RHC) must divide:

- The total Utah Medicaid patient encounters or out-of-state Medicaid patient encounters in any representative, continuous 90-day period in the calendar year prior to Program Year, or in the twelve months prior to the attestation date; by
- The total patient encounters in the same 90-day period.

Data Sources for Patient Volume Verification

Utah runs SQL queries in the Medicaid data warehouse to verify patient volume. Medicaid encounter counts s are compared to the Medicaid encounters attested to by the provider. Since not all patient encounters generate a claim in the data warehouse, program staff also sometimes will rely on verification of a portion of Medicaid patient eligibility on the date of the reported encounter. This requires the provider to submit a roster of Medicaid encounters from the patient volume reporting period. This patient roster is used for an additional SQL query to confirm member eligibility for each month of the patient volume reporting period. There are a number of Medicaid beneficiaries that cross state lines into Utah for services, especially for specialty care with the University of Utah. The SMA reaches out to other states' HITECH staff to confirm member eligibility when appropriate. The vast majority of these out-of-state beneficiaries are from states with a connection to the cHIE.

FQHC/RHC Practice Predominantly Verification

The Utah Medicaid PI Program defines "practice predominantly in an FQHC/RHC" as having 50 percent or more of the total patient volume for the EP over a six-month period take place at a FQHC/RHC location. Program staff may request confirmation from the FQHC clinic to establish the provider's hire date with the FQHC and to establish that the FQHC is the only practice site. The EP must also have a minimum 30 percent patient volume attributable to serving needy individuals.

To support needy patient encounter totals, EPs at FQHCs are required to provide their Uniform Data System (UDS) report, which is reported to the Health Resources and Service Administration (HRSA). The encounters shown on the UDS report assist the reviewer in their determination. RHC numbers are more difficult to verify. The usual method of comparing encounters by NPI or TIN groupings and location of service is generally utilized for the pre-payment verifications.

AIU Verification

Providers confirm adoption, implementation or upgrade (AIU) of certified EHR technology in their first year by attesting to meeting the requirements for AIU. If the provider is selected for post-payment audit, additional documentation will be required. Examples of acceptable documentation include the following:

- Adoption: EHR contract, software license, receipt or proof of acquisition, purchase order
- Implementation: EHR contract, software license, cost or contract evidence
- Upgrade: EHR contract, software license, receipt or proof of acquisition, purchase order

MU Verification

The State will verify Meaningful Use through a number of automated system validations. Business rules in the eMIPP product perform comparisons to look for possible data issues such as measure that should have the same denominator, or denominators that should be smaller subsets of other numbers. Review staff will compare the MU data submitted to the reports generated by the certified EHR. Any data entry errors will be resolved prior to payment. Documentation regarding engagement status with public health registries will be confirmed directly with the state registries, or providers will be required to submit documentation from external registries. The security risk assessment will be collected prior to payment. Additional verification will also occur in post-payment audits. These auditing procedures are not public, but will be submitted in a separate attachment to this document.

State Specific Changes to MU

Utah requested an extension of the 2015 program year. The 2015 Modified Stage 2 regulations required a large number of changes to the SLR. At the time these were announced the program was still operating out of our legacy solution. As the MMIS replacement product and upgraded SLR (eMIPP) were scheduled to go live in July 2016, the state could not justify the programming time and expense to update the legacy system in time for the standard tail period. We applied for permission to extend the tail period to September 30, 2016 and this was granted by CMS staff on 3/22/2016.

An extended tail period was also requested for the 2017 program year. Due to the timing of system upgrades, we were unable to accept the newest version of the meaningful use measures until 4/7/2018. On February 28, 2018, CMS granted approval to extend our tail period to 6/30/2018 to accommodate these upgrades.

The tail period for the 2019 program year was extended, with CMS permission, to 6/30/2020. This allowed us to work around some MMIS updates that made it impossible for providers to update their Medicaid provider records for several weeks.

