

**STATE OF ILLINOIS**  
**DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES**



**STATE MEDICAID HEALTH INFORMATION  
TECHNOLOGY PLAN 2018 UPDATE**

AUGUST 1, 2018    VERSION 4.1



## REVISION HISTORY

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Version 1.0	04/07/2011	HFS	Initial CMS Submission
Version 2.0	07/01/2011	HFS	Address CMS Comments
Version 2.1	07/28/2011	HFS	Address CMS Comments
Version 2.2	09/23/2011	CMS	Address CMS Comments
Version 2.3	8/31/2012	HFS	Annual SMHP Update; address MU processes
Version 3.0	11/05/2013	HFS	Annual SMHP Update; address new technology approach
Version 4.0	3/16/2018	HFS	Annual SMHP Update
Version 4.1	7/12/2018	HFS	Responded to CMS comments regarding populations with unique needs (3.8), attestation tail period request (4.10).



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# 1 EXECUTIVE SUMMARY

## 1.0 Background

The State of Illinois, Department of Healthcare and Family Services (HFS) has prepared this State Medicaid Health Information Plan Update (SMHPU) to report on recent activities completed by the Illinois Medicaid Electronic Health Record (EHR) Provider Incentive Payment Program for its Medicaid Eligible Professionals (EPs) and Eligible Hospitals (EHs), and to inform the Centers for Medicare & Medicaid Services (CMS) of the progress made toward achieving the vision for transforming healthcare through adoption and use of EHRs.

Federal CMS has implemented through provisions of the American Recovery and Reinvestment Act (ARRA) incentive payments to EPs, EHs, and critical access hospitals (CAHs) participating in Medicare and Medicaid programs that are meaningful users of certified EHR technology. The incentive payments are not a reimbursement, but are made to incent EPs and EHs to Adopt, Implement or Upgrade to (A/I/U) certified EHR technology. EPs and EHs participating in the Medicaid EHR Incentive Program may qualify in their first year of participation for an incentive payment by demonstrating that they have adopted (acquired and installed); implemented (trained staff, deployed tools, exchanged data); or upgraded (expanded functionality or interoperability) a certified EHR solution. Incentive payments may also be disbursed to providers who demonstrate Meaningful Use (MU) for an additional five years culminating in 2021.

The Office of the National Coordinator (ONC) issued a closely related Final Rule that specified the Secretary's adoption of an initial set of standards, implementation specifications, and certification criteria for EHR systems. Additionally, the ONC issued a separate Rule related to the certification of Health Information Technology (HIT).

Goals for the national ONC program for HIE include:

- Enhance care coordination and patient safety
- Reduce paperwork and improve efficiencies
- Facilitate electronic information sharing across providers, payers, and state lines
- Enable data sharing using state HIE and the Nationwide Health Information Network (NHIN)

Achieving these goals will improve health outcomes, facilitate access, simplify care, and reduce costs of healthcare nationwide.

HFS continues to work closely with federal and state partners to ensure that the Illinois' Provider Incentive Payment (PIP) Program fits into the overall strategic plan for the ILHIE, thereby advancing both the state and national goals for HIE.



The State Medicaid Health Information Technology Plan (SMHP) was submitted for consideration by federal CMS on September 23, 2011. The original SMHP was approved by CMS on November 12, 2011. HFS submitted an annual SMHP Update (SMHPU) on August 31, 2012, to identify the progress made toward EHR PIP Program goals and objectives, changes that have occurred during the first year of the program, and to provide an update of planned changes in support of Meaningful Use (MU) Stage 1 attestation. The SMHP Update was approved by CMS on December 5, 2012. The most recent SMHP Update was approved November 13, 2013. Three SMHP addendums have been approved since then, including the most recent one approved by CMS on March 13, 2017. This addendum documented changes made to the Illinois Medicaid EHR Incentive Payment Program and systems due to Stage 2 and Stage 3 legislation. Also included were modifications to the 2017 OPSS rule and the 2017 IPSS rule. The most recent IAPD Update, which requested additional funding for Illinois' ADT system implementation activities, was approved on March 13, 2018.

## 2 CURRENT HIT LANDSCAPE ASSESSMENT – THE AS IS ENVIRONMENT

### 2.1 Purpose

This section describes the initiatives, activities, and resources available to the State of Illinois and how the State is leveraging these existing initiatives, activities, and resources already dedicated to HIT. In addition to providing a summary of current initiatives and activities supporting HIT, data was also provided specific to the current rate of EHR adoption across the State based on two different studies of medical providers. The environmental scan provided baseline data and guidance in the development of the HIT Roadmap.

### 2.2 EHR Adoption

#### 2.2.1 Illinois Medicaid EHR Incentive Payments

Illinois made its first Medicaid EHR Incentive payment in March 2012. See tables below (figure 1 - figure 5) for statistics of the Illinois EHR Program:

**EP By Program Year (PY)\***

Year	AIU	MU	Total	Payment Total
PY 2011	2156	0	2,156	\$45,411,269.00
PY 2012	1680	588	2,268	\$40,675,348.41
PY 2013	1429	1972	3,401	\$47,462,602.00
PY 2014	1034	2562	3596	\$45,832,016.00
PY 2015	994	3183	4,177	\$50,229,358.00
PY 2016	1269	3391	4,660	\$57,707,931.00
PY 2017	0	266	266	\$2,258,167.00
<b>TOTAL</b>	<b>8562</b>	<b>11962</b>	<b>20,524</b>	<b>\$289,576,691.41</b>

FIGURE 1

\*Data current as of March 8, 2018

**EH By Program Year (PY)\***

Year	Number	Payment Total
PY 2011	92	\$91,409,021.00
PY 2012	124	\$97,558,896.30
PY 2013	164	\$89,429,620.88
PY 2014	117	\$29,659,809.59
PY 2015	42	\$5,879,666.50
PY 2016	12	\$937,143.00
<b>TOTAL</b>	<b>551</b>	<b>\$314,874,157.27</b>

FIGURE 2

Medicare and Medicaid Payments by State (top 6) from January 2011 through September 2017:

**Medicare Only**

State	Paid Count	Payment Amount
California	81,590	\$1,849,519,913.50
Florida	64,851	\$1,572,695,202.00
Texas	63,202	\$1,697,740,547.69
New York	58,680	\$1,296,136,260.38
Pennsylvania	58,224	\$1,258,088,982.30
Illinois	51,648	\$1,118,441,374.18

FIGURE 3

**Medicaid Only**

State	Paid Count	Payment Amount
California	42,378	\$1,384,894,739.75
New York	28,706	\$856,133,545.67
Texas	21,865	\$837,175,605.23
Illinois	20,010	\$592,692,864.58
Ohio	19,297	\$495,191,266.07
Massachusetts	15,725	\$333,191,360.32

FIGURE 4

**Total Paid Medicare/Medicaid**

State	Paid Count	Payment Amount
California	123,968	\$3,234,414,653.25
New York	87,386	\$2,152,269,806.05
Texas	85,067	\$2,534,916,152.92
Florida	80,154	\$2,124,303,917.02
Pennsylvania	73,756	\$1,683,282,613.49
Illinois	71,658	\$1,711,134,238.76

FIGURE 5

2.2.2 EHR Systems

The charts below (figures 6-7) depict the utilization of EHR Systems in effect in the State of Illinois. The information was derived from various sources, including IDPH's MURS system and the provider. The first chart reflects the statistics for the EP Vendor Systems while the second chart reflects use by EH Vendors. EP totals reflect Medicaid paid providers.

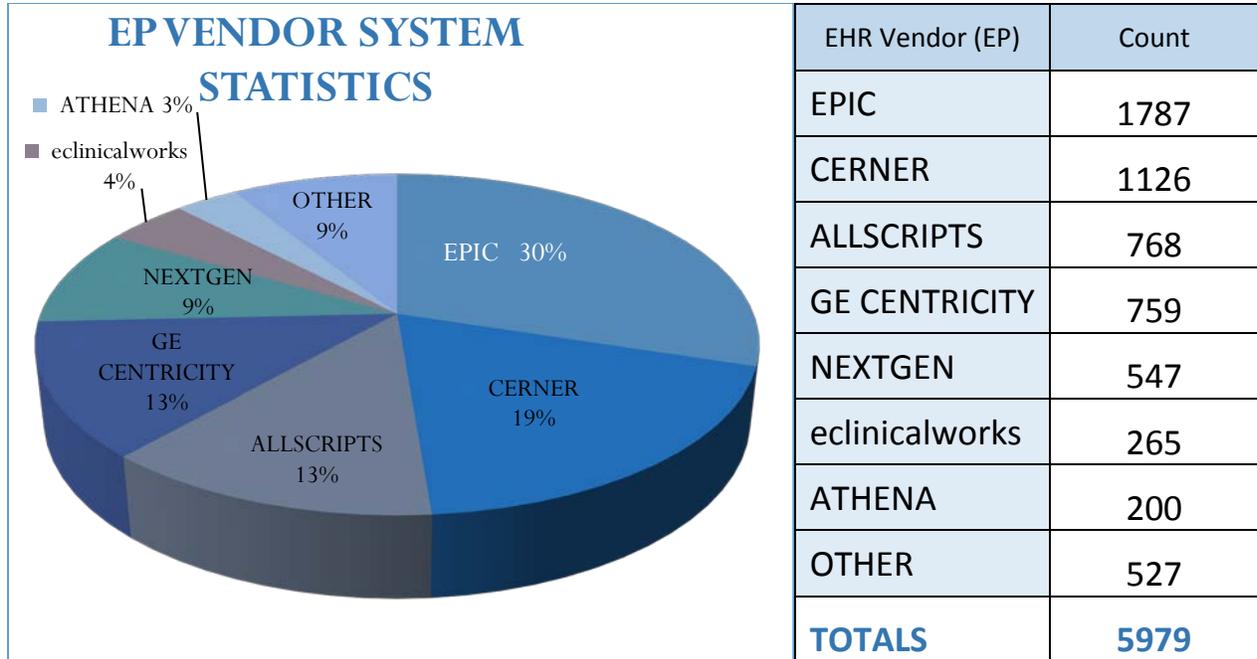


FIGURE 6

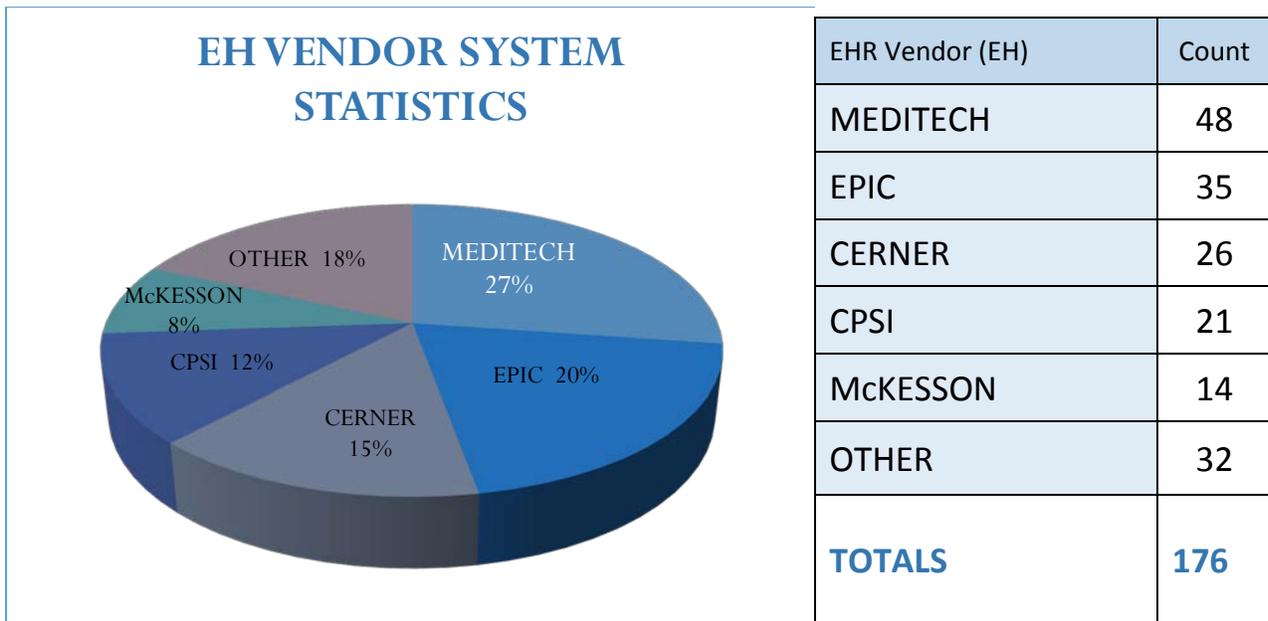


FIGURE 7

*\*Data as of March 1, 2018*

## 2.3 Illinois 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 Illinois, enabling the healthcare community's ability to participate in HIE.

### 2.3.1 HIT/HIE Challenges in Rural Areas

#### 2.3.1.1 Broadband Access

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 Illinois 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.

#### 2.3.1.2 HIE Concerns

Many locations do not have access to a HIE or lack awareness of the availability and benefits of HIEs. Connection costs to HIEs can be prohibitive because of the multiple connections required to reach multiple 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 currently an issue the HIEs are experiencing; however, the data being exchanged today is mostly summary only. As the demand and desire to share larger files increases, like imaging, diagnostic and bi-directional data, the available bandwidth may become a greater challenge as will the potential issue of affordability.

Without a mandate or legislative requirement, creating a business case for HIE continues to be an issue. Larger health systems have been resistant to share data outside of their networks and affiliations. Additionally, larger EMRs like Epic have the ability to function like an HIE now and that can reduce the need/demand for a broader based or statewide HIE.

#### 2.3.1.3 Current Broadband Coverage

According to [BROADBANDNOW](#), 100% of Illinoisans have access to mobile broadband service and 91% have access to fixed wireless service. Fueled in part by access created thru BTOP funded projects, there are now 334 broadband providers in Illinois. However, there are still geographic areas, particularly in west central Illinois and southern Illinois where access to broadband is more limited. Current gap statistics include:

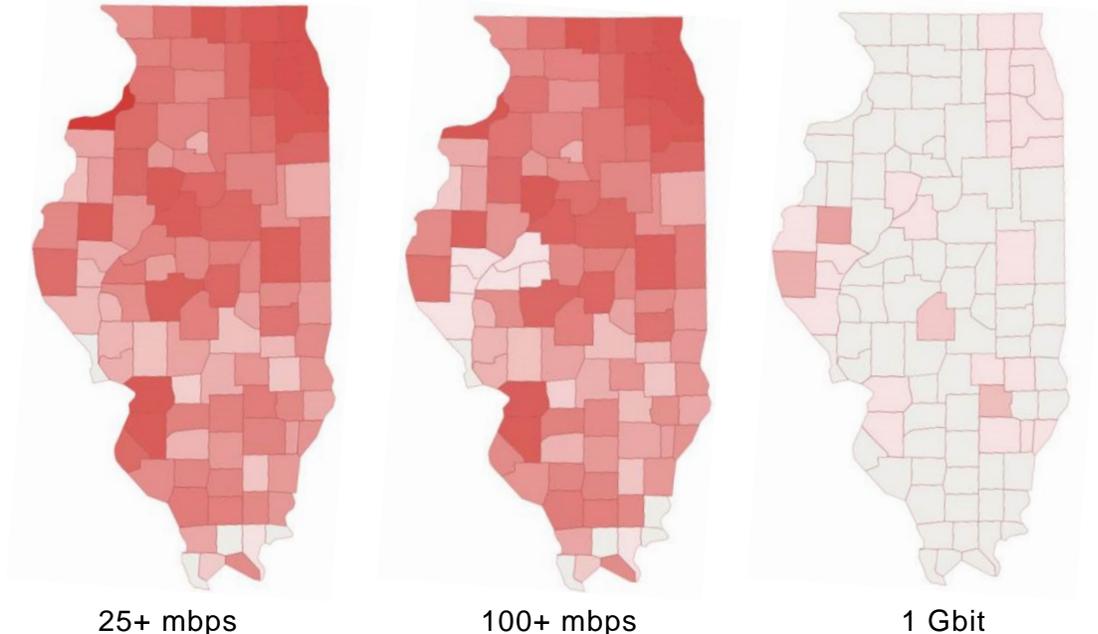
- *There are 994,000 people in Illinois without access to a wired connection capable of 25mbps download speeds.*

- There are 1,100,000 people in Illinois that have access to only one wired provider, leaving them no options to switch.
- Another 351,000 people in Illinois do not have any wired internet providers available where they live.

A broadband speed of 25mbps or faster is accessible to 92.4% of Illinoisans, while 91.3% have access to broadband of 100mbps or faster. Additionally, a broadband speed of 1 gigabit is accessible to 3.8% of Illinoisans, wireline service is accessible to 97.3%, fiber-optic is accessible to 5.4%, cable is accessible to 91.7% and DSL is accessible to 93.3%.

Illinois is rated as the 17th most connected state and averages 44.8 mbps state-wide.

More information and statistics can be found at [www.broadbandnow.com/Illinois](http://www.broadbandnow.com/Illinois) .



**FIGURE 8**  
*Illinois's Broadband: Stats & Figures BROADBANDNOW. Last updated November 30, 2017.*

#### 2.3.1.4 Broadband Grants Received

The state, thru the Illinois Century Network (ICN), received \$62 million in federal ARRA funding and \$34 million from public and private partners to establish the Illinois Broadband Opportunity Partnership-East Central (IBOP-EC). This network created 1000 miles of new fiber and 1000 miles of upgraded fiber to a fifty-five county region in central and eastern Illinois.

In addition to direct state broadband funding, many other organizations statewide have received funding as well. Northern Illinois University (NIU) received \$25 million to

develop a 3100-mile fiber optic network throughout the state and established the Illinois Rural HealthNet (IRHN), a not-for-profit 501(c)(3) organization, in 2009 to develop and manage the statewide communications network. IRHN is dedicated exclusively to healthcare providers, which can include hospitals, health clinics, mental health clinics, educational institutions and medical specialists. Funded in part by the Rural Health Care Pilot Program of the Federal Communications Commission, IRHN provides the high-speed connection that is necessary to improve access to medical applications for rural hospitals and clinics. IRHN currently leverages Health Connect funds to provide 65% of last mile and connectivity costs to rural hospitals and clinics.

Northern Illinois University also received \$68.5 million as part of the National Telecommunications and Information Agency's Broadband Technology Opportunity Program (BTOP) to build a 950-mile network in 9 counties in northwest Illinois. iFiber, a not-for-profit 501(c)(3) organization, was established in 2011 to construct, own and operate the network. iFiber's partners continue to work to expand broadband access throughout the fiber network in the following counties: Boone, Carroll, Jo Daviess, LaSalle, Lee, Ogle, Stephenson, Whiteside and Winnebago. iFiber is a collaboration of representatives from Blackhawk Hills Regional Council, LaSalle County, Northern Illinois University, and the City of Rockford. An additional \$12 million in BTOP funding was received by DeKalb County Government and Northern Illinois University to build a 130-mile fiber-optic network across DeKalb County and northern LaSalle County.

Clearwave Communications received \$53.9 million in BTOP funding to construct a 750-mile high-speed fiber, middle mile network across a 23-county region of southern Illinois to address the lack of adequate broadband access for community anchor institutions in many of the region's rural, economically distressed communities.

The University of Illinois received \$29.2 million in BTOP funding to construct a 225-mile network in the Champaign-Urbana area and created the Urbana-Champaign Big Broadband (UC2B) which is a not-for-profit (NFP) corporation that serves as both an internet service provider (ISP) and a fiber-optic broadband network.

Many other smaller federal and state funded broadband projects have been completed throughout Illinois as well.

## **2.4 Illinois Health Resource and Services Administration (HRSA) Grants**

A number of Federally Qualified Health Centers (FQHCs) across the State received funding from the Health Resources and Services Administration (HRSA) in 2009 and 2010. The funds are part of the \$2 billion 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 new 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.



The Quality Awards (EHR Reporters, Clinical Quality Improvers and National Quality Leaders) received by Illinois providers in August 2017, August 2016, August 2015 and December 2014 are listed below. Health Centers using EHRs to report clinical quality measure data for all patients receive the EHR Reporters award. The Clinical Quality Improvers award is distributed to health centers showing improvement in one or more clinical quality measures during the respective year. The National Quality Leaders award goes to health centers that met or exceeded national clinical quality benchmarks, including Healthy People 2020 objectives for chronic disease management, preventive care, and perinatal/prenatal care.



**AUGUST 2017 HRSA GRANT AWARDS**

Health Center Grantee	City	EHR Reporters <sup>1</sup>	Clinical Quality Improvers <sup>2</sup>	Health Center Quality Leaders <sup>3</sup>
ACCESS COMMUNITY HEALTH NETWORK	Chicago	\$10,500	\$97,097	\$0
ALIVIO MEDICAL CENTER, INC	Chicago	\$10,500	\$18,866	\$33,567
ASIAN HUMAN SERVICES FAMILY HEALTH CENTER	Chicago	\$0	\$9,189	\$32,290
AUNT MARTHA'S YOUTH SERVICE CENTER, INC.	Olympia Fields	\$0	\$41,421	\$46,672
BELOVED COMMUNITY FAMILY WELLNESS CENTER	Chicago	\$0	\$5,411	\$0
CASS, COUNTY OF	Virginia	\$10,500	\$8,634	\$28,584
CHESTNUT HEALTH SYSTEMS, INC.	Bloomington	\$0	\$0	\$0
CHICAGO FAMILY HEALTH CENTER, INC.	Chicago	\$10,500	\$24,145	\$0
CHRISTOPHER RURAL HEALTH PLANNING CORP	Christopher	\$10,500	\$30,444	\$0
CIRCLE FAMILY CARE, INC	Chicago	\$0	\$25,949	\$0
COMM HEALTH CENTER	Springfield	\$0	\$12,523	\$0
COMMUNITY HEALTH & EMERGENCY SERVICES, INC	Cairo	\$10,500	\$0	\$0
COMMUNITY HEALTH IMPROVEMENT CENTER	Decatur	\$10,500	\$16,196	\$36,146
COMMUNITY HEALTH PARTNERSHIP OF ILLINOIS	Chicago	\$0	\$24,486	\$0
COMMUNITY NURSE HEALTH ASSOCIATION	La Grange	\$0	\$8,485	\$28,436
COUNTY OF LAKE	Waukegan	\$10,500	\$23,489	\$0
CRUSADERS CENTRAL CLINIC ASSOCIATION	Rockford	\$10,500	\$28,324	\$0
ERIE FAMILY HEALTH CENTER, INC.	Chicago	\$10,500	\$0	\$60,691
ESPERANZA HEALTH CENTERS	Chicago	\$10,500	\$16,659	\$36,610
FAMILY CHRISTIAN HEALTH CENTER	Harvey	\$10,500	\$13,972	\$0
FRIEND FAMILY HEALTH CENTER, INC.	Chicago	\$10,500	\$0	\$0
GREATER ELGIN FAMILY CARE CENTER	Elgin	\$10,500	\$25,729	\$48,829
HAMDARD CENTER FOR HEALTH & HUMAN SERVICES NFP	Addison	\$10,500	\$0	\$0
HEARTLAND COMMUNITY HEALTH CLINIC	Peoria	\$10,500	\$15,300	\$0
HEARTLAND HEALTH OUTREACH, INC.	Chicago	\$10,500	\$10,608	\$0
HEARTLAND INTERNATIONAL HEALTH CENTERS	Chicago	\$10,500	\$14,292	\$37,393
HENDERSON COUNTY RURAL HEALTH CENTER, INC.	Oquawka	\$10,500	\$8,784	\$23,485
HOWARD BROWN HEALTH CENTER	Chicago	\$10,500	\$0	\$22,274
KNOX, COUNTY OF	Galesburg	\$10,500	\$11,911	\$18,211
LAWNDALE CHRISTIAN HEALTH CENTER	Chicago	\$10,500	\$38,217	\$41,368
MACOUPIN, COUNTY OF	Carlinville	\$10,500	\$6,473	\$24,324
NEAR NORTH HEALTH SERVICE CORPORATION, THE	Chicago	\$10,500	\$28,001	\$0
PCC COMMUNITY WELLNESS CENTER	Chicago	\$0	\$27,329	\$0



PRIMECARE COMMUNITY HEALTH INC	Chicago	\$0	\$15,474	\$30,174
ROSELAND CHRISTIAN HEALTH MINISTRIES (INC)	Chicago	\$0	\$19,815	\$0
RURAL HEALTH INC	Anna	\$10,500	\$0	\$0
SHAWNEE HEALTH SERVICE AND DEVELOPMENT CORP	Murphysboro	\$0	\$22,014	\$31,464
SOUTHERN ILLINOIS HEALTH CARE FOUNDATION, INC.	East St. Louis	\$10,500	\$60,820	\$0
SOUTHERN ILLINOIS UNIVERSITY	Springfield	\$0	\$13,096	\$0
TCA HEALTH, INC. NFP	Chicago	\$10,500	\$9,730	\$0
UNIVERSITY OF ILLINOIS	Chicago	\$0	\$21,115	\$0
VNA HEALTH CARE, AN ILLINOIS NOT-FOR-PROFIT CORP	Aurora	\$0	\$38,336	\$53,036
WHITESIDE, COUNTY OF	Rock Falls	\$0	\$9,477	\$32,577
WILL COUNTY COMMUNITY HEALTH CENTER	Joliet	\$10,500	\$15,835	\$0
<b>TOTALS</b>		<b>\$294,000</b>	<b>\$817,646</b>	<b>\$666,131</b>

FIGURE 9

### AUGUST 2016 HRSA GRANT AWARDS

Health Center Grantee	City	EHR Reporters <sup>1</sup>	Clinical Quality Improvers <sup>2</sup>	National Quality Leaders <sup>3</sup>
ACCESS COMMUNITY HEALTH NETWORK	Chicago		\$93,491	\$0
ALIVIO MEDICAL CENTER	Chicago	\$10,000	\$0	\$31,511
ASIAN HUMAN SERVICES FAMILY HEALTH CENTER, INC.	Chicago		\$14,059	\$30,060
AUNT MARTHA'S YOUTH SERVICE CENTER, INC.	Olympia Fields		\$36,873	\$0
BELOVED COMMUNITY FAMILY WELLNESS CENTER	Chicago		\$10,863	\$16,864
BOARD OF TRUSTEES OF SOUTHERN ILLINOIS UNIVERSITY	Carbondale		\$16,058	\$0
CASS COUNTY HEALTH DEPARTMENT	Virginia	\$10,000	\$5,148	\$22,149
CENTRAL COUNTIES HEALTH CENTERS, INC.	Taylorville		\$0	\$21,825
CHESTNUT HEALTH SYSTEMS	Bloomington		\$10,005	\$21,005
CHICAGO FAMILY HEALTH CENTER, INC.	Chicago		\$30,159	\$0
CHRISTIAN COMMUNITY HEALTH CENTER	Chicago		\$18,699	\$0
CHRISTOPHER GREATER AREA RURAL HEALTH PLANNING CORPORATION	Christopher		\$24,602	\$0
CIRCLE FAMILY HEALTHCARE NETWORK, INC.	Chicago		\$6,824	\$0
COMMUNITY HEALTH & EMERGENCY SVCS., INC.	Cairo		\$26,752	\$0
COMMUNITY HEALTH IMPROVEMENT	Decatur		\$18,991	\$32,991



COMMUNITY HEALTH PARTNERSHIP OF ILLINOIS	Chicago		\$8,491	\$0
COMMUNITY NURSE HEALTH ASSOCIATION	La Grange		\$8,093	\$27,094
COUNTY OF LAKE, DBA LAKE COUNTY HEALTH DEPARTMENT AND COMMUNITY HEALTH CENTER	Waukegan	\$10,000	\$35,161	\$0
CRUSADERS CENTRAL CLINIC ASSOCIATION	Rockford	\$10,000	\$0	\$0
ERIE FAMILY HEALTH CENTER, INC.	Chicago	\$10,000	\$37,208	\$59,209
ESPERANZA HEALTH CENTERS	Chicago		\$18,258	\$34,259
FAMILY CHRISTIAN HEALTH CENTER	Harvey	\$10,000	\$16,412	\$0
FRIEND FAMILY HEALTH CENTER, INC.	Chicago	\$10,000	\$18,353	\$0
GREATER ELGIN FAMILY CARE CENTER	Elgin		\$29,333	\$45,333
HAMDARD CENTER FOR HEALTH & HUMAN SERVICES NFP	Addison	\$10,000	\$15,827	\$0
HEARTLAND COMMUNITY HEALTH CLINIC	Peoria		\$17,828	\$0
HEARTLAND HEALTH OUTREACH, INC.	Chicago	\$10,000	\$0	\$0
HEARTLAND INTERNATIONAL HEALTH CENTER	Chicago	\$10,000	\$20,804	\$34,805
HENDERSON CO. RURAL HEALTH CENTER, INC.	Oquawka	\$10,000	\$17,509	\$17,509
HOWARD BROWN HEALTH CENTER	Chicago	\$10,000	\$0	\$25,025
KNOX COUNTY HEALTH DEPARTMENT	Galesburg		\$26,361	\$0
LAWNDALE CHRISTIAN HEALTH CENTER	Chicago	\$10,000	\$27,570	\$39,571
MACOUPIN COUNTY PUBLIC HEALTH DEPARTMENT	Carlinville	\$10,000	\$8,442	\$22,443
NEAR NORTH HEALTH SERVICE CORPORATION	Chicago	\$10,000	\$26,368	\$0
PCC COMMUNITY WELLNESS CENTER	Chicago	\$10,000	\$26,592	\$0
PRIMECARE COMMUNITY HEALTH, INC.	Chicago		\$28,545	\$30,546
RURAL HEALTH, INC.	Anna		\$18,326	\$0
SHAWNEE HEALTH SERVICE AND DEVELOPMENT CORPORATION	Murphysboro		\$0	\$30,088
SOUTHERN ILLINOIS HEALTHCARE FOUNDATION	East St. Louis		\$59,812	\$0
TCA HEALTH INC.	Chicago	\$10,000	\$9,525	\$0
THE BOARD OF TRUSTEES OF THE UNIVERSITY OF ILLINOIS	Chicago		\$24,859	\$0
VNA HEALTH CARE	Aurora		\$39,858	\$50,859
WHITESIDE COUNTY HEALTH DEPARTMENT AND WHITESIDE COUNTY COMMUNITY HEALTH CLINIC, INC.	Rock Falls		\$15,272	\$31,273
WILL COUNTY HEALTH DEPARTMENT/WILL COUNTY CHC	Joliet	\$10,000	\$15,444	\$0
<b>TOTALS</b>		<b>\$180,000</b>	<b>\$882,775</b>	<b>\$624,419</b>

FIGURE 10



**AUGUST 2015 HRSA GRANT AWARDS**

Health Center Grantee	City	EHR Reporters <sup>1</sup>	Clinical Quality Improvers <sup>2</sup>	National Quality Leaders <sup>3</sup>
ACCESS COMMUNITY HEALTH NETWORK	Chicago	\$0	\$100,195	\$0
ALIVIO MEDICAL CENTER, INC	Chicago	\$15,000	\$27,651	\$0
ASIAN HUMAN SERVICES FAMILY HEALTH CENTER	Chicago	\$0	\$8,652	\$0
AUNT MARTHA'S YOUTH SERVICE CENTER, INC.	Olympia Fields	\$0	\$40,401	\$0
BELOVED COMMUNITY FAMILY WELLNESS CENTER	Chicago	\$0	\$21,576	\$0
CASS, COUNTY OF	Virginia	\$0	\$14,049	\$0
CHESTNUT HEALTH SYSTEMS, INC.	Bloomington	\$0	\$20,830	\$0
CHICAGO FAMILY HEALTH CENTER, INC.	Chicago	\$0	\$27,118	\$0
CHRISTOPHER RURAL HEALTH PLANNING CORP	Christopher	\$0	\$42,694	\$0
CIRCLE FAMILY CARE, INC	Chicago	\$0	\$36,925	\$0
COMM HEALTH CENTER	Springfield	\$0	\$11,722	\$0
COMMUNITY HEALTH & EMERGENCY SERVICES, INC	Cairo	\$0	\$45,013	\$0
COMMUNITY HEALTH IMPROVEMENT CENTER	Decatur	\$0	\$30,817	\$40,817
COMMUNITY HEALTH PARTNERSHIP OF ILLINOIS	Chicago	\$0	\$20,859	\$0
COMMUNITY NURSE HEALTH ASSOCIATION	La Grange	\$0	\$13,954	\$0
COUNTY OF LAKE	Waukegan	\$15,000	\$23,578	\$0
ERIE FAMILY HEALTH CENTER, INC.	Chicago	\$15,000	\$34,930	\$0
ESPERANZA HEALTH CENTERS	Chicago	\$0	\$16,621	\$0
FAMILY CHRISTIAN HEALTH CENTER	Harvey	\$0	\$22,617	\$0
FRIEND FAMILY HEALTH CENTER, INC.	Chicago	\$0	\$29,599	\$0
GREATER ELGIN FAMILY CARE CENTER	Elgin	\$0	\$26,795	\$0
HAMDARD CENTER FOR HEALTH & HUMAN SERVICES NFP	Addison	\$15,000	\$0	\$0
HEARTLAND COMMUNITY HEALTH CLINIC	Peoria	\$0	\$16,604	\$0
HEARTLAND HEALTH OUTREACH, INC.	Chicago	\$15,000	\$11,831	\$0
HEARTLAND INTERNATIONAL HEALTH CENTERS	Chicago	\$15,000	\$21,048	\$0
KNOX, COUNTY OF	Galesburg	\$0	\$5,969	\$0
LAWNDALE CHRISTIAN HEALTH CENTER	Chicago	\$0	\$34,785	\$0
MACOUPIN, COUNTY OF	Carlinville	\$15,000	\$10,270	\$0
NEAR NORTH HEALTH SERVICE CORPORATION, THE	Chicago	\$15,000	\$29,038	\$0
ROSELAND CHRISTIAN HEALTH MINISTRIES (INC)	Chicago	\$0	\$18,285	\$0
RURAL HEALTH INC	Anna	\$0	\$17,486	\$35,486
SHAWNEE HEALTH SERVICE AND DEVELOPMENT CORPORATION	Cartersville	\$0	\$19,176	\$0
SOUTHERN ILLINOIS HEALTH CARE FOUNDATION, INC.	East Saint Louis	\$0	\$65,027	\$0



Health Center Grantee	City	EHR Reporters <sup>1</sup>	Clinical Quality Improvers <sup>2</sup>	National Quality Leaders <sup>3</sup>
SOUTHERN ILLINOIS UNIVERSITY	Springfield	\$0	\$10,520	\$0
TCA HEALTH, INC. NFP	Chicago	\$15,000	\$19,483	\$0
VNA HEALTH CARE, AN ILLINOIS NOT-FOR-PROFIT CORPORATION	Aurora	\$0	\$33,951	\$0
WHITESIDE, COUNTY OF	Rock Falls	\$0	\$14,239	\$0
WILL COUNTY COMMUNITY HEALTH CENTER	Joliet	\$15,000	\$19,052	\$0
<b>TOTALS</b>		<b>\$150,000</b>	<b>\$963,360</b>	<b>\$76,303</b>

FIGURE 11

**DECEMBER 2014 HRSA GRANT AWARDS**

Health Center Grantee	City	EHR Reporters <sup>1</sup>	Clinical Quality Improvers <sup>2</sup>	National Quality Leaders <sup>3</sup>
ACCESS COMMUNITY HEALTH NETWORK	Chicago	\$0	\$92,805	\$0
ALIVIO MEDICAL CENTER, INC	Chicago	\$0	\$20,548	\$0
ASIAN HUMAN SERVICES FAMILY HEALTH CENTER	Chicago	\$0	\$11,657	\$0
AUNT MARTHA'S YOUTH SERVICE CENTER, INC.	Olympia Fields	\$0	\$36,003	\$0
BELOVED COMMUNITY FAMILY WELLNESS CENTER	Chicago	\$0	\$8,949	\$0
CHRISTOPHER RURAL HEALTH PLANNING CORP	Christopher	\$0	\$29,712	\$0
CIRCLE FAMILY CARE, INC	Chicago	\$0	\$7,933	\$0
COMMUNITY HEALTH & EMERGENCY SERVICES, INC	Cairo	\$0	\$12,216	\$0
COMMUNITY HEALTH IMPROVEMENT CENTER	Decatur	\$0	\$12,875	\$0
COMMUNITY HEALTH PARTNERSHIP OF ILLINOIS	Chicago	\$0	\$12,254	\$0
COMMUNITY NURSE HEALTH ASSOCIATION	La Grange	\$0	\$14,109	\$0
COUNTY OF CASS	Virginia	\$0	\$14,551	\$0
COUNTY OF LAKE	Waukegan	\$0	\$36,879	\$0
CRUSADERS CENTRAL CLINIC ASSOCIATION	Rockford	\$0	\$31,858	\$0
ERIE FAMILY HEALTH CENTER, INC.	Chicago	\$0	\$33,584	\$0
Esperanza Health Centers	Chicago	\$0	\$12,650	\$0
FAMILY CHRISTIAN HEALTH CENTER	Harvey	\$0	\$18,813	\$0
FRIEND FAMILY HEALTH CENTER, INC.	Chicago	\$0	\$21,156	\$0
GREATER ELGIN FAMILY CARE CENTER	Elgin	\$0	\$24,474	\$0
HEARTLAND COMMUNITY HEALTH CLINIC	Peoria	\$0	\$13,323	\$0
HEARTLAND HEALTH OUTREACH, INC.	Chicago	\$0	\$16,785	\$0
Heartland International Health Centers	Chicago	\$15,000	\$14,458	\$0



Health Center Grantee	City	EHR Reporters <sup>1</sup>	Clinical Quality Improvers <sup>2</sup>	National Quality Leaders <sup>3</sup>
HENDERSON COUNTY RURAL HEALTH CENTER, INC.	Oquawka	\$0	\$13,182	\$0
KNOX, COUNTY OF	Galesburg	\$0	\$16,836	\$0
MACOUPIN, COUNTY OF	Carlinville	\$15,000	\$12,236	\$0
NEAR NORTH HEALTH SERVICE CORPORATION, THE	Chicago	\$15,000	\$19,798	\$0
PCC COMMUNITY WELLNESS CENTER	Oak Park	\$0	\$35,618	\$0
PRIMECARE COMMUNITY HEALTH INC	Chicago	\$0	\$17,502	\$0
ROSELAND CHRISTIAN HEALTH MINISTRIES (INC)	Chicago	\$0	\$11,383	\$0
SHAWNEE HEALTH SERVICE AND DEVELOPMENT CORPORATION	Cartersville	\$0	\$28,095	\$0
Southern Illinois Health Care Foundation, Inc.	E. St. Louis	\$0	\$54,846	\$0
SOUTHERN ILLINOIS UNIVERSITY	Springfield	\$0	\$14,249	\$0
TCA HEALTH, INC. NFP	Chicago	\$15,000	\$12,904	\$0
UNIVERSITY OF ILLINOIS	Chicago	\$0	\$16,753	\$0
VISITING NURSE ASSOCIATION OF FOX VALLEY	Aurora	\$0	\$30,440	\$0
WHITESIDE, COUNTY OF	Rock Falls	\$0	\$11,304	\$31,304
WILL COUNTY COMMUNITY HEALTH CENTER	Joliet	\$0	\$15,635	\$0
<b>TOTALS</b>		<b>\$60,000</b>	<b>\$808,373</b>	<b>\$31,304</b>

FIGURE 12

<sup>1</sup> **EHR Reporters** – Health centers received funding if they used Electronic Health Records (EHRs) to report clinical quality measure data for all patients, a foundation to quality in all aspects of clinical operations.

<sup>2</sup> **Clinical Quality Improvers** - Health centers that have demonstrated improvements in one or more clinical measures between 2013 and 2014 demonstrating a significant improvement to their patient's health received funding.

<sup>3</sup> **National Quality Leaders** – Health centers received funding if they met or exceeded national clinical quality benchmarks, including Healthy People 2020 objectives, for disease management chronic, preventive care, and perinatal/prenatal care, demonstrating health centers' critical role in improving quality health care nationwide.

## 2.5 Illinois Department of Veterans Affairs

The Illinois Department of Veterans Affairs (IDVA) operates four long-term care (LTC) facilities across the State. Currently, a mix of in-house developed and purchased applications are used to provide the clinical services to IDVA residents. These systems include pharmacy, infection control, inventory, lab, orders, Resource Utilization Groups (RUGS) assessments, Minimum Data Sets (MDS) documentation, and a host of others ancillary services. IDVA is interested in updating and consolidating many of these applications.

The American Indian Health Services of Chicago (AIHSC) is the only qualifying tribal entity in Illinois and operates as an FQHC. The State also has no connectivity with Federal VA EHRs, Indian Health Services or State psychiatric facilities, including Mental Illness (MI)/Mental Retardation (MR) facilities.

## 2.6 HIT/HIE Engaged Stakeholders

An engaged group of stakeholders assist HFS to increase EHR adoption and utilization in Illinois. Public and private entities compose this stakeholder group, each contributing to the task of improving healthcare in Illinois through the use of EHRs.