Due to the shortened MU reporting period for program year 2020, the attestation tail period opened up on July 1, 2020. Providers had until 3/31/2021 to attest for 2020.

Eligible providers were invited to attest for program year 2021 as soon as their 2020 payment had been processed and 2021 attestations were accepted until 9/30/2021.

Utah will continue to consult with CMS regarding tail periods if additional modifications are required.

Other than requesting these attestation deadline extensions, Utah has not implemented any changes to the definition of Meaningful Use as it has been defined in federal legislation.

Certified EHR Technology Verification

Entry of the EHR Certification number is required during attestation. The number is verified via WSDL transactions (web calls) to the federal Office of the National Coordinator (ONC) Certified HIT Product List (CHPL) web site. eMIPP automatically verifies the program year of the certification as appropriate for the attestation. In some instances reviewers request additional information regarding system name and version so that the EHR certification number can be further validated. Post-payment audits may include additional verification of the provider's Certified Electronic Health Record Technology. Please see the state's Audit Plan for additional detail.

Collection of MU Data

Utah EPs and Medicaid-only EHs may submit their meaningful use data via eMIPP in three ways: manually enter the data, complete a PDF form to be uploaded to eMIPP, or electronically upload a QRDA file (which was extracted from the provider's EHR system). Information from dually eligible hospitals is received via a C5 transaction from CMS.

Utah made the decision not to require the QRDA submission. As QRDA becomes more familiar to Utah providers, we had hoped that this method would become the more prevalent method of providing meaningful use data. However, at this time a very small group of providers have chosen this option and it is not likely that this will become a significant data source for the Utah program.

Attestation Goals

As of the end of the 2016 program year, no new providers can begin participation in the PI program. The pool of providers who can continue participation must have already received at least one payment from Utah or from another state Medicaid agency. As the pool of participants will no longer be growing, the program focus will shift away from participation outreach and redirect to Stage 3 meaningful use education. Program staff will continue to do education and outreach to returning participants to maximize continued participation in the program.

Program participation for program years 2019-2021 is expected to trend slightly smaller each year. This is due in part to the previously mentioned barriers to new participants, but also the barriers posed by the more demanding Stage 3 measures. UDOH has observed that as meaningful use stages have advanced, fewer small group practices and solo providers are able to continue participation. The bulk of participants come from larger established practices who have extensive administrative support to assist with monitoring progress toward meaningful use thresholds and to facilitate attestation and documentation.

The smaller pool of attestations going forward will allow UDOH to review attestations in a timelier fashion. Providers will benefit from reduced waits for their incentive payments. Reduced processing times also allow for the state to stay on schedule with program year tail periods. As the eMIPP system does not allow for providers to have more than one program year open at one time, so a provider cannot attest for program year 2019 until the 2018 attestation has been paid or denied. Our goal will be to review and make all payments for a particular program year before the tail period for the next program year is scheduled to open. This will help the program stay on schedule as the 12/31/2021 end date for PI program payments grows closer. This goal was met.

Final Environmental Scan

In 2021 Utah contracted with Myers and Stauffer LC to conduct Utah's final Environmental Scan (eScan). The eScan report uses various data sources, state surveys and national surveys to capture the current Health IT and HIE landscape in Utah. This report illustrates the State's progress from inception of the PI program to present an overall impact of HITECH on health IT adoption and utilization.

Since initiating the PI program in 2011 Utah has made great strides developing interoperability and health data exchange. Some highlights of Utah's progress in health IT include:

- From 2012 to 2016 immunization records processed through the Utah Statewide Immunization Information System (USIIS) via EHR interfaces increased 429 percent.
- Over the years, EHR adoption has increased amongst all hospitals in Utah.
- cHIE covers 95 percent of hospitals and 90 percent of large clinics in Utah.
- Telehealth network and other community-based initiatives are actively addressing issues such as health equity. In March of 2021, Utah Governor Spencer Cox signed a bill into law that expands coverage of telehealth services to include mental health services.

To develop the 2021 Utah eScan, stakeholders were engaged to gain an understanding of their goals, vision, challenges, and opportunities within the health IT and HIE ecosystem. The primary method of data collection for this eScan was through the distribution of a community survey. Supplementing the survey, the project team conducted key informant interviews with select representatives from state agencies and community organizations.

A total of 392 survey respondents participated in the eScan (78% Urban and 22% Rural; 92% Medicaid providers, 6% non-Medicaid providers and 2% unsure). The survey covered topics including EHR and Health IT Adoption, HIE and Interoperability, Patient Portals, Broadband and Telehealth, Public Health Registries, Social Determinants of Health (SDOH) and COVID-19.

81% of respondents indicated using or implementing an EHR in 2021 compared to 59% in 2010. 49% of respondents are entirely paperless and 43% primarily use EHR while still maintaining some paper charts. 10% of respondents are currently participating in the PI program. Stakeholders expressed that EHR vendors charging providers separate fees to use additional features on an EHR has been a major barrier and impedes the use of its maximum capabilities.

10% of respondents indicated currently participating in the PI program. The Utah PI Program gave providers an opportunity to adopt technology and Utah saw a good mix of participation from both large and small healthcare organizations. Many stakeholders

suggested that the PI Program helped booster relationships between state agencies, community organizations, providers and patients.

Regarding Health Information Exchange in Utah, 48% of respondents still use phone/fax or mail as their primary method of sending patient related data for care coordination. 47% of respondents selected a lack of connectivity between EHRs as their main obstacle in exchanging clinical information electronically with other health care providers. Stakeholders said UHIN's cHIE is not a robust, high volume area to exchange information. Multiple stakeholders mentioned technical design, difficult user interface and cost associated EHR Integration as their main barriers to using cHIE. 46% of respondents were not aware of the state HIE – UHIN cHIE. There is a significant gap in interoperability between HIE and EHR systems in Utah.

One major change to the health IT landscape in Utah is access to and use of Patient Portals. Ten years ago, logging into a patient portal was not common but today patients get to play more active roles in their health care with the level of transparency patient portals can provide. 61% of respondents offer online patient portals. 43% of respondents noted that their EHR does not offer a patient portal. Respondents suggested that the top two functions patients use an online portal for are appointment requests and to review their medical record.

Stakeholders mentioned that the increased use of technology has helped give public health some leverage it didn't have before. 32% of respondents submit information to disease registries through EHR and 22% of respondents submit immunization to the USIIS registry through an EHR. The pandemic helped shift provider perspective on the use of registries and need for live data. It has led to the increased use of public health data to create dashboards, measure progress and track metrics. 65% of respondents use telehealth to provide patient care and 87% plan to continue offering telehealth services post-pandemic.

While the overall perception among community stakeholders is that Utah's PI grogram has been successful, ongoing improvements to the Health IT Landscape in Utah are possible. Unfortunately, barriers still exist, primarily the initial provider cost of EHR implementation followed by recurring costs of an EHR system. Other respondents noted "pharmacies all have different software vendors that don't integrate with healthcare provider EHRs. We waste a lot of time calling physician's offices to ask for clarifications. Having access to EHR would help pharmacists' clinical judgment."

Increased connection to UHIN cHIE is another major opportunity for improvement in Utah. 45.5% of respondents were not aware of UHIN cHIE and 24.6% were aware but not interested in connecting. Only 18.8% of respondents were fully connected to UHIN cHIE. Respondents who were unaware of UHIN cHIE were asked to identify the top three out of 10 obstacles related to exchanging clinical health data electronically (not through fax). The top three barriers were: lack of connectivity between their EHR and other system, costs related to EHR integration, and insufficient resources within the organization. For those respondents who were aware of or connected to UHIN cHIE, they were asked to select the top three barriers related to connecting to the HIE, specifically to exchange health data electronically with other organizations. The top barriers included no direct HIE integration, insufficient resources, and organizations I share patients with don't use the HIE.