The Illinois EHR program workgroup meets bi-weekly and includes representatives from HFS Medical Programs, HFS Inspector General, the Illinois Department of Public Health (DPH), Regional Extension Centers and providers representing various hospitals, physician practices, groups and alliances. Representatives from the Illinois Health and Hospital association, the Critical Access Hospital Network, the Alliance of Chicago, the Illinois State Medical Society, Advocate Health Care, and Access Community Health Network are frequently present as well as many others. HFS updates the group on program activities including CMS announcements, deadlines and policy changes. The remainder of the meeting is open for providers to discuss issues and policies related to HFS, EHR or Medicaid and Medicare. The call is open to all providers as a means to further engage stakeholders, allowing an opportunity to voice concerns and make suggestions.

Illinois' alliance with the State of Michigan regarding support and maintenance of the eMIPP application is beneficial to both states. The two states share information on CMS interpretations of final rules, discuss implementation strategy and share test scenarios and results. The result is an application that is more accurate with regards to CMS policy, has fewer errors and costs less than it would have if each state were functioning independently.

The two Regional Extension Centers in Illinois, CHITREC and IL HITREC, are contracted to perform outreach activities for the state. The RECs greatly enhance the state's ability to communicate with providers and assist in the expansion and growth of meaningful use. The RECs also provide HIE knowledge through their associations with state regional health information organizations (RHIOs). The state also has direct contact with private HIEs, but the additional perspective and participation of the RECs is beneficial to strengthening HIE integration and coordination.

Staff from the HFS Office of the Inspector General participates in most Illinois Medicaid incentive program meetings. As the EHR program evolves, OIG audit responsibility must also. Therefore, it is critical for OIG staff to remain active and aware of any update or change to the program. Coordination between OIG and stakeholders is valuable, effective and considered to be a key asset to our program.

HFS Medical Program staff meets periodically with DPH staff. Information regarding Public Health objectives and sub-measures are discussed. HFS and Public Health have coordinated policies towards successful provider completion of meaningful measures.

As program policies and regulations evolve or change, the communication between the State Medicaid Agency (SMA) and DPH are vital.

In an attempt to promote the alignment of the Illinois HIE vendor community to healthcare business needs, the State of Illinois concluded in 2015 that the State-run HIE, the Illinois Health Information Exchange Authority (ILHIEA), had proven to be financially unsustainable and infrequently utilized. The decision was made for ILHIEA to stop offering technical HIE services in the hope that providers would direct their needs to the private Illinois RHIO market. While ILHIEA was repurposed to support and promote private RHIO market growth, provider commitment to existing Illinois HIE options remained limited. As of late 2016, most IL RHIOs appear to have largely either stalled due to limited growth achieved or appear to be in the process of closing.

One known exception is the Central Illinois Health Information Exchange (CIHIE). In 2016, CIHIE made significant strides to expand its service offerings to customers through a two-year ONC Advance Interoperable HIE grant pursued with the State of Illinois. It is anticipated that this funding will allow CIHIE to more readily meet customer demands, including the offering of Admission, Discharge, and Transfer (ADT) alert notifications. While advancements are occurring by CIHIE, the challenge remains that progress is limited to a confined geographic region of the State. The need to address provider to provider data exchange needs across the state remains unmet and even unplanned.

While commitment to existing IL HIE service offerings is weak; conversely, the need for strong and flexible HIE solutions is great. HFS, as the State's Medicaid agency, is spearheading an eleven (11) agency collaborative effort to transform health and human services in the State. The initial focus of the transformation effort has been on behavioral health (mental health and substance use) and specifically on the integration of behavioral and physical health. Promoting effective provider to provider electronic health data exchange is an integral part of this transformation, especially as HFS continues to expand Illinois Medicaid managed care, membership of which has increased from 4 percent to 64 percent of total Medicaid beneficiaries in Illinois over the past four years. It is expected that approximately 80 percent of beneficiaries will be enrolled in a managed care organization by the end of calendar year 2018. The transformation goals of Illinois' Medicaid program cannot be maximized without essential HIE technologies that support evidence-based and data driven decisions and value-based healthcare delivery.

To better align the need for HIE with oversight responsibility, the decision was made to move ILHIEA, including all HIE planning functions, under HFS through an intergovernmental agreement between the Office of the Illinois Governor, ILHIEA, and HFS in September 2016. With the move of ILHIEA to HFS, HFS became the designated state entity for the ONC Advance Interoperable HIE grant as well as the State HIT Coordinator. The request from Governor Bruce Rauner was approved by Dr. Vindell Washington, National Coordinator for Health Information Technology. As HFS submits and is responsible for the Advanced Planning Documents (APDs) related to HIT, including HIE; the transfer of the designated entity from the Authority to HFS gives HFS closer proximity to the HIE planning, implementation and governance in order to

ensure successful outcomes. The transfer of the Authority's functions to the jurisdiction and control of HFS also increases the State's ability to align programmatic efforts, convene stakeholders, avoid inefficiencies and reduce administrative costs when implementing HIE.

Illinois participated in the National Governor's Association (NGA) Health Policy Technical Assistance Program – "[Getting the Right Information, to the Right Health Care Providers, at the Right Time – How States Can Improve Data Flow](#)". The program is described by the NGA as "a flexible technical assistance opportunity to help governors' senior staff and other state officials address policy issues that limit the flow of health care information between providers." The project helps states ensure providers have the information they need, when they need it, to improve care delivery and outcomes. It provides an opportunity for states seeking to modify policies, implement new policies, conduct outreach, and gain stakeholder buy-in on complex legal and market-based challenges and solutions.

HFS submitted Illinois' winning application which focused on the need for Illinois to learn from states successful in HIE. The immediate goal is to implement a state-wide Admission, Discharge and Transfer (ADT) alerting notification system to advance our care coordination objectives. An IAPD was approved by CMS on March 13, 2018 assisting Illinois with funding for the ADT notification system. The longer-term goal is to build off the foundation of ADT alerting notification to more advanced provider to provider data exchanges including labs, prescription and imaging files.

## 2.7 HIT/HIE Relationships with Outside Entities

In addition to the stakeholder relationships listed above, other entities also exist with which the Illinois Medicaid incentive payment program has a relationship. The Department of Innovation and Technology (DoIT) is a new Illinois Agency created on January 25, 2016.

DoIT's mission is to empower the State of Illinois through high-value, customer-centric technology by delivering best-in-class innovation to client agencies fostering collaboration and empowering employees to provide better services to residents, businesses, and visitors.

The DoIT delivers statewide information technology and telecommunication services and innovation to state government agencies, boards and commissions as well as policy and standards development, lifecycle investment planning, enterprise solutions, privacy and security management, and leads the nation in Smart State initiatives. These initiatives have resulted from an NGA effort to help states identify how they can use information and communication technology (ICT) to enhance economic development, sustainability, resilience and quality of life across urban, suburban and rural communities—all while improving the operational efficiency of state government. NGA is partnering with the state of Illinois, a first-mover in smart states work, and the Smart Cities Council, an association of leading companies that advise governments across the globe.

DoIT manages the Illinois Century Network, a service that creates and maintains high speed telecommunications networks providing reliable communication links to and among Illinois schools, institutions of higher education, libraries, museums, research institutions, state agencies, units of local government and other local entities providing services to Illinois citizens.

DoIT launched the First Enterprise Financial Platform (through Enterprise Resource Planning or ERP), a single system for finance, human resources, procurement, grants management, asset management and other administrative functions of Illinois agencies. There are currently 13 agencies up and running on the platform that runs ERP, with an additional 25 agencies going live on the system in 2018. HFS continues to build a strong relationship with DoIT as it leads the state in efforts to deliver important technological solutions for healthcare.

## 2.8 HIE Governance Structure

The governance structure of only one RHIO in the State has been verified. The Central Illinois Health Information Exchange (CIHIE) services a region running from the eastern center to the north eastern area of the state. Currently, 26 Illinois hospitals are connected to CIHIE, with another 6 connections in the planning stages. CIHIE also connects 20 primary and specialty care clinics, home health and behavioral clinics in addition to over 65 long term care facilities. CIHIE has an active community board and a small, solid management structure.

CIHIE and HFS are currently involved together in a two-year ONC Advance Interoperable HIE grant and communicate at least bi-weekly. The grant's goal is to enable the send, receive, find, and use capabilities of health information across organizational, vendor, and geographic boundaries, and increase the integration of health information in interoperable health IT to support care processes and decision making.

Until mid-2016, HFS had a strong understanding of another RHIO, Metro-Chicago HIE (MCHIE). This RHIO was projected to have approximately 70% of the Illinois provider market share. MCHIE's technical vendor, Sandlot Solutions, abruptly went out of business in 2016, disrupting MCHIE operations. In late 2016, MCHIE ceased operations.

## 2.9 MMIS in Current HIT/HIE Environment

Illinois is in the process of modernizing its 30-year-old Medicaid Management Information System (MMIS) system. This step was taken, in large part, to meet federal requirements in the Affordable Care Act. In modernizing the dated MMIS system, Illinois has addressed previous challenges, including support for advanced administrative functions, such as claims processing from providers and eligibility verification of Medicaid enrollees.

Five agencies are working together to develop a MMIS that standardizes, expedites and simplifies processes for providers serving Medicaid clients:

- Illinois Department of Healthcare & Family Services (HFS)
- Illinois Department on Aging (IDoA)
- Illinois Department of Children & Family Services (DCFS)
- Illinois Department of Human Services (DHS)
  - Division of Alcoholism and Substance Abuse (DASA)
  - Division of Family & Community Services, Bureau of Early Intervention (EI)
  - Division of Developmental Disabilities (DDD)
  - Division of Mental Health (DMH)
  - Division of Rehabilitation Services (DRS)
  - UIC Department of Specialized Care for Children (DSCC)

### 2.9.1 MMIS

HFS currently manages and operates the MMIS to support claims processing for the Illinois Medicaid Enterprise. The MMIS environment includes the database subsystems (e.g., Provider, Recipient, Reference and Prior Approval); the Hospital, Pharmacy and NIPS claims processing subsystems; the Management and Reporting System (MARS); the Enterprise Data Warehouse; the Pharmacy point of sale system and the web-based applications provided in the Medical Electronic Data Interchange (MEDI) system.

### 2.9.2 NIPS

The Non-Institutional Practitioner Subsystem adjudicates services provided to clients by Non-Institutional Providers such as physicians, pharmacists, optometrists, podiatrists, medical transportation providers, clinics and suppliers of medical equipment.

### 2.9.3 Pharmacy

The Illinois Provider Portal is a web-based collection of tools for prescribers, pharmacies, and HFS staff. It provides a secure interface for providers to look up participant eligibility, participant history, drug formulary information, Preferred Drug List (PDL) criteria, and submit and confirm Prior Authorization (PA) requests online. Prescribers are guided through preferred or non-preferred selections, as well as potential step therapy, dose limits, or other PDL criteria to allow them the ability to make informed drug choices. Information is tailored to each type of user: prescriber, pharmacist, hotline staff, or state administrator.

Some of the features that are available from the Illinois Provider Portal include the following:

- **Participant Inquiry** – Search for and review Illinois Medicaid recipient information, including eligibility, claim profile, and pharmacy claims history
- **Prescriber Inquiry** – View prescriber information
- **Pharmacy Inquiry** – View pharmacy information
- **Formulary Inquiry** – View drug information, including coverage and preferred/non-preferred status
- **Diagnosis Inquiry** – View diagnosis code and/or definitions

### 2.9.4 Hospital/Data Entry

The Hospital subsystem adjudicates services provided to clients by hospitals, nursing homes, the Office of Alcohol and Substance Abuse (OASA), and state-operated long-term care facilities.

A hospital must be enrolled for the specific category of service (COS) for which charges are to be made.

The categories of service for which a hospital may enroll are:

#### **COS Service Definition**

- 020 Inpatient Hospital Services (General)
- 021 Inpatient Hospital Services (Psychiatric)
- 022 Inpatient Hospital Services (Physical Rehabilitation)
- 024 Ambulatory (Outpatient) Hospital Services (General)
- 025 Ambulatory (Outpatient) End Stage Renal Disease Services
- 027 Ambulatory Services (Psychiatric Clinic Type A)
- 028 Ambulatory Services (Psychiatric Clinic Type B)

**The standard fee-for-service categories of service assigned are:**

- 001 Physician Services
- 011 Physical Therapy Services
- 012 Occupational Therapy Services
- 013 Speech Therapy/Pathology Services
- 014 Audiology Services
- 017 Anesthesia Services
- 030 Healthy Kids Services

*2.9.5 MARS (Medicaid Analysis and Reporting System)*

The MMIS MARS unit is responsible for the maintenance of the repository of long-term history of paid and rejected Medicaid claims and produces hundreds of ongoing reports of expenditures, service provision, program effectiveness, and processing statistics.

*2.9.6 RPR (Recipient, Provider and Reference)*

The Recipient/Provider Reference (RPR) unit maintains subsystems that support the claims processing and reporting systems. Information on client and provider eligibility data as well as medical treatment (procedure codes) and illness (diagnosis codes) information is available. Many types of ongoing service payments that can be derived from information available in the eligibility files are generated automatically from these subsystems and are forwarded to the claims processing systems for payment. Examples of those types of services are LTC, State-operated LTC, managed care premiums, dental premium payments and day training services. Automated adjustment processes are maintained for these generated services.

The RPR unit is also responsible for many critical system interfaces to other agency systems and to outside entities and maintains the eligibility programs that are used by Recipient Eligibility Verification (REV) System, the Automated Voice Response System (AVRS) and the Medical Electronic Data interchange (MEDI) system.

*2.9.7 Financial Recovery and Admin Systems*

The Third Party Liability (TPL) and Technical Recovery units are responsible for the systems used to recover funds paid by the agency for health claims and medical and financial assistance. The Admin Systems area is responsible for the support of various programs used for Healthcare Purchasing, tape generation for daily mainframe job streams, and support of the Systems Warehouse & Asset System (WAMS) for equipment and commodities for HFS.

## **2.10 MMIS To-Be**

The current MMIS was fully implemented in 1982 and was primarily built to support a fee-for-service Medicaid program. Throughout the years, HFS made many enhancements and modifications to the MMIS; however, it is an older legacy system

that is becoming increasingly more difficult to maintain and modify. Additionally, the federal Centers for Medicare and Medicaid Services (CMS) has since developed the Medicaid Information Technology Architecture (MITA), a national framework to support improved systems development and health care management.

Rather than develop a new system, Illinois has obtained a fully-operational, federally-certified MMIS partnership. This cloud-based approach will decrease up-front development costs and is expected to reduce the time required for implementation by two years.

### *2.10.1 IMPACT Phase 1: eMIPP*

The first phase of IMPACT included the launch of the Electronic Health Records Medicaid Incentive Payment Program (eMIPP), which provides incentive payments to eligible professionals and hospitals to adopt, implement, upgrade or demonstrate meaningful use of certified electronic health records (EHR) technology. As part of that effort, Illinois launched MyHFS.Illinois.gov, a secure provider web portal for authorized users to access and submit Medicaid information.

### *2.10.2 IMPACT Phase 2: Provider Enrollment*

In July 2015, providers seeking to serve Medicaid clients were required to enroll and revalidate through the new IMPACT web portal. Paper enrollment applications or updates were replaced by the on-line system and email has become the primary method for provider communication.

Existing Medicaid providers enrolled in the current legacy MMIS were required to revalidate their information in IMPACT. Subsequently, providers who deliver services through Medicaid waiver programs, including providers previously not required to enroll in MMIS, were required to enroll in IMPACT beginning in 2016.

### *2.10.3 Later Phases of IMPACT: PBMS and Full Implementation*

In March 2017, IMPACT launched the new Illinois Rx Portal Pharmacy Benefits Management System (PBMS). The ILLINOIS Rx Portal is part of the Illinois MMIS system upgrade and gives prescribers and pharmacies quick and secure web-access for processing and managing pharmacy benefits including:

- Viewing participant eligibility
- Submitting prior authorizations (PAs)
- Checking the status of submitted PA requests
- Viewing preferred drug list (PDL) criteria
- Viewing drug formulary information

The new system gives users alternatives to phone and fax for submitting PAs and following up on PA status.

Prescribers and pharmacies must be enrolled and approved in IMPACT to access the ILLINOIS Rx Portal. Once they are an approved provider, they will receive an e-mail with the instructions for accessing the Portal.

In 2020, Illinois expects a full transition to use of the single web-based system for all Medicaid claims processing – referred to as “full IMPACT implementation.”

## 2.11 HIT/MITA Coordination

HFS recently contracted Cognosante to perform a MITA State Self-Assessment (MITA SS-A) for the Medicaid Information Technology Architecture (3.0). The May 2017 SS-A describes the utilization of shared technology and business processes to advance Illinois’ healthcare transformation. The transformation aims to achieve its mission of providing quality healthcare coverage at sustainable costs for the people, families, and communities of Illinois.

Illinois is in the process of modernizing its 35-year-old MMIS, and other systems that comprise its Medicaid Enterprise. In 2013, HFS entered an Intergovernmental Agreement (IGA) with the state of Michigan’s Department of Health and Human Services (MDHSS) to begin a feasibility study to determine the viability and practicality of a shared Medicaid Enterprise between the two states. The resulting IMPACT project is a multi-phase initiative to deliver to HFS a state-of-the art federally certified MMIS through a cloud-enabled service as well as Medicaid Enterprise modules for:

- Provider Enrollment (PE)
- Pharmacy Benefits Management System (PBMS) Point of Sale (POS)
- Reference and Prior Approval
- Management and Reporting (MARS)
- Enterprise Data Warehouse (EDW)

The guiding principles established for this assessment were aligned with those documented in the Illinois HFS 2015 annual report, completed in March of 2016:

- Beneficiaries should receive the right care, at the right time, at the right cost
- Care should be holistic – integrating the physical and mental health needs of beneficiaries
- Care should be evidence-based to deliver the best quality at the lowest cost
- Pay for what works to improve and maintain health and stop paying for what doesn’t work
- Transform health care to a system focused on prevention and keeping beneficiaries healthy
- Prevent chronic disease whenever possible, coordinate care to improve quality of life and reduce chronic care costs
- Enable seniors and people with disabilities to live in their homes or community-based settings, instead of a higher-cost setting like a nursing home

HFS has a multi-pronged strategy with numerous initiatives to address healthcare challenges across the State’s Medicaid Enterprise. The overarching strategies are:

- Facilitate integration and decrease system fragmentation
- Automate repeated manual tasks and processes, where feasible
- Reduce processing time of requests for services
- Improve care planning and delivery

### 2.11.1 *Summary of Key Findings*

HFS is generally operating at an As Is MITA Maturity Level of 1 across the MITA business areas. Most the capability scores operate at a Level 1 and a few areas at a Level 2, with most reliant on fragmented systems and manual processes. While technology improvement projects, such as Health-e-Illinois Plus (HEAplus), have provided significant capability improvements in some business areas, HFS continues to have manual data entry and fragmented processes across programs and business areas. HFS will focus future development on automation and implementing standard data and processes; however, many of the MITA Level 3 capabilities still lack national standard definitions. For this reason, HFS seeks to standardize and automate to the fullest extent of MITA Level 2 and will explore MITA Level 3 standards as they are developed and adopted by CMS.

### 2.11.2 *Common Themes Emerging From the SS-A*

Subject matter experts across the different business areas identified several areas where current operations would benefit from improvements such as standard data storage, exchanges of data, and the way business processes are shared and completed across the enterprise.

There are several underlying themes that will provide both a foundation for decision-making and a challenge to the Illinois Medicaid Enterprise's ability to meet and exceed the targeted MMLs identified by the SMEs.

### 2.11.3 *Conclusions*

HFS has several key projects that have achieved the objectives from its 2009 MITA SS-A. However, some key capabilities must still be met to fully move business, technical, and information capabilities to higher MMLs. Limited resources, funding, staff shortages and managing the many new state and federal initiatives have been key constraints in successful completion of projects. However, HFS is intent to fully utilize federal funding opportunities to complete the projects and project planning initiatives on its To Be Roadmap.

On a scale of MML 1 to 5, the Illinois Medicaid Enterprise, in large part, was assessed at Level 1 with a goal to be at Level 2, and in some cases Level 3, within a 5-year timeframe. Of the six projects included in the To Be Roadmap, the IMPACT project is currently in process. As HFS completes the improvements identified in the Roadmap, the net effect is that the To Be items identified in HFS' MITA Maturity Capability Matrix will become the new As Is. Ongoing assessment cycles should ensure the appropriate business process and technical capability documentation remains current and establishes the new To Be Maturity Levels. This will form the foundation for

subsequent projects, streamline planning and support the new methodology chosen for the Medicaid Enterprise.

## 2.12 State Activities to Facilitate HIE and EHR Adoption

### 2.12.1 *IL HIE*

In September 2016, ILHIEA, including all HIE planning functions, was moved under HFS through an interagency agreement between the Office of the Illinois Governor, ILHIEA, and HFS. The National Governor’s Association (NGA) selected Illinois as one of three states to receive technical assistance related to “provider to provider” data exchange. The immediate goal is to implement a state-wide Admission, Discharge and Transfer (ADT) alerting notification system to advance our care coordination objectives. An IAPD was approved by CMS on March 13, 2018, assisting Illinois with funding for the ADT notification system. The longer term goal is to build off the foundation of ADT alerting notification to more advanced provider to provider data exchanges including labs, prescription and imaging files.