Many community-level stakeholders stated that Utah is behind in HIE adoption and utilization. UHIN offers multiple product solutions to providers. Though cHIE is the state-designated HIE, UHIN solutions are primarily used for eligibility, claims, and billing. Providers across the state have exhibited openness and readiness to adopt the HIE if it demonstrates improved functionality (i.e., reliable alerts) and integrations with statewide systems and national systems (i.e., EHR vendors). In some cases, providers are simply not using UHIN cHIE because their perception that it is lacking

provider/facility connection that would benefit them. Stakeholders expressed there is a general frustration among providers due to UHINs lack of responsiveness or willingness to colloborate. UHIN should conduct stakeholder outreach to understand and address these concerns.

At the conclusion of the 2021 survey, providers were given the option to submit an open response stating how the COVID-19 pandemic and PHE has impacted their outlook on health IT and needs for infrastructure and data sharing. The majority of open responses received touched on telehealth and the increasing need to be able to access data remotely. Some noted that telehealth is cost prohibitive for smaller rural facilities and how the pandemic has emphasized the need for improved infrastructure. Many highlighted the benefits of virtual medicine: increasing access to care, reduction of viral transmission, and reduced burden on existing workforce. Additionally, stakeholders noted that while the pandemic encouraged creative approaches and innovation, people have started thinking about leveraging technology in new ways outside of provider-patient scenarios, like case management, driving under the influence education, and group therapy sessions.

The full eScan is linked in the Attachments and Reference section at the end of this SMHP.

The Close of the Program and Future Pursuits

As discussed above, Utah has made great strides in the efforts to help providers across the state take on electronic health records and continually improve the functionality of these tools. Utah has also grown in the ability of our own systems to efficiently facilitate the state's HIT efforts. Going forward, we will continue to drive these efforts.

The findings of the Final Environmental Scan will be made available to stakeholders including the HIE, UHIN. The SMA will encourage UHIN to make improvements to the functionality and usefulness of the cHIE as well as general responsiveness and increased provider outreach.

In 2023, the MMIS replacement project will go live. At that time, Utah Medicaid providers will no longer be able to submit paper claims. As providers will be forced to submit electronic claims, use of EHR or other electronic systems is encouraged by the SMA for ease of claims submission as is registration and participation in the cHIE. The SMA estimates 100% of Utah Medicaid providers will participate in the cHIE over the next five years.

The Consumer Engagement Portal (Utah Medicaid's Member Portal) will also go live in 2023. The Consumer Engagement Portal will be a secure portal much like the secure patient portal options available through member's providers' EHR systems. Eligible members over the age of 18 will be able to view and update member demographics, view benefit, cost share and other insurance details. They will be able to track letters and the status of inquiries, waiver applications and to file and track the status of complaints and administrative hearings. The Consumer Engagement portal will allow them to track health goals, fill out a Health Risk Assessment and track their favorite Medicaid providers. Members will be able to securely email their providers' information about themselves from the portal. For member convenience, there will also be an app available for Android and iOS mobile devices.

Utah Medicaid members will greatly benefit from increased access to their electronic health information. The ability to track inquiries, applications, complaints and hearings will furthers the long term goals of the Promoting Interoperability program by increasing

efficiency and giving members increased control and participation in their health records and decision making. Better access to resources and data is a primary goal of the MITA transition plan and we are pleased to offer these services to our members.

Utah Medicaid continues to analyze needs and opportunities for new initiatives in health information exchange that will improve connectivity and coordination of care for Medicaid patients and for Utahns in general.