### 2.12.2 *Public Health*

Illinois requested Federal Financial Participation (FFP) funds in a recent IAPD to improve the Public Health registry on-boarding. This IAPD request was approved June 7, 2017. Additional staff for on-boarding will reduce a backlog with the Public Health registries and subsequent use of data associated with immunizations, syndromic surveillance, cancer registry and other public health registries.

### 2.12.3 *Regional Extension Centers*

The two Regional Extension Centers in Illinois, CHITREC and IL HITREC, are contracted via a State grant to perform outreach activities. The RECs greatly enhance the state’s ability to communicate and assist providers in their pursuit of meaningful use. Providers contact the RECs for assistance with the purchase, installation and configuration of their EHR systems. The RECs routinely schedule seminars and/or webinars, send email notifications and issue newsletters all aimed to update, inform, educate and assist providers. Subject matter is aimed toward the successful completion of an eMIPP attestation and generally includes program deadlines, policy updates, system changes and legislative mandates or issues. Through established contacts, the RECs also assist the State in recruiting new providers to participate in the incentive program.

#### 2.12.3.1 Direct Technical Assistance in EHR Adoption and Meaningful Use

During 2016 (through November), the RECs have completed 2,089 practice engagements including direct technical assistance, incoming requests for support and outgoing targeted communications to assist practices in the meaningful use process.

On-site and remote direct technical assistance in EHR adoption and meaningful use (382 engagements):

- EHR selection and implementation
- MU
- Small practice support for MU staff turnover
- Understanding HIE options and implementation
- Public health registry options and selection
- Patient centered medical home
- Privacy and security support and resources
- Patient portals and engagement
- Incentive program processes and attestation
- Quality improvement and use of data to measure goals
- Customized education and training specific to practice needs

Meaningful Use Helpdesk and REC support mechanisms:

- Dedicated meaningful use helpdesk
- REC support phone and email request systems
  - 799 Incoming requests to date in 2016
  - 908 Outgoing communications to date in 2016

#### 2.12.3.2 Education and Training

In addition to individual education and training initiatives specific to practice needs, the RECs provide broad-based webinars and training opportunities to Medicaid eligible practices on topics including:

- EHR selection and adoption
- Understanding registration and attestation
- eMIPP registration and attestation
- Health Information Exchange options and implementation
- Public health registries
- EHR optimization
- Patient engagement and patient portals
- Privacy and security
- Quality improvement leveraging EHR data
- Blood pressure management
- Patient centered medical home
- Audits and penalties

#### 2.12.3.3 Outreach and Targeted Communications

The RECs conducted outreach and targeted communications to Medicaid eligible providers leveraging extensive listserves of current practice contacts derived from both Medicare and Medicaid incentive program activities and other sources. Outreach activities focus on enrolling eligible providers in the eMIPP incentive program, providing up-to-date information on system maintenance, changes to meaningful use requirements by stages, and advanced meaningful use education and resources.

#### 2.12.3.4 Recruitment and Enrollment in eMIPP

The RECs implement a diverse array of activities targeting enrollment in the EHR Program, including:

- Direct mail leveraging Medicaid encounters database. Letters and communications are sent to providers with over 100 Medicaid encounters who are not already registered in eMIPP. Because of the source, this list would include all potentially eligible providers.
- Emails to eMIPP contacts. Targeted emails are sent to all contacts in the eMIPP system letting them know that any new providers in their organization need to register and attest in 2016 to participate in the program.
- Direct communication with eMIPP contacts. Direct contacts are made by field staff to eMIPP contacts that have providers who are registered only, letting them know that those providers need to attest in 2016 to continue in the incentive program.
- State and regional healthcare and medical associations. The RECs engage more than a dozen medical and healthcare related associations and professional societies for final year communications leveraging their listservs, member databases, newsletters, websites, or other direct communications.
- Promotion at regional/state conferences and meetings. RECs staff participate and provide representation at various conferences and meetings to expand outreach and recruitment.

#### 2.12.3.5 Data Analytics

Through the use of various data sources, the RECs analyze, monitor and identify groups for participation in the EHR Program.

Data analytics activities include:

- Determine program status, progression through MU and provide technical support to assist providers
- Conduct geographic and environmental scans to assess current status of provider populations and concerns related to achieving MU, including unique needs of MCE providers
- Perform analysis and report on outreach metrics
- Support HFS to guide program success and improvement

#### 2.12.3.6 Partnerships and Collaborations

The RECs develop, foster, and maintain key partnerships and collaborations to expand education, outreach, and support, as well as, align funded activities across the state to reduce redundancy and improve efficiency.

- Partner with the CIHIE to provide expertise and assistance to eligible providers to achieve MU goals
- Participate in essential collaboration meetings, including: bi-weekly meetings with HFS and ILHIE Medicaid workgroup, quarterly meetings with IDPH and any other necessary meetings
- Facilitate collaborations with national RECs for issues and trends in achieving and maintaining MU

- Collaborate with state QIO to leverage resources and coordinate efforts
- Leverage state and regional health associations and organizations to facilitate outreach, education and participation in the Medicaid EHR program

#### 2.12.3.7 Projected Medicaid Provider Targets

Illinois' two Regional Extension Centers provide outreach plans to the State through ongoing communications, projected targets have included:

- Providers who have not registered at CMS
- Providers who have had challenges registering for EHR or have registered, but haven't attested to AIU
- Providers who have enrolled in eMIPP, have met AIU, but have not yet reached MU
- Providers who have reached MU, but have not progressed
- Providers who have sufficient Medicaid patient volume, but have not yet enrolled in eMIPP
- Providers paid for AIU or MU in a prior program year, but not the most recent program year

Key themes and messages used to convince providers to attest to MU include:

- 2016 last year to start receiving incentive payments
- Limited time for REC assistance
- Financial incentives
- Avoid potential payment adjustments
- Increase quality of care and improve patient care
- Increase efficiency and reduce errors

## 2.13 State HIT Coordinator

As discussed in section 2.4, ILHIEA's functions moved to HFS in September 2016, including all HIE planning functions, through an intergovernmental agreement between the Office of the Illinois Governor, ILHIEA, and HFS. With the move of ILHIEA to HFS, HFS became the designated state entity for the ONC Advance Interoperable HIE grant as well as the State HIT Coordinator. The request from Governor Bruce Rauner was approved by Dr. Vindell Washington, National Coordinator for Health Information Technology. Ray Marchiori, HFS Chief of Staff, served as the State HIT Coordinator. This position is currently vacant. As HFS submits and is responsible for the Advanced Planning Documents (APDs) related to HIT, including HIE; the transfer of the designated entity from the Authority to HFS gives HFS closer proximity to the HIE planning, implementation and governance in order to ensure successful outcomes. The transfer of the Authority's functions to the jurisdiction and control of HFS also increases the State's ability to align programmatic efforts, convene stakeholders, avoid inefficiencies and reduce administrative costs when implementing HIE.

## 2.14 SMA Activities Influencing the EHR Incentive Program

### 2.14.1 *Behavioral Health Transformation*

Illinois has embarked on a transformation of its health and human services. In his 2016 announcement, Governor Rauner stated that the transformation “puts a strong new focus on prevention and public health; pay for value and outcomes rather than volume and services; make evidence-based and data-driven decisions and move individuals from institutions to community care, allowing patients to remain more closely connected to their family and community.”

Since then, the HFS has been collaborating with the Governor’s office and 11 other state agencies, including representatives from health, human services, education, criminal justice and even the broader stake holder community to accomplish this major transformation.

The initial focus and effort has been on behavioral health (mental health and substance abuse) and the integration of behavioral and physical health service delivery. Medicaid clients with behavioral health needs or “behavioral health clients” represent 25% of Illinois Medicaid recipients but account for 56% of all Medicaid spending. Further, building a nation-leading behavioral health strategy will hopefully turn the tide of the opioid epidemic, reduce violent crimes, encounters with police, and improve maternal and child health.

### 2.14.2 *Key Challenges*

To understand what drives the high spend and variable outcomes in the behavioral health system, Illinois has conducted quantitative and qualitative analyses and sought extensive stakeholder input. Core challenges identified include:

- Insufficient community-based behavioral health services capacity
- Over-reliance on institutional care
- Lack of coordination of behavioral health services
- Limited support services to address “whole-person” needs
- Duplication and gaps in behavioral health services across agencies that raise costs
- Limitations in data, analytics, and transparency

### 2.14.3 *Behavioral Health Transformation Strategy*

Illinois, with input from over 2,000 stakeholders, has developed a comprehensive strategy to transform Behavioral Health Services. The strategy puts customers at the center, integrates behavioral and physical health, and transforms a fragmented and unsustainable system with new payment and delivery models, increased managed care, enhanced workforce capacity, and greater accountability across the system. This strategy – the four central approaches and ten initiatives to support them – is illustrated below (Figure 13):

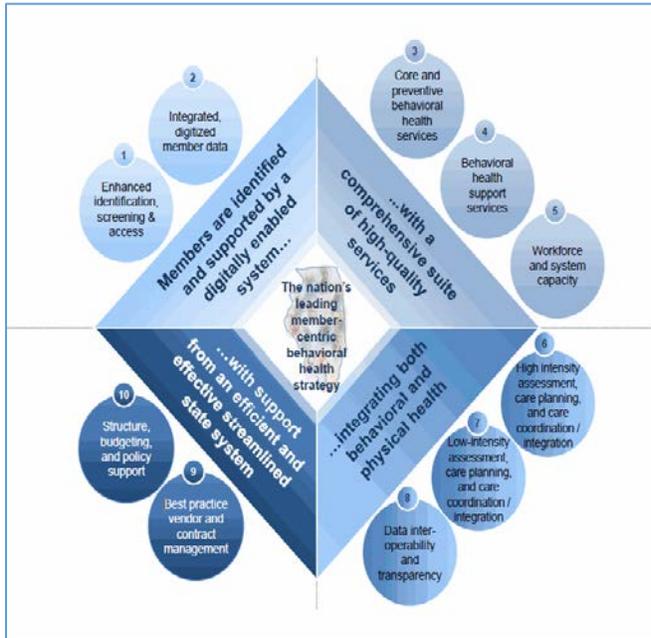


FIGURE 13

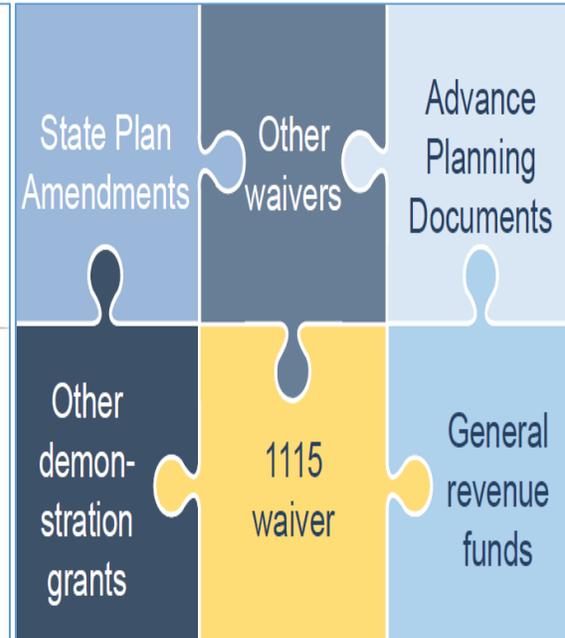


FIGURE 14

On May 7, 2018, Illinois received CMS approval for a Section 1115 Medicaid demonstration waiver. The approval covers the timeframe from July 1, 2018 through June 30, 2023. This proposal is just one component of a broader funding strategy to fuel the behavioral health transformation as demonstrated above (Figure 14).

#### 2.14.4 Goals of Illinois' 1115 Waiver Demonstration

Through the 1115 Waiver demonstration, Illinois aims to achieve six main goals:

1. Rebalance the behavioral health ecosystem, reducing over-reliance on institutional care and shifting to community-based care.
2. Promote integration in the delivery of behavioral and physical health care for behavioral health clients with high needs.
3. Promote integration of behavioral health and primary care for behavioral health clients with lower needs.
4. Support development of robust and sustainable behavior health services that provide both core and preventative care to ensure clients receive the full complement of high-quality treatment they need
5. Invest in support services to address the larger needs of behavioral health clients, such as housing and employment services
6. Create an enabling environment to move behavioral health providers toward outcomes and value-based payments

### 2.14.5 *Pilots to be tested under the Waiver*

Through the 1115 demonstration waiver, Illinois intends to test a set of benefits. The pilots are services provided to a defined population by a set of eligible providers.

The following pilots are included:

**1. Residential and Inpatient Treatment for Individuals with Substance Use Disorder (SUD) Pilot.** This pilot will include Opioid Use Disorder /SUD treatment services, including services provided in residential and inpatient treatment settings that qualify as an Institution for Mental Diseases (IMD), which are not otherwise matchable expenditures under section 1903 of the Act. The state will be eligible to receive FFP for Illinois Medicaid recipients who are short-term residents in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD benefits, which would otherwise be matchable if the beneficiary were not residing in an IMD. This pilot will operate statewide, and the state may not institute annual enrollment limits.

**2. Clinically Managed Withdrawal Management Services Pilot.** Under this pilot, the state will cover clinically managed withdrawal management services. The components of withdrawal management services are intake, observation, medication services and discharge services. Beneficiaries are eligible for this pilot if a physician or licensed practitioner of the healing arts determines the beneficiary demonstrates moderate withdrawal signs and symptoms, has a primary diagnosis of OUD/SUD, and requires 24-hour structure and support to complete withdrawal management and increase the likelihood of continuing treatment and recovery. The state may implement this pilot less than statewide and may institute annual enrollment limits.

**3. SUD Case Management Pilot.** Under this pilot, the state will cover SUD case management services that assist a beneficiary to access needed medical, social, educational, and other services. Case management services are individualized for beneficiaries in treatment, reflecting particular needs identified in the assessment process, and those developed within the treatment. Beneficiaries with an OUD/SUD diagnosis that qualify for diversion into treatment from the criminal justice system are eligible for this pilot. The state may not claim FFP for services provided to inmates of a public institution as defined in 42 CFR 435.1010. The state may implement this pilot less than statewide and may institute annual enrollment limits.

**4. Peer Recovery Support Services Pilot.** Under this pilot, the state will cover peer recovery support services delivered by individuals in recovery from a substance use disorder (peer recovery coach) who is supervised to provide counseling support to help prevent relapse and promote recovery. Beneficiaries receiving SUD treatment, have a primary diagnosis of OUD/SUD, and have an assessed need by a physician or other licensed practitioner of the healing arts for recovery support are eligible for this pilot. The state may implement this pilot less than statewide and may institute annual enrollment limits.

**5. Crisis Intervention Services Pilot.** Under this pilot the state will cover crisis intervention services support stabilization, rapid recovery, and discharge of the individual experiencing a psychiatric crisis. Beneficiaries aged 6 through 64 who are experiencing a psychiatric crisis and require stabilization and support, including 24-hour clinical supervision and observation are eligible for this pilot. The state may implement this pilot less than statewide and may institute annual enrollment limits.

**6. Evidence-based Home Visiting Services Pilot.** Under this pilot, the state will cover evidence-based postpartum home visit services to beneficiaries during their 60 day postpartum period and home visit services to Medicaid eligible newborn infants born with withdrawal symptoms to beneficiaries until the child reaches 5 years of age. The state may implement this pilot less than statewide and may institute annual enrollment limits.

**7. Assistance in Community Integration Services Pilot.** Under this pilot, the state will cover a set of HCBS, specifically assistance in community integration services including pre-tenancy supports and tenancy sustaining services. Beneficiaries eligible for these services must meet needs-based criteria that includes health and housing criteria. The state may implement this pilot less than statewide and may institute annual enrollment limits.

**8. Supported Employment Services Pilot.** Under this pilot, the state will cover a set of HCBS, specifically supported employment services including pre-employment services, employment sustaining services, job analysis, job coaching, benefits education and planning, transportation and follow-along supports. Beneficiaries eligible for these services must meet needs-based criteria that includes behavioral health criteria and is expected to benefit from supported employment services, which means expressing a desire to work. The state may implement this pilot less than statewide and may institute annual enrollment limits.

**9. Intensive In-Home Services Pilot.** Under this pilot, the state will cover intensive in home services, which include face-to-face, time-limited, focused interventions to stabilize behaviors that may lead to crisis or may result in inpatient hospitalizations or residential care. Beneficiaries aged 3 to 21 who meet the requirements of Tier A (high physical, high behavioral health needs) or Tier B (high behavioral health, low physical needs) of the Integrated Health home and have a history or be at risk for specific behavioral health services. The state may implement this pilot less than statewide and may institute annual enrollment limits.

**10. Respite Services Pilot.** Respite care is a set of individualized time-limited services that provide families scheduled relief to help prevent stressful situations, including avoiding a crisis or escalation within the home. Services can be delivered in or out of the home as long as they take place in community-based settings. Respite services provide safe and supportive environments on a short-term basis to Medicaid clients age 3 up to age 21 with behavioral health conditions when their families need relief. The beneficiary must meet the requirements of the Tier A (high physical, high behavioral health needs) or Tier B (high behavioral health, low physical needs) of the

Integrated Health Home and exhibit certain risk factors. The state may implement this pilot less than statewide and may institute annual enrollment limits.

#### 2.14.6 *Integrated Health Homes (IHH)*

The Integrated Health Home (IHH) program is intended to be a new, fully-integrated from of care coordination, for all clients of the Illinois Medicaid population, with a provision for high needs clients covered through a state plan amendment (SPA). Six (6) care delivery improvement goals have been identified for all IHH clients:

1. Integrated Care Planning and Monitoring
2. Physical Health Provider Engagement
3. Behavioral Health Provider Engagement
4. Supportive Service Engagement
5. Client Engagement and Education
6. Population Health Management

Each client in the Medicaid population would be linked to an Integrated Health Home provider based on their level of need and the provider's ability to meet these needs. The Integrated Health Home would be responsible for care coordination for clients across their physical, behavioral, and social care needs. Integrated Health Homes would not, however, be responsible for provision for all services and treatment to clients. The program is intended to launch in late 2018.

Clients would be assigned to one of several tiers based on their level of need and would be provided with a commensurate level of care coordination. This would be ascertained, first and foremost, with reference to their medical history and profile. Specific criteria for eligibility for each tier of membership would be defined, and clients' MCOs (or the State, for FFS populations) would be responsible for the review of their medical history for evidence of these criteria and the assignment of the client to the appropriate tier of need. MCOs (or the State, for FFS populations) would also transfer them to different tiers of care as their needs change over time, following predefined reassignment criteria, and manage the manual assignment of clients without available medical history data. After assignment to a tier of care, clients would be attributed to an IHH provider best able to meet their needs, drawn from a broad pool of potential provider types, following predetermined attribution logic. The client would be notified of their place within the program and their prospective IHH provider, together with rights to opt out of the program or request a different provider. Likewise, the provider to which the client has been attributed would be alerted to this, to permit them to begin outreach. Clients enrolled in MCOs, would play a key supporting role in this process.

Two main support streams are intended for IHHs. In order to deliver care coordination (as needed) from a pre-determined set of IHH activities, providers would receive from MCOs (or the State, for FFS populations) per member per month reimbursements. Submission of claims to generate a reimbursement will be required (as opposed to automatic, prospective off-claims transfers). The second stream to which providers would potentially be eligible is an outcome based stream, calibrated to incentivize

value over volume. Provider performance against a set of quality and efficiency measures for their panel would be monitored for the duration of their membership in the program. Strong performance on these measures – without sacrificing quality in the pursuit of cost savings – would be used to determine both eligibility for this stream, and the extent of the value of the remuneration to. Information on provider performance (together with actionable next steps) may be provided to providers via a report card at regular intervals.

#### *2.14.7 Integrated Eligibility System (IES)*

The Integrated Eligibility System (IES) determines eligibility for all medical programs. IES replaces the 30 plus-year old COBOL mainframe application that was built before there was a functional internet or wide use of relational databases. HFS is implementing IES in collaboration with the DHS and the DoIT.

The following benefits are available through IES:

#### **Supplemental Nutrition Assistance Program (SNAP)**

SNAP is the Supplemental Nutrition Assistance Program and was previously known as Food Stamps. SNAP helps low income people buy the food they need for good nutritional health. SNAP beneficiaries receive an Illinois Link Card which functions similarly to a debit card. Funds are distributed to the card on a monthly basis and can be utilized to pay for food at most grocery stores.

#### **Cash Assistance**

Cash Assistance can help pay for food, shelter, utilities, and expenses other than medical costs. A small amount of cash assistance is available to people who fit into one of three groups:

- Low-income pregnant women or families that include at least one dependent child under the age of 18, may qualify for TANF Cash Assistance. TANF is short for Temporary Assistance for Needy Families. If someone receives TANF, they will also receive Medicaid or All Kids health care coverage.
- Low-income seniors age 65 or older, people who are blind, and people who have a permanent disability may qualify for AABD Cash Assistance. AABD is short for Aid to the Aged, Blind and Disabled. People who qualify for AABD cash assistance also receive Medicaid health care coverage.
- Immigrants with refugee or asylee status may be eligible for cash assistance through the Refugee Resettlement Program (RRP). Refugees may be eligible for assistance up to 8 months after the date of entry into the United States. Asylees may be eligible for assistance up to 8 months after the date asylum is granted. People who qualify for RRP Cash Assistance also receive Medicaid health care coverage. People who qualify for TANF or AABD cash assistance do not qualify for RRP cash assistance.

## Health care coverage

Medicaid and All Kids cover health care for low income people of all ages in Illinois.

## Medicare Savings Programs (MSPs)

Medicare Savings Programs (MSPs) cover the cost of Medicare premiums for low income seniors and people with disabilities on Medicare. People who qualify for one of the MSP do not have to use their Social Security income to pay Medicare premiums. For some people, Medicare deductibles and co-insurance charges are also covered.

### *2.14.8 Illinois Medicaid Program Advanced Cloud Technology (IMPACT)*

The IMPACT initiative is a multi-agency effort that modernizes the Department's 30 year-old MMIS which was built to support a fee-for-service Medicaid program. The MMIS supports claims processing for the HFS medical assistance programs.

The MMIS environment includes:

- *Database Subsystems (e.g. Provider, Recipient, Reference and Prior Approval)*
- *Hospital, Pharmacy and NIPS Claims Processing Subsystems*
- *Management and Reporting System (MARS)*
- *Enterprise Data Warehouse*
- *Pharmacy Point-of-Sale System*
- *Web-based Applications Provided in the Medical Electronic Data Interchange (MEDI) system*

Throughout the years, HFS made many enhancements and modifications to the MMIS; however, it is an older legacy system that has become increasingly more difficult to maintain and modify. Rather than develop a new system, Illinois obtained a federally-certified MMIS through an intergovernmental agreement with the State of Michigan Department of Community Health (MDCH), which is being enhanced to fulfill HFS' business needs. By implementing an enhanced MDCH MMIS and not building a new system, up-front development costs are decreased, and the time required for implementation is reduced.

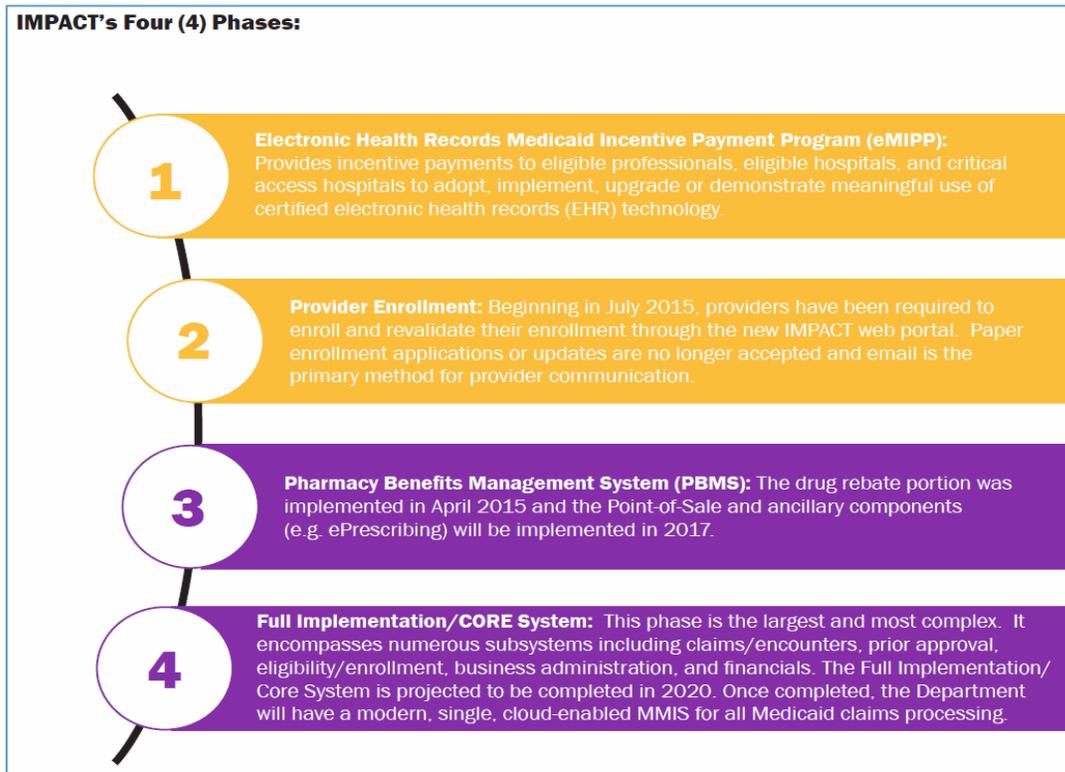


FIGURE 15

## 2.15 State Laws or Regulations

There have been no recent laws or regulations passed which would significantly affect the EHR Incentive Program in Illinois.

## 2.16 Interstate HIT/HIE Activities

There is no current activity across State borders. In NGA planning sessions, the HIE design strategy by HFS is to acquire a system that allows ADT notifications to be shared with other States followed by more advanced file types, such as those related to labs, prescriptions and imaging.

## 2.17 Public Health Interoperability Status

To complete the Public Health objective during attestation, providers have several options. The options below are available via the IDPH. The Illinois Prescription Monitoring Program (PMP) is hosted by the DHS as an agent of the IDPH.

### Immunization Reporting

- I-CARE currently accepts immunization data from providers in HL7 2.3.1 and 2.5.1
- Testing and ongoing submission of data from EPs, EHs and CAHs for Meaningful Use is

underway

- Immunization Reporting: I-CARE will accept Stage 3 MU standards on/after January 1, 2017 (Bi-directional exchange QBP/RSP and capacity to receive NDC Codes using HL7 2.5.1 r1.5 plus Addendum)

#### **Electronic Laboratory Reporting (ELR)**

- I-NEDSS currently accepts ELR data from hospital laboratories in HL7 2.5.1
- Testing and ongoing submission of data from EHs and CAHs for Meaningful Use is underway

#### **Syndromic Surveillance Reporting (updated 6/30/17)**

- IDPH currently accepts syndromic surveillance data from Eligible Hospitals
- Stage 2 included Emergency department data only in HL7 2.5.1
- Stage 3 includes Emergency department, inpatient and urgent care type visits
- Illinois will accept syndromic surveillance data from EPs in an urgent care setting only
- IDPH Syndromic Surveillance Data Element List

#### **Electronic Case Reporting (eCR) (updated 6/30/17). For Stage 3 reporting only, beginning 1/1/2018**

- IDPH will accept HL7 standard, electronic Initial Case Reports (eICR) from Eligible Hospitals and Eligible Providers
- IDPH will accept certified electronic case reports that follow the 2015 edition test methods.

#### **Specialized Registry Reporting - Stage 2 only. Will continue to accept data in 2018.**

- Illinois Prescription Monitoring Program

#### **Cancer Reporting**

- The Illinois State Cancer Registry currently accepts cancer case information from providers using the HL7 CDA, Release 2
- Testing and ongoing submission of data from EPs for Meaningful Use is underway
- Stage 2 – as specialized registry.
- Stage 3 - as public health registry

## **2.18 HIT Grants Awards to the State**

### *2.18.1 Medicaid Emergency Psychiatric Demonstration<sup>1</sup>*

#### **EXECUTIVE SUMMARY**

Section 2707 of the Affordable Care Act (ACA; P.L. 111-148) required the U.S. Department of Health and Human Services (HHS) to conduct and evaluate a demonstration on the effects of providing Medicaid reimbursements to private psychiatric hospitals that treat beneficiaries ages 21 to 64 with psychiatric emergency medical conditions (EMCs).<sup>2</sup> The demonstration tested the extent to which reimbursing these hospitals for inpatient services needed to stabilize a psychiatric EMC, which is generally prohibited under Medicaid statute, improved access to and quality of care for beneficiaries and reduced overall Medicaid costs and utilization.

<sup>2</sup> Psychiatric EMCs were deemed to be present when an individual expressed suicidal or homicidal thoughts or gestures, or was judged to be a danger to him- or herself or others.

### **Rationale for the demonstration**

Since the enactment of Medicaid in 1965, institutions for mental disease (IMDs), defined as “hospitals, nursing facilities, or other institutions primarily engaged in providing diagnosis, treatment, or care of persons with mental illness,” have been prohibited by statute from receiving federal Medicaid matching funds for inpatient treatment provided to adults ages 21 to 64. Through this exclusion, Congress sought to maintain the historic responsibility of states for long-term hospitalization in large mental institutions and emphasize community-based care as an alternative. As a result of widespread “deinstitutionalization” that began in the 1950s, fewer hospital beds were needed, and over the next five decades publicly funded, state IMDs closed or were downsized significantly. Individuals experiencing psychiatric emergencies were served in small psychiatric facilities or the psychiatric units of general hospitals, both of which are exempt from the IMD exclusion, or through community-based alternatives to hospitalization. During the past ten years, however, frequent boarding of psychiatric patients in general hospital emergency departments (EDs) has been reported to occur when specialized inpatient psychiatric beds are not available.

This situation is further complicated by requirements under the 1986 Emergency Medical Treatment and Labor Act that hospitals participating in Medicare examine any person who comes to the ER to determine whether he or she has an EMC. The hospital must provide treatment to stabilize the condition or provide for an appropriate transfer to another facility. An IMD that participates in Medicare and has specialized capabilities and the capacity to treat psychiatric EMCs must admit or accept transfers of patients with such conditions for stabilizing treatment, regardless of the individual’s ability to pay. As a result, in states that do not cover the costs of inpatient treatment for Medicaid beneficiaries using state-only funds, IMDs excluded from Medicaid reimbursement may be required to provide uncompensated treatment to beneficiaries with psychiatric EMCs.

### **Implementation of the demonstration**

In response to these concerns and legislative requirements, CMS implemented the Medicaid Emergency Psychiatric Services Demonstration (MEPD) and its evaluation. In August 2011, CMS solicited applications from states to participate in the demonstration and in March 2012 selected 11 states (Alabama, California, Connecticut, Illinois, Maine, Maryland, Missouri, North Carolina, Rhode Island, Washington, and West Virginia) and the District of Columbia (hereafter referred to as a state) to participate; 28 private IMDs participated in the demonstration. MEPD began on July 1, 2012 and, in accordance with legislative requirements, ended three years later, on June 30, 2015.

Data submitted by participating states to CMS for payment and monitoring purposes show the following:

- MEPD funded 16,731 admissions of 11,850 Medicaid beneficiaries.
- About three-quarters of admissions were judged eligible for MEPD on the basis of suicidal thoughts or gestures; relatively few (10 percent) were based on homicidality.
- About two-thirds of beneficiaries were admitted with diagnoses of mood disorders and one-third with diagnoses of schizophrenia or other psychotic disorders.
- Of the 11,850 beneficiaries, 77 percent were admitted to a participating IMD just once during MEPD.
- The average IMD length of stay was 8.6 days. However, the distribution of length of stays was skewed, and, although the vast majority were for less than a month, some were substantially longer (with a maximum of 147 days).
- For 90 percent of admissions, beneficiaries were discharged to their homes or self-care; another 3 percent were discharged home under the care of a home health service organization. The extent to which such placements included discharge to homeless shelters, group homes or other supervised living arrangements, and the streets is unknown; follow-up care arrangements for individuals discharged to their homes or self-care were also unspecified in these data. Four percent of admissions were transferred to other institutions.
- The ACA authorized \$75 million in federal funds for MEPD. Total federal and state expenditures on claims were approximately \$113 million. Depending on the state, the federal share of these claims ranged from 50 to 73 percent.

## Results

Exhibit ES.1 summarizes the results of the evaluation. Overall, we found little to no evidence of MEPD effects on inpatient admissions to IMDs or general hospital scatter beds; IMD or scatter bed lengths of stays; ER visits and ED boarding; discharge planning by participating IMDs; or the Medicaid share of IMD admissions of adults with psychiatric EMCs. Federal costs for IMD admissions increased, as expected, and costs to states decreased. The extent to which these findings were driven by data limitations, were affected by external events, or reflect true effects of MEPD is difficult to determine.

**Exhibit ES.1. Summary of evaluation results, by ACA area**

Measure	Findings
<b>Access to inpatient mental health services under the Medicaid program, average lengths of inpatient stays, and ER visits</b>	
Inpatient IMD admissions <sup>a</sup>	The one statistically significant change that showed a decrease in IMD admissions is likely due to a data quality issue in one quarter of the pre-demonstration period.  In the one state with 1.5 years of data during the MEPD, admissions increased late in the MEPD period.
General hospital scatter bed admissions	No effects (use was low but increased during MEPD in both MEPD and comparison groups)
IMD length of stay	No effects (nonsignificant trend for IMD stays to be longer than stays in general hospital psychiatric units)
General hospital scatter bed length of stay	No effects
ER visits	No effects (trend toward more ER visits during MEPD)
ED boarding time	No effects

**Discharge planning by participating IMDs**

- In most states, IMDs did not change their discharge planning processes for MEPD<sup>b</sup> and used identical procedures for Medicaid and non-Medicaid patients.
- The vast majority of beneficiaries were discharged to their homes rather than transferred to other facilities.
- A third of the states implemented specific procedures to improve linkages with community-based providers for beneficiaries with EMCs.
- With few exceptions, beneficiaries interviewed expressed satisfaction with the discharge planning processes at the IMDs, and 88 percent felt safe to leave the IMD when they were discharged.
- IMDs appeared to provide better connection to and documentation of recommendations for aftercare than medical-surgical units in general hospitals serving beneficiaries in scatter beds.
- Discharge planning was hampered by lack of available community-based care.

Measure	Findings
<b>Costs of the full range of mental health services (including inpatient, emergency department, and ambulatory care)<sup>c</sup></b>	
Federal Medicaid/MEPD costs for IMD inpatient stays	Costs increased
State costs for Medicaid beneficiary IMD inpatient stays	Costs decreased
IMD costs for Medicaid beneficiary IMD inpatient stays	Increased in one state, decreased in the other
Medicaid and Medicare costs for full range of mental health services <sup>d</sup>	Increased in two states, no effect in three
<b>Percentage of consumers with Medicaid coverage admitted to inpatient facilities as a result of MEPD, compared to those admitted to same facilities through other means</b>	
Proportion of admissions meeting MEPD eligibility criteria	Increase in proportion of Medicaid admissions may be due to ACA Medicaid expansion

<sup>a</sup> The evaluation did not separately examine MEPD's effects on readmissions.

<sup>b</sup> Neither the ACA nor CMS required states or IMDs to change care processes for the MEPD.

<sup>c</sup> Note that the ACA did not require CMS or states participating in MEPD to demonstrate cost neutrality. Not all MEPD states were included in the analyses, due to insufficient usable data.

<sup>d</sup> Medicare costs were included for dual Medicare-Medicaid enrollees.

<sup>1</sup>Information in the section from [Medicaid Emergency Psychiatric Services Demonstration Evaluation: Final Report](#), August 18, 2016. Mathematica Policy Research. Reference Number 40123.444

### 2.18.2 *Prevention and Management of Childhood Obesity Grant*

**Grantee:** *Illinois Chapter, American Academy of Pediatrics*

**Project/Grant Name:** *Promoting Health: Raising the Standard of Care for Prevention and Management of Childhood Obesity in Illinois*

**Grant Period:** *May 15, 2015 – April 30, 2017*

**Grant Amount:** *\$300,000*

**Grant Description:**

The Grantee performed activities related to improving the standard of care for prevention and management of childhood obesity in Illinois. Primary activities include the provision of continuing medical education and other resources, related to childhood obesity care, for pediatricians, pediatric specialists, and other child health care providers throughout Illinois and specifically targeted providers enrolled in the Illinois Medical Assistance Program; development and implementation of obesity-related education modules; development and implementation of obesity-related quality improvement activities to improve pediatric health care of children and adolescents. The Grantee assisted the Department in raising the standard of obesity care for pediatric beneficiaries in Illinois covered by various medical assistance programs by increasing the number of Medicaid-enrolled health care providers receiving training and implementing practice change to improve their quality of care for patients at risk of obesity and obesity-related chronic conditions.

### 2.18.3 *Florida-Illinois CHIPRA Quality Demonstration Grant*

In February 2010 as part of the Children’s Health Insurance Program Reauthorization Act (CHIPRA), the Centers for Medicare and Medicaid Services (CMS) awarded 10 quality demonstration grants, funding 18 states, to improve health care quality and delivery systems for children enrolled in Medicaid and the Children’s Health Insurance Program (CHIP). Under this grant opportunity, the Florida Agency for Health Care Administration (AHCA) and HFS were jointly awarded \$11.3 million for work to be completed over the subsequent 5-year period.

To achieve the overarching goal of the grant of improving child health and child health outcomes, Florida and Illinois embarked on a number of initiatives in four key federal priority areas:

- Experimenting with and evaluating the use of quality measures to improve child health care;
- Promoting the use of HIT in the delivery of care for children;
- Evaluating provider-based models that improve the delivery of Medicaid/CHIP children's health care services; and
- Assessing the utility of other innovative approaches to enhance child health care quality.

Florida and Illinois worked both collaboratively and independently on developing and implementing a variety of initiatives in each of these priority areas. Projects were

tailored to their own unique state environments and priorities while also working collaboratively, where applicable, to develop and deploy joint products and resources, share best practices and progress, and benefit from cross-state learning opportunities.

Across project areas, consistent themes emerged and led to the formation of several culminating focus areas for improvements in child health care quality. The CHIPRA grant work offers valuable insights and reveals ample opportunity for stakeholders to further the influence of this grant and spread and implement improvements in these focus areas. The final grant report described opportunities for how federal and state government, public and private payers, providers, advocates and other stakeholders can build on critical areas of the CHIPRA Quality Demonstration Grant's success in the following identified areas:

- Transformation of practices to meet standard, nationally-endorsed medical home standards and principles
- Quality collaborative to identify quality improvement methods and improve care
- Ongoing and credible performance measurement and reporting at the provider, plan and state level designed to achieve buy-in and engagement in quality improvement.
- Investment in robust, certified electronic health records (EHRs) that support management of preventive, acute, and chronic pediatric care and support for pediatricians and pediatric subspecialists to utilize these functions to meet Meaningful Use requirements.

Principally, the Florida and Illinois CHIPRA grant project teams recommended that Medicaid and CHIP should optimize health outcomes for women and children by ensuring a high-quality health care system that utilizes standard, nationally-endorsed quality measurement; evidence-based quality improvement science at the provider, plan and state level; the meaningful use of robust, certified electronic health information technology; and public/private collaboration and alignment. The final report described the aspects of the Florida-Illinois CHIPRA Quality Demonstration Grant activities that led to the formulation of these culminating focus areas and how they could be supported and built upon. In providing this information, Florida and Illinois hope to spread and sustain the cumulative knowledge derived from this work.

*This section was taken from the Florida-Illinois CHIPRA Project Key Messages Report. This report is available at <https://www.healthmanagement.com/wp-content/uploads/CHIPRA-Key-Focus-Report-Final.pdf>*

### *2.18.3 National Governor's Association Technical Assistance*

Illinois participated in the NGA Health Policy Technical Assistance Program – "[Getting the Right Information, to the Right Health Care Providers, at the Right Time – How States Can Improve Data Flow](#)". The program is described by the NGA as "a flexible technical assistance opportunity to help governors' senior staff and other state officials address policy issues that limit the flow of health care information between providers." The project helps states ensure providers have the information they need, when they need it, to improve care delivery and outcomes. It provides an opportunity for states

seeking to modify policies, implement new policies, conduct outreach, and gain stakeholder buy-in on complex legal and market-based challenges and solutions.

HFS submitted Illinois' winning application which focused on the need for Illinois to learn from states successful in HIE. The immediate goal is to implement a state-wide Admission, Discharge and Transfer (ADT) alerting notification system to advance our care coordination objectives. An IAPD was approved by CMS on March 13, 2018 assisting Illinois with funding for the ADT notification system. The longer-term goal is to build off the foundation of ADT alerting notification to more advanced provider to provider data exchanges including labs, prescription and imaging files.

## 3 HFS TO BE LANDSCAPE

### 3.1 HIT Goals and Objectives

#### 3.1.1 *HIE and Public Health Goals*

At the end of the 2016 program year, new providers may no longer enroll in the EHR Incentive Program. EHR Incentive Program goals will be redirected to Stage 3 meaningful use issues, HIE/data transmissions, Public Health and other HIT concerns or issues.