Decommissioning the SLR and Other Closeout Activities

As the program sunsets, the SMA will work with CNSI to decommission the SLR and retain program data for at least three years after the final annual report is submitted to CMS. This process will take place following the completion of program activities related to audits and appeals in FFY 2023. A HITECH Closeout Workgroup has been created to track and complete closeout activities, including the decommission of the SLR.

While the program may be ending, policies and procedures are in place to continue much of the tasks associated with this program. For instance, the SMA will still be able to confirm if a provider is not sanctioned or is properly licensed and is monitored regularly by SMA Provider Enrollment team. Should the state need to confirm if an eligible provider is hospital based over the next five years, the state will use the same procedures documented in the Hospital-Based Determination section of the Administration and Oversight section of this document. Claims and eligibility tools and queries created to help verify patient volume will still be available to SMA staff over the next five years should the SMA need to confirm minimum Medicaid patient volume thresholds for a provider.

The SMA will be available for participant questions and concerns via email and the program hotline for one full year after the completion of post-payment audits. Providers who did not participate in the 2021 program year have been apprised that they are no longer eligible for additional payments via an automated email sent from eMIPP. Historical program data, including the final SMHP will be available to providers and the public on the Medicaid HIT website through June 2025.

The SMA will continue to closely monitor staff time and other activities related to HITECH and use the appropriate funding strings to bill hours worked on HITECH activities as opposed to MMIS or other activities. The MMIS replacement project continues and the next phase is expected to be operational January 2023.

Interoperability and Patient Access Rule Implementation

The CMS Interoperability and Patient Access Final Rule was released March 9, 2020. The final rule requires certain payers including Medicaid Fee-For-Service programs, Medicaid managed care plans, and CHIP managed care entities, to provide patients with access to their claims data, similar to the Blue Button 2.0 program, and requires a number of actions by providers to improve interoperability. Utah Medicaid is currently in the development and testing phase of implementing this required functionality.

Payer Responsibilities and Deadlines

- Patient Access API - Claims, Encounters, & Clinical Data: Make member health information available to them through APIs connecting third party software apps beginning July 1, 2021 go live October 2022

- Provider Directory API: Maintain and publish provider directory data through APIs with latest updates beginning July 1, 2021 go live May 2022
- Payer to Payer Data Exchange: Exchange data set (of up to five years) to another plan that currently covers the enrollee beginning January 1, 2023
- Increased Frequency of Federal-State Data Exchanges for Dually Eligible Clients: From weekly or monthly, to daily exchange starting April 1, 2023

Additional projects that may be pursued in the future are listed below:

Death Certification

The Utah Department of Health recognizes the importance of timely and accurate death reporting. When an individual dies, certification of the cause of death by a physician is required before a death certificate can be registered with the state. Physician death certification currently requires doctors to either complete a paper death certificate or log in to a state's web-based death registration system to complete the process. If this project is pursued, the goal would be to improve the timeliness and quality of physician death certification through a standards-based approach for physicians to certify deaths from within their electronic health record (EHR) systems. By removing the need to log in to a third-party application, this project will reduce the reporting burden on providers and improve the timeliness of reports. It will also provide physicians with access to relevant health history when entering cause of death information, resulting in higher quality cause of death information.

Goals that this project would support:

- Decrease CMS spending by improving the timeliness and accuracy of death reporting
- Identify at-risk populations for opioid deaths
- Improve the identification of leading causes of preventable death through higher quality physician-provided cause of death information
- Reduce physician burden of reporting cause of death information and promote meaningful use of Certified Electronic Health Record Technology (CEHRT).
- Improve the ability of hospitals to document patient mortality and report more accurate eCQM measures.

Social Determinants of Health

Many factors affect the health of a person and a community. Access to quality healthcare, educational access, economic stability, conditions in specific neighborhoods, and social and family connections all play a role in a person's overall health. This Social Determinant of Health (SDOH) data is a valuable piece in understanding a person's health risks and outcomes. Stakeholders in Utah recognize the importance of this SDOH data and there is growing interest in the creation of an API solution to capture this data and connect it with core clinical data in the United States Core Data for Interoperability. Pairing this SDOH data with clinical data gives providers a robust set of information for decision making.

Goals that this project would support:

- Improve individual and population health;
- Improve health equity;
- Improve public health services.

Other Strategic Health IT Goals

Through an iterative development process, the executive work group which is part of the State of Utah Health IT Task Force has developed proposed goals and objectives for HIT within the State of Utah. We hope to make significant progress towards these goals over the next five years. The current HIT Strategic Goals from the Digital Health Service Commission include:

GOAL 1: ADVANCE THE HEALTH AND WELL-BEING OF INDIVIDUALS AND COMMUNITIES THROUGH PERSON-CENTERED AND SELF-MANAGED HEALTH
OBJECTIVES:

- 1A. Increase use of individual health information for engagement and shared decision making as part of the team – Enable individuals to understand and act upon available cost and quality information
- 1B. Advance individuals' abilities to "access, control and amend" their health information
- 1C. Increase adoption and use of patient portals and consumer-focused HIT
- 1D. Promote patient education and use of HIT tools for wellness and self-care
- 1E. Increase effective patient/consumer-mediated and generated exchange
- 1F. Advance individual's access to and appropriate sharing of public health data

GOAL 2: STRENGTHEN HEALTH CARE DELIVERY TRANSFORMATION
OBJECTIVES:

- 2A. Increase HIT functions to support transparency of and access to quality and cost information at the community and provider level to improve care
- 2B. Increase implementation of HIT functions to support innovative models of care that promote high value health care – Medical Home, ACOs, Telehealth
- 2C. Increase use of electronic quality improvement tools and measurements that support provider adherence to evidence-based guidelines, improved outcomes and reduced waste
- 2D. Support the use of health IT to help providers and communities to better serve high-risk individuals and populations

GOAL 3: ENHANCE UTAH'S INTEROPERABLE HEALTH IT INFRASTRUCTURE
OBJECTIVES:

- 3A. Endorse basic guidelines for HIT standards that align with and strengthen national certification requirements, including interoperability, to increase effective health information exchange
- 3B. Protect privacy and security of electronic health information by increasing adherence to federal electronic health information security guidelines in independent facilities and practices
- 3C. Increase functionality and effectiveness of state-wide HIE (CHIE) and support increased connections with other data sources including integrated delivery systems (IDS), HIEs, and providers.
- 3D. Increase ability to exchange public health information with providers through various exchange methods to improve population health
- 3E. Develop governance, access, and support for health data to be made available for analysis and use
- 3F. Increase Utah's influence on the national forums related to effective delivery of care through HIT
- 3G. DHSC will attend conferences to promote interoperability work.

GOAL 4: SUPPORT INNOVATION AND APPLIED RESEARCH TO EFFICIENTLY IMPLEMENT STATEWIDE HEALTH IT INITIATIVES
OBJECTIVES:

- 4A. Promote collaborative innovation and research to advance implementation, utilization and improvement of health IT in public, private and academic settings
- 4B. Broaden statewide partnership and engagement in implementing the Utah HIT strategic plan
- 4C. Disseminate evidence-based best practices to enhance statewide adoption of technology solutions

Applicable Road Maps & Work Flow Diagrams


Utah HITECH Road Map.pdf

Attachments & References Not Hyperlinked

Appeal Documentation


appeal letter eMIPP.pdf


HearingRequest2019.pdf

Environmental Scan


UT_eScan_Report_FINAL_03-01-2022 (1).

Provider Correspondence


provider approval email.pdf


provider auto re-enroll.pdf


provider denial letter.pdf


provider request for addtl info - rejec

USIM Grant and Strategic Plan


Utah-HIT-Strategic-Plan-2016-2020_9-4-


USIM Final Deliverable Draft Fir