The current HIE goal is to have a State-wide ADT Notification System in place by the end of 2018 that would be available to all providers in Illinois. HFS has recently posted a Request for Proposal (RFP) to contract a vendor to secure the use of a software as a service (SaaS) state-wide Admission, Discharge and Transfer (ADT) Notification System (“System”). To support its managed care goals and other healthcare transformation initiatives, HFS needs a unified state-wide System where all Illinois hospitals connect and contribute ADT notifications to a centralized system. Real-time ADT notifications will be delivered to the care coordination team of each Illinois Medicaid Managed Care Organization (“MCO”) and integrated health home. Medicaid providers will receive ADT notifications from MCOs, integrated health homes or directly from the System. Among other quality improvements and cost savings strategies, the ability to send and receive ADT notifications will assist the community of care givers to improve care transitions, leading to a reduction in unnecessary hospital and Emergency Department/Emergency Room admissions and readmissions.

Illinois was awarded Federal Financial Participation (FFP) funds in a recent IAPD to improve the Public Health registry on-boarding. Additional staff will reduce a backlog with the Public Health registries and improve data associated with other DPH registries. Other goals include improving connectivity to behavioral health facilities, long term care facilities and assisting home health issues.

Following the ADT notification implementation, HFS will focus on developing capabilities such as sharing notifications across state borders, ensuring advanced file types may be shared, and ensuring data sharing for Illinois citizens with or without Medicaid insurance occurs.

#### 3.1.2 *Attestation Goals*

Statistics for Illinois providers participating in the Medicare and Medicaid EHR Incentive programs are shown in the tables below. Yearly attestation totals for the Illinois Medicaid EHR Incentive Program increased on average of approximately 20% for the years 2012-2015. For 2016, a significant increase was realized in the number of EP AIU attestations (last program year to attest for year 1) and a slight increase



experienced in the number of EP MU attestations. Eligible Hospitals were not expected to increase as 174 hospitals have already attested.

**Illinois EP Program Statistics**

Program Year	Count	Payment Amount
2011	3,630	\$60,928,628.95
2012	9,629	\$143,449,670.86
2013	11,912	\$126,577,528.76
2014	11,210	\$86,875,041.11
2015	9,328	\$42,257,443.36
2016	6,690	\$18,568,275.38
All Years	52,399	\$478,656,588.42

FIGURE 16

**Illinois EH Program Statistics**

Program Year	Count	Payment Amount
2011	66	\$78,592,834.66
2012	166	\$148,585,644.25
2013	240	\$216,268,754.39
2014	196	\$132,345,102.66
2015	101	\$64,368,593.08
2016	50	\$21,529,668.09
All Years	819	\$661,690,597.13

FIGURE 17

**Illinois Medicaid EP Participation Details\***

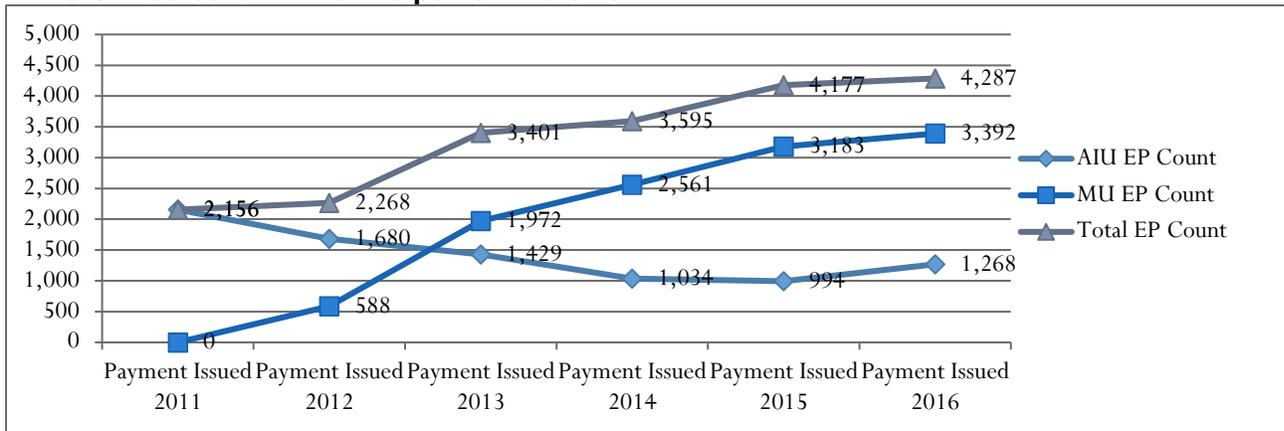


FIGURE 18

**Illinois Medicaid EH Participation Details\***

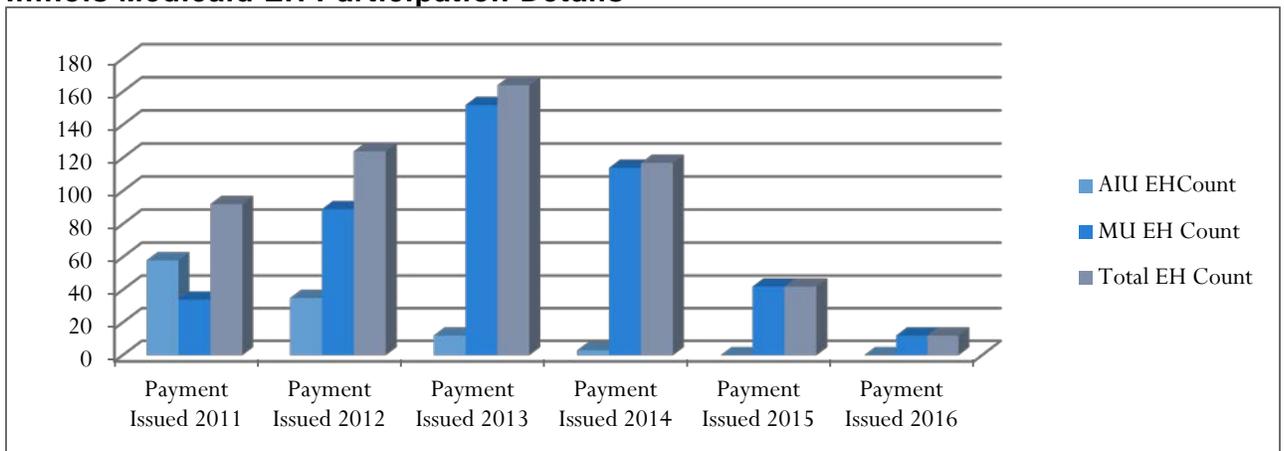


FIGURE 19

\*Data as of December 8, 2017



**Illinois EP's Meeting Medicare Meaningful Use**

Program Year	Attestation Status	EP Count	EH Count
2011	Payment Issued or Passed	3,513	43
2012	Payment Issued or Passed	9,233	106
2013	Payment Issued or Passed	11,236	166
2014	Payment Issued or Passed	10,792	169
2015	Payment Issued or Passed	10,313	168
2016	Payment Issued or Passed	10,792	169

FIGURE 20

**EH Payment Status**

Status	Paymt Year	Paymt Count	Payment Amount
Paid	1	174	\$146,407,214.50
Paid	2	173	\$119,836,982.98
Paid	3	36	\$12,753,568.00
Paid	4	1	\$194,283.00
Final	2	1	\$769,706.00
Final	3	133	\$29,043,958.99
Final	4	32	\$5,674,160.80
Final	5	1	\$194,283.00
Total Final		167	\$35,682,108.79
Total All		551	\$314,874,157.27

**EP Payment Status**

Status Code	Paymt Year	Paymt Count	Payment Amount
Paid	1	9,060	\$191,299,636.36
Paid	2	4,857	\$41,066,354.05
Paid	3	3,173	\$26,803,353.00
Paid	4	1,805	\$15,271,675.00
Paid	5	867	\$7,346,836.00
Final	6	160	\$1,357,167.00
Total Final		160	\$1,357,167.00
Total All		19,922	\$283,145,021.41

FIGURE 22

FIGURE 21

\*Final indicates all incentive payments have been issued and received by the Provider.

\*\*Data as of December 1, 2017

**Historical and Projected Attestations for PY2017**

YEAR	AIU	MU YR1	MU YR2	YR2 % of YR1 Previous	MU YR3	YR3 % of YR2 Previous	MU YR4	Y4 % of YR3 Previous	MU YR5	Y5 % of YR4 Previous	MU YR6	YR6% of YR5 Previous	TOTAL
2011 actual	2156	0	0		0		0		0		0		2156
2012 actual	1680	34	554	25.70%	0		0		0		0		2268
2013 actual	1429	46	1475	86.06%	451	81.41%	0		0		0		3401
2014 actual	1034	178	967	65.56%	1129	76.54%	288	63.86%	0		0		3598
2015 actual	994	183	1084	89.44%	852	88.11%	868	76.88%	196	68.06%	0		4180
2016 actual	1269	163	813	69.07%	800	73.80%	708	83.10%	737	84.91%	170	86.73%	4663
2017 projections	0	0	1117	78.00%	650	80.00%	600	75.00%	538	76.00%	589	80.00%	3497

FIGURE 23

\*Data as of March 13, 2018

## 3.2 SMA IT System Architecture

In 2013, it was announced that Illinois would join Michigan in employing a shared MMIS platform. The first phase of the project, Electronic Medicaid Incentive Payment Program (eMIPP) went live for Illinois in November 2013. In July of 2015, the Provider Enrollment (PE) phase of the project was implemented.

HFS currently manages and operates the Illinois legacy MMIS. The Illinois legacy MMIS meets all certification requirements as set forth by CMS in the State Medicaid Manual, Part 11 – Medicaid Management Information System. The MMIS was fully implemented in 1982 and was primarily built to support a fee-for-service Medicaid Program. Through the years, HFS has made many enhancements and modifications to the current MMIS. However, it is an older legacy system that has become increasingly difficult to maintain and modify. HFS, therefore, embarked on a structured planning project to identify needed functionality and explore the best alternatives to acquire and operate a new MMIS.

In March 2012, Illinois was approached by the State of Michigan to discuss the “state sharing” option for the new MMIS. It was determined Illinois and Michigan would benefit financially in the Operations and Maintenance Phase (post implementation) such that costs normally borne by the State (25%) would be shared with Michigan, and both states would share in enhancement efforts and costs. In addition, subsequent design, development and implementation (DDI) efforts to maintain compliance with future federal regulations would also be shared between both states. Michigan would extend its MMIS to accommodate Illinois’ claim volumes.

The State of Michigan undertook the replacement of its MMIS in 2005. The system was put into production use in 2009 and was certified by CMS in 2011 with no defects. The system is MITA and HIPAA compliant and meets the Seven Conditions and Standards set forth by CMS. Michigan has started the ICD-10 compliance project and expects to complete that effort according to the federally-mandated deadlines. The system is scalable and can be extended to accommodate Illinois’ Medicaid claim volumes and business practices without diminishing the State of Michigan’s Medicaid program objectives.

The State of Michigan conceived taking its current MMIS through a refinement process to transform into a service that can be offered to other states. This private cloud MMIS service will be known as Medicaid Management Information System as a Service or MaaS.

Per the definitions provided by the National Institute of Standards and Technology (NIST) in Special Publication 500-292 entitled “NIST Cloud Computing Reference Architecture,” the envisioned MaaS implementation will be a multi-tenant (community), private cloud. The services of the MaaS could be provided to multiple states from a cloud service infrastructure that is dedicated solely to delivering the MaaS.

States would use the service in a largely as-is manner, and instead of following a traditional DDI process, a Configuration Conversion and Deployment (CCD) process

will be conducted. This model represents considerable savings in terms of time and cost over the DDI approach of a traditional MMIS installment.

States would share the costs of operations and the costs of necessary upgrades to functionality as new initiatives, such as ICD and Correct Coding Initiative (CCI) upgrades, are introduced.

The Illinois HFS entered into an Intergovernmental Agreement (IGA) with the State of Michigan Department of Community Health (MDCH) on December 12, 2012 to determine the feasibility of the viability and practicality of a shared MMIS Enterprise between the two states. Prior to the IGA, Illinois and Michigan signed a Memorandum of Understanding on August 20, 2012, entering into formal planning discussions about MaaS under an IGA.

HFS submitted requests for enhanced FFP through Planning Advanced Planning Document Updates (PAPDUs) and As Needed Planning Advanced Planning Document Updates (AN-PAPDUs). The Illinois Core MMIS PAPD included three projects:

- Electronic Data Warehouse Implementation
- MMIS Core Planning Activities
- Provider Enrollment (PE) Implementation

### *3.2.1 Provider Enrollment System Project*

The IMPACT project is a three-phase initiative to deliver to the HFS the MDCH state-of-the-art federally certified MMIS through a cloud-enabled service. The first phase, Electronic Health Record (EHR) - electronic Medicaid Incentive Payment Program (eMIPP), was completed in November 2013. The second phase, completed in July 2015, was the implementation of the Provider Enrollment System. The third phase is the full implementation of a cloud-enabled MMIS, referred to as the Cloud Enablement Phase scheduled for full completion in 2020.

The Provider Enrollment System was initially implemented as a stand-alone system and is integrated with existing HFS legacy MMIS. The implementation is the first step toward the full cloud enabled MMIS for the State of Illinois. This project continues the work initiated during third quarter 2013.

There were three major advantages to the early implementation of provider enrollment functionality. The first is that it allows State of Illinois users and providers the opportunity to become familiar with the operation of the new MMIS and its modern business processes. This step supports training providers to use the system well in advance of the implementation of the full MMIS. The second is that MDCH and HFS are able to demonstrate completion of another successful milestone toward implementation of the full MMIS in the Cloud Enablement phase. The third major advantage is that Illinois will now be in compliance with ACA requirements.

Illinois and Michigan gained agreement and signed a Statement of Work (SOW) on July 30, 2014. The SOW includes agreed upon terms, approach, project management, scope, deliverables and cost.

### 3.2.2 *Enterprise Data Warehouse (EDW) Project*

Illinois will implement the Enterprise Data Warehouse (EDW) Project in parallel with the MMIS implementation activities. The EDW Project, although included in the PAPDU and approved by CMS as a pre-MMIS implementation activity, is considered a separate sub-project that includes:

- Analysis and implementation of the EDW Reports and Queries
- Design and data analysis of the Michigan MMIS / Illinois EDW environment
- Governance and security planning for the Illinois EDW
- Metadata analysis of the Michigan EDW
- Extending the Informatica and Teradata Illinois EDW platform with test environments that can support the new MMIS implementation
- Establishing the telecommunications connectivity from the Michigan Data Center to the Illinois Data Center for EDW transmissions and test data transmissions
- Implementation of the EDW Data Analytics Platform
- Fraud and abuse detection analytics

The Department of Health & Human Services, Office of Inspector General (OIG) has developed a series of fraud and abuse detection analytics based on fee-for-service / provider-based criteria. As the provider enrollment data will change substantially upon migration to the Michigan MMIS and as Integrated Care models are introduced into the EDW, these analytics will need to be reviewed and modified based on changes to the EDW to accommodate the new MMIS data structures.

An initial set of federal reports were migrated to the EDW environment in January 2012 as part of IL-Mar Phase 1. More of the federal non-financial reports will be migrated to the EDW environment as part of IL-Mar Phase 2. This will continue the standardization of all federal reporting onto the IL-MAR/Informatica based platform within the Illinois EDW environment.

### 3.2.3 *Background and Purpose*

The State of Illinois has embarked on a project to replace its existing MMIS. The current legacy MMIS system is maintained and operated by the State. It was fully implemented in 1982 and was built to support a fee-for-service Medicaid program. It currently serves approximately 3.15 million customers and over 62,000 providers, and it processes 88.8 million claims per year, for a total in excess of \$13.18 billion.

Technology has advanced significantly since the Illinois MMIS was implemented in the early 1980s. Development of a new system was considered costly and is not in alignment with CMS goals. The gap between the 34-year-old Illinois system and a system compliant with Medicaid Information Technology Architecture (MITA) principles and the Seven Conditions and Standards as defined by CMS has widened.

Implementation time and cost were concerns to the state, and Illinois sought a unique model of implementation for the new MMIS. The approach identified is based on the Leverage condition outlined in the Seven Conditions and Standards. As part of the project, MI will re-author the MMIS system deployed in Michigan to compartmentalize information and business rules and allow for a flexible system capable of serving several states. Michigan and Illinois will become the first tenant states for the MMIS; however, the capacity for additional states will exist. The time required to implement this MMIS in future states will be significantly shorter, and as states join this solution with new requirements, the base system will become more robust and feature-rich. This allows a shared solution. States could ultimately share MMIS resources and leverage one system, one data center, and one staffing structure.

### *3.2.4 Cloud Approach*

Computing systems are rarely utilized to their limits and generally have capacity for growth and additional resources. Cloud-based technology allows multiple consumers to share a hardware and software operating model while maintaining segregation of data and business rules. A single cloud computing infrastructure can serve many clients more efficiently. Multiple subscribers can leverage a single computing infrastructure more efficiently by requiring fewer servers, less duplicative system administration staff and consolidated networking services. Each subscriber merely pays for a share of the overall services instead of requiring a completely duplicative computing environment.

Illinois recognizes Michigan for its successful MMIS implementation. Both states have aligned to create the Illinois Michigan Program Alliance for Core Technology (IMPACT) as a shared cloud-based MMIS model serving both states with the ability to serve other states as well. This program will allow Michigan to convert its existing system to a cloud-enabled model capable of hosting other state MMIS services, with Illinois and Michigan as its initial subscribers. As shown below, this model allows states to share a common system while still maintaining different rules and policies in the administration and implementation of Medicaid programs.

IMPACT has already successfully implemented eMIPP and Provider Enrollment on the Michigan infrastructure. The final phase is the full implementation of a cloud-enabled MMIS, referred to as the Cloud Enablement Phase scheduled for completion in 2020.

Cloud implementation of an existing successful MMIS will provide a system capable of meeting the requirements of state customers with varying needs. This will result in a system that can be customized or configured more easily for future states wishing to use this shared model. Since the implementation must natively offer the capability to host two states within the same system, flexibility must be designed in as it is cloud-enabled. A more open and configurable system allows for faster and more simplified onboarding of future states. As additional states subscribe to the cloud model, shared savings through leveraging existing systems and resources will allow for reduced implementation and operating costs to states as well as CMS. Changes in policy can be programmed into a single system and potentially applied to several subscribing state workflow models with a single vendor development effort.

### Example Cloud-Enabled Model

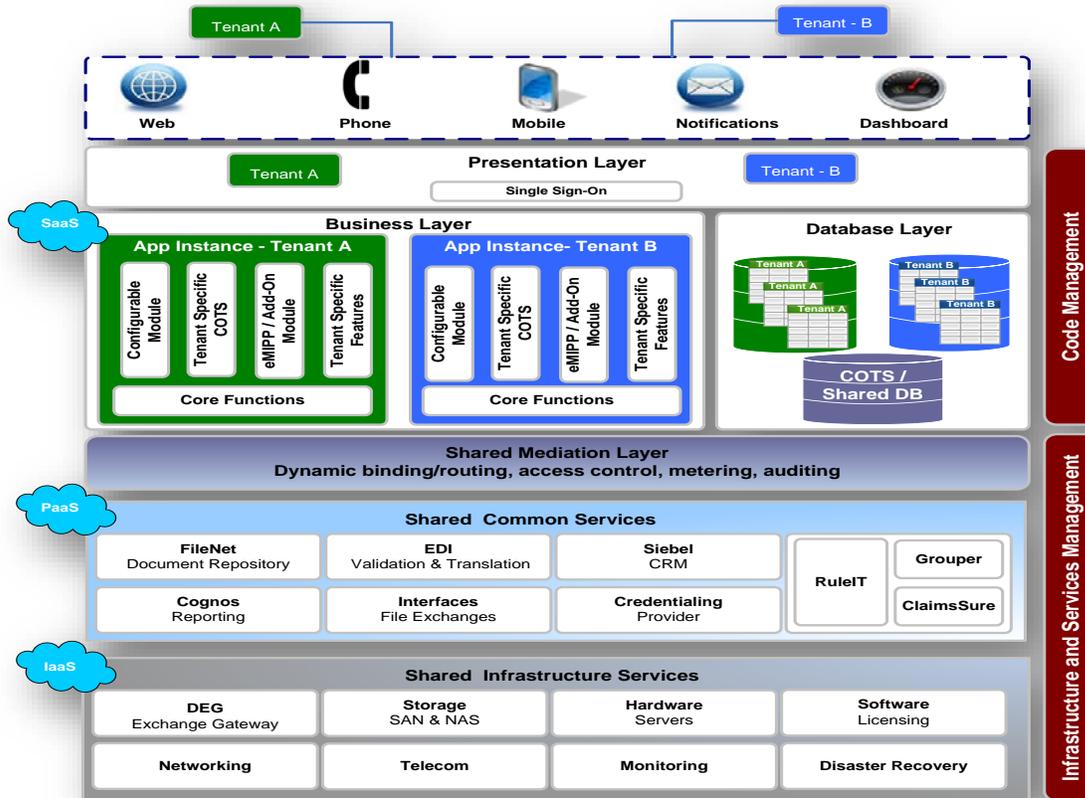


FIGURE 24

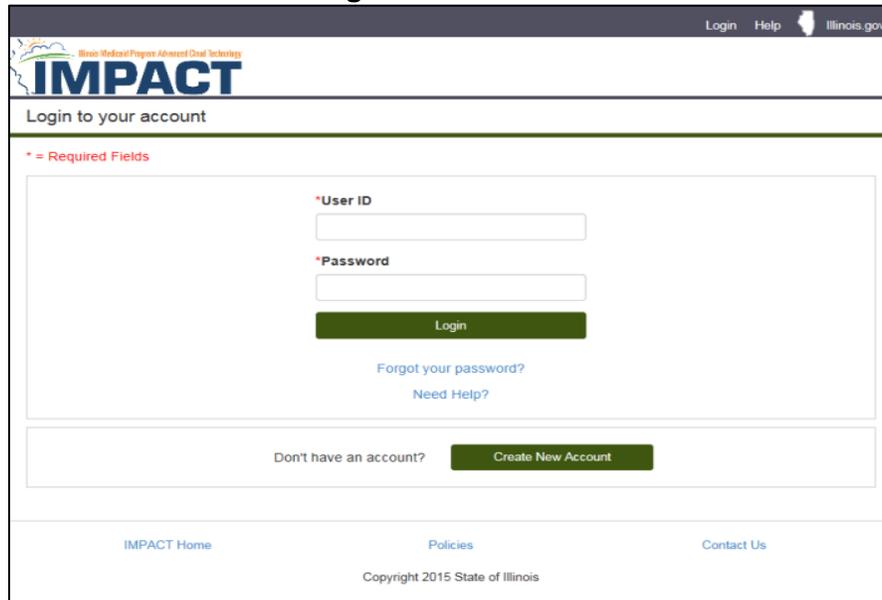
### 3.3 Provider Interfaces with SMA IT System

Illinois providers who wish to receive an Illinois Medicaid EHR incentive payment must first register with the CMS Registration and Attestation website. After registration, a CMS transaction is sent to Illinois to verify Medicaid eligibility information. If eligible, CMS makes assurance no other obstacles (paid elsewhere, sanctioned, provider deceased, etc.) exist. Illinois emails the provider to inform them of their eligibility to attest.

The Illinois Medicaid EHR Incentive Program gathers attestation information from a web-application called eMIPP (Electronic Medicaid Incentive Payment Program). Since October 2016, eMIPP has been integrated into IMPACT, the provider enrollment system. The coordinated security front end allows providers to login to IMPACT and utilize either application action (provider enrollment or eMIPP).

Users can access the IMPACT Login Screen at: <http://IMPACT.illinois.gov>, and will login with an IMPACT user id and password. New providers will click “Create New Account” and follow the instructions for Single Sign-on. Information is available on the IMPACT Presentations and Materials webpage: <https://www.illinois.gov/hfs/IMPACT/Pages/PresentationsAndMaterials.aspx> .

### Login Instructions:



The screenshot shows the IMPACT login interface. At the top, there is a navigation bar with "Login", "Help", and the "Illinois.gov" logo. Below this is the "IMPACT" logo and the text "Illinois Medicaid Program Addressed Care Technology". The main heading is "Login to your account". A red asterisk indicates required fields. The form contains two input fields: "\*User ID" and "\*Password". Below these fields is a green "Login" button. There are also links for "Forgot your password?" and "Need Help?". At the bottom of the form, there is a "Don't have an account?" link and a green "Create New Account" button. The footer includes "IMPACT Home", "Policies", "Contact Us", and "Copyright 2015 State of Illinois".

FIGURE 25

Once a user obtains is registered, the screen below appears for the user to select the IMPACT application:

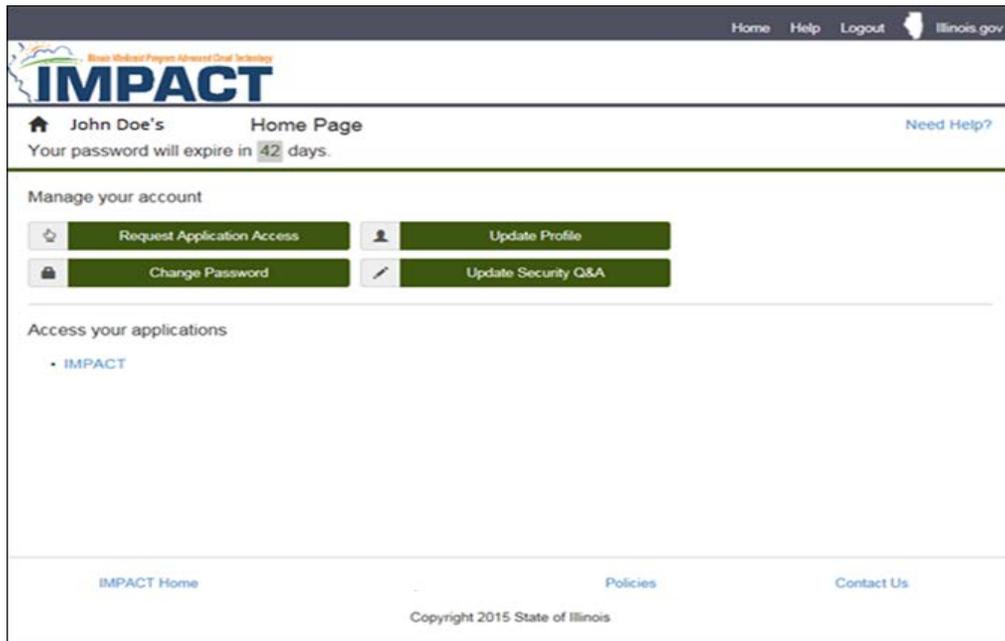


FIGURE 26

The user will then enter their user Domain (Name/NPI) and select EHR Domain Administrator.



FIGURE 27

The user will then be directed to the IMPACT My Inbox screen below:

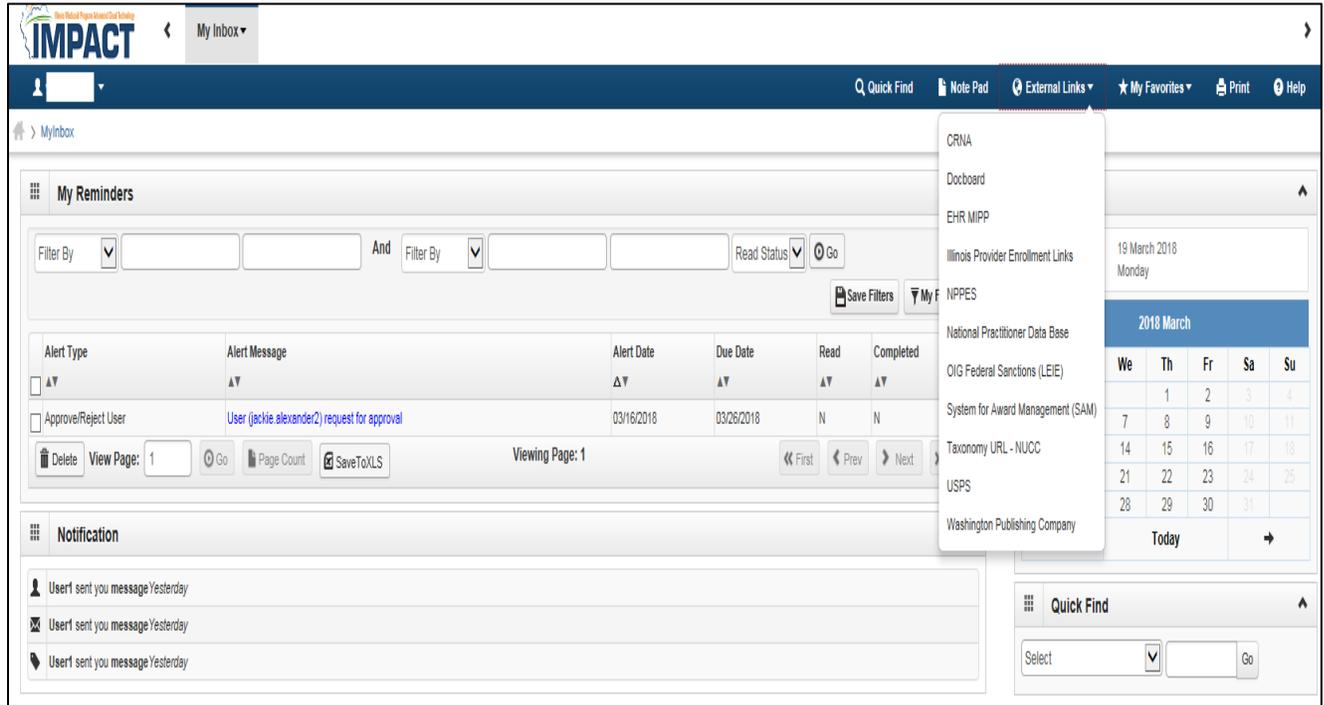


FIGURE 28

The user will click on the External Links drop down list and select EHR MIPP to start, complete or view their attestations, shown below:



FIGURE 29

### 3.3.1 Reporting MU Data

The eMIPP application allows providers to attest to either AIU or Meaningful Use (MU). Providers have three available methods of submitting MU data: manual online

attestation, uploading MU information from a completed PDF form or uploading from a QRDA III file.

**MU Upload options:**

**Meaningful Use Information**

**MU CQM Reporting Period**

Start Date: 01/01/2017  
End Date: 12/31/2017

**Meaningful Use Submission**

Submission Method:  Online  PDF  QRDA III  
Upload Template: P:\HITPO\QDRA III\2017 QDI Browse...  
Upload QRDA xml and click save.

**Meaningful Use Reporting Completion**

**Checklist**

MU Objectives Complete  
 MU Public Health Measures Complete

**Check**

When each component of meaningful use reporting is complete, the system will check the corresponding checkbox. Click on the Save button to save the data.

Buttons: Save, Cancel

FIGURE 30

Providers may also upload documents into eMIPP. Common examples are documents illustrating purchase agreements, licensure, patient volume, audit documentation and proof of registry.

**Upload documents screens:**

Registration In-Process | State Review | State Approval | Payment Process

Return to Search

Payment Year	Program Year	Payee NPI	View	Upload
2	2017	1234567890		
1	2011	1234567890		

Navigation: FEDERAL INFORMATION, ELIGIBILITY, MEANINGFUL USE, UPLOAD DOCUMENT, REVIEW, PAYMENT INFORMATION, AUDIT

FIGURE 31

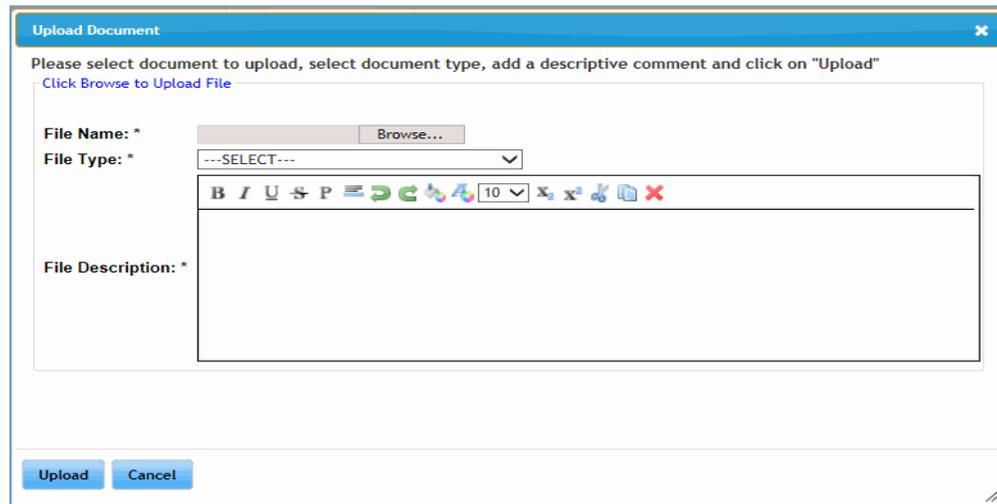


FIGURE 32

### 3.3.2 Leveraging State Level Repository Data

HFS has initiated exploring additional uses of the State Level Repository (SLR) data with DPH and REC's. Discussions focused on SLR data being combined with environmental scan information and clinical and payment data as means to influence decision-making to improve health outcomes.

### 3.3.3 Medicaid Providers Interfacing with SMA IT System

Below is a list of the providers potentially eligible to participate in the Illinois EHR Incentive Payment Program:

#### Eligible Professionals (EP):

- Physician
- Physician Assistant (PA) practicing in a FQHC or RHC if the PA is one of the following:
  - The primary provider,
  - The clinical director at a clinical site of practice, or
  - The owner of the RHC.
- Pediatrician, either Board Certified or at least 90% of recipients are under the age of 21
- Nurse Practitioner
- Certified Nurse Midwife
- Dentist
- Optometrist

#### Eligible Hospitals (EH):

- Acute care hospital
- Children's hospital
- Critical access hospital

*Note: Some provider types who are eligible for the Medicare program, such as Podiatrists and Chiropractors, are not currently eligible for the Illinois EHR Program.*

Additionally, the following providers and organizations are eligible to enroll in other Illinois Medicaid programs:

**Individual Provider Type or Specialty**

- Audiologists
- Chiropractors
- Development training providers
- Eligibility Application Agent
- Medical transportation providers
- Nurses
- Orthotists
- Podiatrists
- Physiotherapists
- Physician Assistants
- Podiatrists
- Pharmacists
- Prosthetists
- Suppliers of Medical Equipment
- Therapists

**Organizational Provider Types**

- Ambulatory Surgical treatment centers
- Birthing centers
- Children's community-based health centers
- Clinics
- Community based facilities
- Education agencies
- Home health
- Hospices
- Hospitals (Rehab, Psych)
- Imaging Services
- Laboratories
- Long Term Care facilities
- Nursing Homes
- Pharmacies
- Public Health Departments
- Rehabilitation Facilities
- Residential Extended Care facilities
- Schools

### 3.3.4 Local and State Programs Interfacing with SMA IT System

The eMIPP application used for the Illinois Medicaid EHR incentive payments program is one component of the IMPACT system. IMPACT also includes Provider Enrollment, which was consolidated in October 2016 when eMIPP began using Provider Enrollment's security functionality. In March 2017, the Pharmacy Benefits Management System (PBMS) was also added to IMPACT. Remaining MMIS functionality is expected to be incorporated into IMPACT in 2020.

## 3.4 Governance Structures

While commitment to existing IL HIE service offerings is weak; conversely, the need for strong and flexible HIE solutions is great. HFS, as the State's Medicaid agency, is spearheading an eleven (11) agency collaborative effort to transform health and human services in the State of Illinois. With the move of ILHIEA to HFS, HFS became the designated state entity for the ONC Advance Interoperable HIE grant as well as the State HIT Coordinator. As HFS submits and is responsible for the Advanced Planning Documents (APDs) related to HIT, including HIE, the transfer from the Authority to HFS gives HFS closer proximity to the HIE planning, implementation and governance in order to ensure successful outcomes. The transfer of the Authority's functions to the jurisdiction and control of HFS also increases the State's ability to align programmatic efforts, convene stakeholders, avoid inefficiencies and reduce administrative costs

when implementing HIE. Systematically, the goal is to assure information is obtained, made accessible and shared appropriately to allow for improved fiscal management, enhanced decision making, superior treatment, greater preparation and intensified prevention capability.

### **3.5 Future Adoption**

The State has contracted, via a State Grant, with two Regional Extension Centers (HITREC and CHITREC) to assist with outreach efforts. The RECs provide a yearly outreach plan (Appendix A).

Projected Medicaid provider target information is included in section 2.9 and a list of REC activities is in section 2.8.3. The State focused outreach toward encouraging all eligible providers to attest prior to the State's March 31, 2017 deadline for the 2016 program year. Providers who have not attested at least once by the State's Medicaid EHR Incentive attestation deadline will be unable to receive incentive payments. Moving forward, the State will still encourage new providers to attest for meaningful use, but will lack the financial incentive backing of previous years.

### **3.6 FQHC Resource Leveraging**

A number of Federally Qualified Health Centers (FQHCs) across the State received funding from the Health Resources and Services Administration (HRSA). The funds were part of the \$2 billion 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 new 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.

The Quality Awards (EHR Reporters, Clinical Quality Improvers and National Quality Leaders) received by Illinois providers are listed in section 2.3. Health Centers using EHRs to report clinical quality measure data for all patients receive the EHR Reporters award. The Clinical Quality Improvers award is distributed to health centers showing improvement in one or more clinical quality measures. The National Quality Leaders award goes to health centers that met or exceeded national clinical quality benchmarks, including Healthy people 2020 objectives for chronic disease management, preventive care, and perinatal/prenatal care. The awards will assist FQHC's in their attempts to meet MU.

### **3.7 Technical Assistance**

Illinois has contracted with the RECs to perform various functions, including Technical Assistance. On-site and remote direct technical assistance activities have included the following:

- EHR selection and implementation
- Meaningful use
- Small practice support for meaningful use staff turnover

- Understanding HIE options and implementation
- Public health registry options and selection
- Patient centered medical home
- Privacy and Security support and resources
- Patient portals and engagement
- Incentive program processes and attestation
- Quality improvement and use of data to measure goals
- Customized education and training specific to practice needs
- Dedicated meaningful use helpdesk
- REC support phone and email request systems

In addition to REC assistance, the State of Illinois provides additional methods of technical assistance.

- A state help desk number is available to assist with program questions regarding policy or technical topics.
- State staff email query data regarding the program.
- IMPACT staff assists with password issues.
- IMPACT staff assists with provider enrollment issues.
- A bi-weekly provider meeting allows providers to introduce technical or program issues.

To promote stage advancement, HFS works with the RECs to monitor previous attestations and assist provider progression through the Medicaid EHR Incentive Program. Illinois has also held initial discussions with CMS regarding the possibility of connecting school health professionals together with incentive program funding. Illinois is planning a State-wide ADT notification system which would be available to all providers in Illinois.

### 3.8 Populations with Unique Needs

The EHR Incentive Payment Program has addressed populations with unique needs in several ways. From 2011-2013 the only children’s CQM’s were Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (CMS 155) and Childhood Immunization Status (CMS117). In 2014, CMS added several measures with children populations:

Type	CMS #	Description
EP	75	Children who have dental decay or cavities
EP	117	Childhood Immunization Status
EP	136	Follow-up care for Children prescribed with Attention-Deficit/Hyperactivity Disorder Medication
EP	146	Appropriate Testing for Children with Pharyngitis
EP	154	Appropriate Testing for Children with Upper Respiratory infection
EP	177	Child & Adolescent Major Depressive Disorder (MDD); Suicide Risk Assessment
EH	9	Exclusive Breast Milk Feeding

EH	31	Hearing Screening Prior to Hospital Discharge
EH	185	Healthy Term Newborn (later removed in the 2017 IPPS rule)

The EHR Incentive Program and Meaningful Use is helping hospitals and health care providers increase the collection and reporting of Public Health data to Public Health Agencies. Since providers must attest to the Public Health reporting objective of the EHR Incentive program, data for childhood immunizations has increased. In attempts to meet the measures, more children are also encouraged to prevent dental decay by brushing their teeth, more children receive follow-up care for ADHD, more children are tested for Pharyngitis or Upper Respiratory infections, and more children receive care for Major Depressive Disorder (MDD).

Additional Illinois Medicaid programs concerning children include the Children’s Health Insurance Program and All Kids.

### 3.8.1 *Children’s Health Insurance Program*

Medicaid and the Children's Health Insurance Program (CHIP) provide no-cost or low-cost health coverage for eligible children in Illinois. These programs provide health coverage for children so that they can get routine check-ups, immunizations and dental care to keep them healthy.

### 3.8.2 *All Kids*

All Kids is Illinois' program for children who need comprehensive, affordable, health insurance, regardless of immigration status or health condition. With All Kids, children can get the care they need, when they need it. To date, there are over 1.6 million Illinois children enrolled in All Kids.

All Kids is complete health insurance for your child. All Kids covers doctor visits, hospital stays, prescription drugs, vision care, dental care, and eyeglasses. All Kids covers regular check-ups and immunizations (shots). All Kids also covers special services like medical equipment, speech therapy, and physical therapy for children who need them.

Children can get All Kids health insurance if:

1. They live in Illinois
2. They are age 18 or younger.
3. They meet the insurance requirement for All Kids.
4. Their family’s income meets the All Kids income limit.

### 3.8.3 *Illinois Children’s Medicaid Waiver Programs*

Illinois has several home and community-based services (HCBS) waivers currently open to children.

- **Support waiver for children and young adults with developmental disabilities**  
*Provides information and assistance in support of participant direction, adaptive equipment, assistive technology, behavior intervention and treatment, home accessibility modifications, personal support, temporary assistance, training and counseling services for unpaid caregivers, and vehicle modifications for individuals with autism, IID, DD ages 3-21.*
- **Residential Waiver for children and young adults with developmental disabilities**  
*Provides child group home, adaptive equipment, assistive technology, behavior intervention and treatment for individuals with autism, DD, IID ages 3-21.*
- **HCBS Waiver for children who are medically fragile, technology dependent**  
*Provides respite, environmental accessibility adaptations, family training, medically supervised day care, nurse training, placement maintenance counseling, specialized medical equipment and supplies for individuals who are medically fragile and technology dependent ages 0 - 20.*
- **HCBS Waiver for Persons with brain injury**  
*Provides adult day care, day habilitation, homemaker, personal assistant, prevocational, respite, supported employment, home health aide, intermittent nursing, OT, PT, speech therapist, cognitive behavioral therapies, environmental accessibility adaptations, home delivered meals, in-home shift nursing, PERS, and specialized medical equipment for individuals with brain injury, all ages.*
- **HCBS Waiver for persons with HIV or AIDS**  
*Provides adult day care, homemaker, personal assistant, respite, home health aide, intermittent nursing, OT, PT, speech therapy, environmental accessibility adaptations, home delivered meals, in-home shift nursing, PERS, and specialized medical equipment for individuals with HIV/AIDS of all ages.*
- **Persons with disabilities waiver**  
*Provides adult day care, homemaker, individual provider (personal assistant - non-agency), respite, home health aide, occupational therapy, physical therapy, speech therapy, environmental accessibility adaptations, home delivered meals, in-home shift nursing, intermittent nursing, personal emergency response system, and specialized medical equipment for physically disabled individuals, ages 0 – 59.*

#### 3.8.4 Maternal and Child Health Promotion

The Department of Healthcare and Family Services (Department, HFS or Agency) is committed to improving the health of women and children. HFS serves as an advocate in promoting wellness through a continuum of comprehensive health care programs that address such issues as social emotional development, immunizations, lead screening and family case management. Improving the health status of mothers and children can be achieved through education, prevention, and partnerships with other programs. The managed care organization (MCO) must follow specific contractual guidelines for maternal and child health promotion such as family planning and reproductive health, including ensuring that national recognized standards of care

and guidelines for sexual and reproductive health are followed. More information on the programs offered by HFS and HFS requirements for MCOs can be found at: <https://www.illinois.gov/hfs/MedicalClients/MaternalandChildHealth/Pages/default.aspx> and <https://www.illinois.gov/hfs/MedicalProviders/cc/Pages/default.aspx>.

### *3.8.5 Mobile Crisis Response Services*

The Children's Mental Health Act of 2003 ([Public Act 93-0495](#)) required the Department to develop protocols for screening and assessing children and youth prior to any admission to an inpatient hospital that is to be funded by the Medicaid program. In response to this requirement, HFS, in collaboration with the Departments of Children and Family Services (DCFS) and Human Services (DHS), developed the Screening, Assessment and Support Services (SASS) program. Since July 1, 2004, the SASS program has operated as a single, statewide system serving children and youth who are experiencing a mental health crisis and whose care requires public funding from HFS, DCFS, or DHS. SASS operates 24 hours a day, 7 days a week for children and youth in fee-for-service (FFS) delivery system providing crisis intervention services; facilitating inpatient psychiatric hospitalization, when clinically appropriate; and providing case management and treatment services following a crisis event. SASS features a centralized point of intake known as the Crisis and Referral Entry System (CARES) Line. The CARES Line receives referrals for children and youth in crisis, determines whether the level of acuity meets the threshold of crisis, and refers the call to the most appropriate community resource, which may include the dispatch of a SASS crisis responder. In Fiscal Year (FY) 2017, the CARES Line received 128,000 calls, of which 122,000 were due to a crisis.

### *3.8.6 Psychiatric Consultation Phone Line – Illinois DocAssist*

The Illinois DocAssist Program (DocAssist) is a Statewide psychiatric consultation and training service for primary care providers (PCP) or practitioners serving Medicaid enrolled children and youth under age 21 in the fee-for-service and managed care delivery system. DocAssist is staffed by child and adolescent psychiatrists and allied medical professionals from the University of Illinois at Chicago, College of Pharmacy and College of Medicine - Department of Psychiatry. DocAssist provides consultation services to assist front-line primary care practitioners meet the need for early intervention for children for children and youth. In addition to providing direct phone consultation, DocAssist supports HFS providers by offering targeted training and educational seminars on common child and adolescent behavioral health issues and makes resources available through its website: [Illinois DocAssist](#).

### *3.8.7 Dental Services*

The FFS HFS Dental program is administered by DentaQuest of Illinois, LLC (DentaQuest). HFS, through DentaQuest, offers a comprehensive package of services to children, including preventative, diagnostic, and restorative services. The adult dental coverage has a more limited dental services scope offering X-rays, restorative and complete dentures. DentaQuest is responsible for dental claims adjudication and payment, prior approval of services, ongoing reporting to the Department, quality assurance monitoring, and developing and maintaining the Dental Office Reference Manual. In addition, DentaQuest provides services aimed at ensuring

participant access to care for medically necessary dental services such as provider recruitment and training, enrollee education and referral coordination, an interactive website, and toll-free telephone systems.

### *3.8.8 Bright Smiles from Birth Program*

HFS, in cooperation with the Illinois Chapter of the American Academy of Pediatrics (ICAAP), has developed a Statewide Bright Smiles from Birth Program that uses a web-based training to educate physicians, nurse practitioners, and federally qualified health centers on how to perform oral health screenings, assessments, and fluoride and varnish applications in both the FFS and managed care delivery system. The program also gives guidance and makes referrals to dentists for necessary follow-up care and establishment of ongoing dental services. The initiative has proven successful in improving access to dental care and studies confirm that fluoride varnish applications are effective at reducing early childhood caries in young children. See <http://illinoisAAP.org/projects/bright-smiles/> for more information.

## **3.9 Leveraging of Grant Awards for EHR Incentive Program**

Grant awards have allowed for an expanded collection of information whether it is the RECs or with IDPH. Also, HFS was recently awarded a grant through the NGA with the immediate goal is to implement a state-wide Admission, Discharge and Transfer (ADT) alerting notification system to advance our care coordination objectives. The longer-term goal is to build off the foundation of ADT alerting notification to more advanced provider to provider data exchanges including labs, prescription and imaging files. Finally, HFS is in the early stages of discussions and research with schools and Local Education Agencies (LEA) to examine interest and capability to incorporate EHR systems as a grant opportunity.

## **3.10 New Legislation Requirements**

No new legislation is proposed or is required for the EHR Incentive Program.

## **3.11 Other Issues**

The management of care will incorporate the processing, evaluation and review of health information to assure quality, efficient and effective treatment. As HFS ventures into expanded MCO enrollments, or revisions in the delivery of treatment policies for behavior health or as with the opportunity for EHR coordination with local education agencies, health data and information and how it is utilized will play a major role in determining program success.

## 4 ADMINISTRATION AND OVERSIGHT

### 4.1 SANCTIONS & LICENSING VERIFICATION

Once a provider has enrolled at the CMS R&A web site the registration will be sent to the state by the next business day. Federal sanction verifications will be completed on a registration before being sent to the State.

eMIPP will perform daily automated validation checks (provider type, sanctions, death match, provider/payee relationship, Medicaid enrollment) and notify the provider via email to complete their attestation. When a complete attestation is submitted, HFS will perform all manual reasonableness checks within thirty days of submittal and make a decision regarding program eligibility.

For eligible providers, eMIPP will transmit an "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.

Illinois conducts license verifications during the provider enrollment review process. In addition to these verifications, eMIPP adjudicators verify pediatrician licensing, when appropriate, for pediatricians qualifying with a patient volume percentage below 30%, but greater than or equal to 20%. Pediatricians may also qualify if the Medicaid enrolled provider serves a patient base that consists of 90 percent or greater of patients under the age of 21 (age of the patient at the time the service is rendered).

### 4.2 HOSPITAL-BASED DETERMINATION

During Illinois' 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 help message (see Figure 34 below) states, "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 EHR MIPP. 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."

FIGURE 33

### 4.3 Provider Attestation Overall Content Verification

Provider attestation content verification is adjudicated by Medical Programs Provider Enrollment staff. Adjudicators adhere to a checklist developed for their process (see below). Providers with incorrect or missing information are rejected with adjudicator’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 – see figure 35 below)
- Verify completion of MU Objectives Compliance, MU Public Health Measures Compliance and Clinical Quality Measures Compliance (compliance recognized by a green checkmark, a red checkmark designates non-compliance)

### Meaningful Use Reviewer Summary Screen

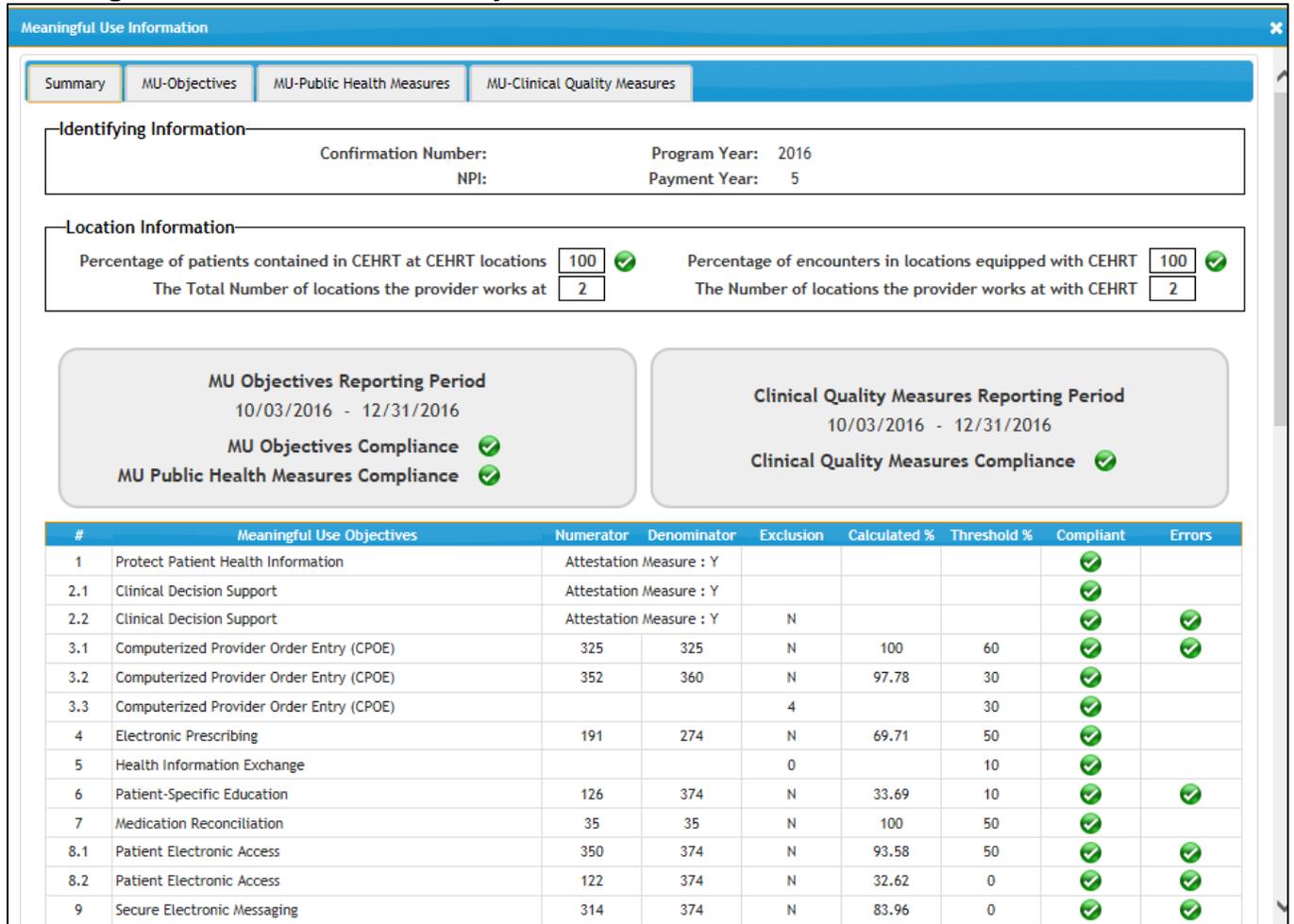


FIGURE 34

Upload documents tab:

- AIU attestations must upload invoice, contract or receipt for purchasing EHR program and certification letter.
- MU attestations must upload a MU Attestations Summary.
- FQHCs must upload Table 4: Selected Patient Characteristics of the UDS for the date range used for patient volume.
- Providers may upload any other documents they feel necessary for their EHR attestation.

Review tab:

- Verify that patient volume is at least 20-29% for pediatricians or 30% for all other providers.
- Click on Claims Activity Data link.
  - Notate billing TIN

- Verify Title 19 & 21 totals for that TIN are within the 15% Medicaid encounters threshold. If not, follow instructions below.

Verifying encounter data:

- Run query on TIN for selected 90-day range.
  - Compare individual or group totals as necessary
  - Reject if not within 15% of each other
- If HFS' number is lower than the provider's number, they might have Medicaid Managed Care in their counts. Ask the provider for a breakdown to show how many encounters are traditional Medicaid and how many are Medicaid Managed Care. Compare their traditional Medicaid total to our Medicaid total to see if they are now within 15% of each other. If so, they may re-submit their attestation as is.
- If the provider number is lower than HFS' 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.

## 4.4 Provider communications

### 4.4.1 *EHR Incentive Program Workgroup*

A bi-weekly phone conference is held with providers to discuss the EHR Incentive Program. Data regarding attestation counts, payment information is announced. Current issues, legislation, CMS announcements and deadlines are also discussed. Providers may bring up questions or concerns regarding any EHR Incentive Program topic.

### 4.4.2 *Provider Notices*

Illinois HFS posts provider notices and bulletins containing pertinent information for participating providers for medical services provided or for claims submitted for reimbursement. These provider notices are posted on the HFS website available via this link.

### 4.4.3 *Regional Extension Center Outreach*

Illinois has contracted with two Regional Extension Centers (RECs), CHITREC and IL HITREC. The RECs assist the state with program outreach, webinars, seminars and conference calls regarding EHR Program topics. The RECs also send out EHR incentive emails, notifying providers of program news, program deadlines, etc. A help desk is also operated by the RECs with state funding.

### 4.4.4 *Automated Emails to Providers*

The providers may receive an automated email from the eMIPP system at several points in the attestation process.

#### 4.4.5 *Attestation Complete Email*

When the attestation is complete, a notice that the attestation has been received informs the registration contact(s) of the following:

- HFS has received the completed attestation
- The attestation is now being reviewed by the adjudication staff
- The review can take up to 30 days
- The provider will be notified by email when an eligibility determination has been made
- Adjudication staff contact information (phone number, email)

The provider is also requested to review their registration information (registration number, NPI, attestation id, contact email) for any errors.

#### 4.4.6 *Attestation Approved Email*

When the attestation is approved by adjudication staff, an email will inform the registration contact(s) of the following:

- The attestation has been approved (detailing the registration number, NPI, attestation id, contact email)
- The incentive payment will be issued within 45 days of receipt of the approval email
- Adjudication staff contact information (phone number, email)

The provider is also requested to share the email information with the appropriate individuals in their organization.

#### 4.4.7 *Attestation Denial Email*

If the attestation is denied, an email will inform the registration contact(s) of the following:

- The attestation has been denied (detailing the registration number, NPI, attestation id, contact email)
- The reason code, reason description and denial comments
- How to appeal
- Address where appeal will be filed
- Adjudication staff contact information (phone number, email)

#### 4.4.8 *In-Progress CMS Registration Email*

During the daily processing of the B6 file from CMS, any registration in IN\_PROGRESS status generates an automated email to the provider:

- The provider is informed that they should complete their registration at the federal CMS website.
- Once the provider's modification has been received by the state, an email will notify them that they may return to eMIPP to complete their Medicaid EHR incentive payment attestation.

- The file is processed daily and is fully automated.

#### 4.4.9 *Payment Issued Notification Email*

When the incentive payment has been issued:

- An email notifies the provider that payment has been issued. The email contains the registration number, NPI, attestation ID and contact email.
- The email notifies the provider of the disbursed amount and warrant number issued by the Illinois Office of the Comptroller.
- Adjudication staff contact information (phone number, email) is included in the email.

#### 4.4.10 *Rejection Email*

When adjudication staff reject the attestation:

- An email notifies the provider that the attestation has been rejected. The email includes the registration number, NPI, attestation ID and contact email.
- The email includes the reason for rejection.
- The email includes the instructions for resolution.
- Adjudication staff contact information (phone number, email) is included in the email.

#### 4.4.11 *Welcome Email*

When a registration is received in a B6 Add transaction:

- A “welcome” email is sent confirming that the state has received the registration.
- The email asks the provider to review and store the registration number.
- The email lists examples of information the provider should store in case of an audit.

#### 4.4.12 *Update to CMS Registration Email*

When a provider modifies their registration information on the CMS EHR Registration website:

- An email notifies the provider that HFS has been notified of a modification to the provider’s EHR Incentive Program registration.
- Adjudication staff contact information (phone number, email) is included in the email.

## 4.5 **Establishing Patient Volume**

An Illinois Medicaid provider must meet patient volume requirements annually. The patient funding source identifies who can be counted in the patient volume: Title XIX (TXIX) – Medicaid and Title XXI (TXXI) – CHIP (Children’s Health Insurance Program). There are several items to be considered when calculating Medicaid patient volume, including:

- Methodology for determining patient volume
- Individual volume vs. group proxy
- Out-of-state encounters

#### 4.5.1 *Methodology for Determining Eligible Professional Patient Volume*

All EPs (except EPs predominantly practicing in an FQHC/RHC) will calculate patient volume based on encounters with Medicaid (billed to HFS) and out-of-state Medicaid patients. The EHR statute allows for an EP practicing predominantly in a FQHC or RHC to consider CHIP patients under the needy individual patient volume requirements.

##### 4.5.1.1 Definition of an Eligible Professional 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 billable service was provided.

It also includes Managed Care Organization encounters and Dual Eligible (Medicare/Medicaid) encounters.

##### 4.5.1.2 Definition of an Eligible Professional 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 HFS;
- 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.

##### 4.5.1.3 Calculating Eligible Professional Patient Volume

To calculate patient volume, providers must include a ratio where the numerator is the total number of Medicaid (billed to HFS) 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 encounters billed to HFS during the 90-day period; the denominator must consist of all encounters billed to any entity during the 90-day period.

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

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



Total Medicaid Recipient Encounters billed to HFS in  
any 90-day period in the preceding calendar year or  
twelve months prior to the attestation date

\*100 = %Medicaid patient  
volume

-----  
Total Patient Encounters in that same 90-day period

To calculate needy individual patient volume, EPs practicing predominantly in a FQHC/RHC must divide:

- The total needy individual patient encounters in any representative, continuous 90-day period in the preceding calendar year or twelve months prior to the attestation date; by
- The total patient encounters in the same 90-day period.

#### 4.5.1.4 Individual vs. Group Patient Volume

Medicaid patient volume thresholds may be met at the individual level (by provider NPI) or at the group practice level (by organizational NPI/TIN). EPs may attest to patient volume under the individual calculation or the group/clinic calculation in any participation year.

##### 4.5.1.4.1 EPs Using Individual Patient Volume

For EPs calculating individual patient volume, the numerator must consist of all encounters billed to HFS. The following is an example of how the EP will calculate the Medicaid patient volume:

- Example: Dr. Smith reviews the encounters in his practice management system and determines that, for a 90-day period from October 1, 2012 – December 29, 2012, he has 500 paid claims/accepted encounter data for HFS recipients and his total volume of encounters for this period is 1,000.

500 encounters billed to HFS	*100= 50% Medicaid Patient Volume
----- 1,000 total encounters	

##### 4.5.1.4.2 EPs Using Group Patient Volume Method

EPs may use a clinic or group practice's patient volume as a proxy for their own under these conditions:

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation).
- There is an auditable data source to support the clinic's patient volume determination.

- All the EPs in the group practice use the same methodology for the payment year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data).
- The clinic or practice must use the entire group's patient volume and not limit it in any way.
- If the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice and not the EP's outside encounters.

The following is an example of how an EP would use the group patient volume method:

- Example #1: Dr. Sue, a physician practicing in pediatrics, works for ZZ Clinic, YY Clinic and individually. She alone has 19% patient volume therefore does not qualify for the program.

Professional	Provider Type	Medicaid Encounters	All Encounters	Patient Volume %
Ms. Leigh	Dietician	50	100	50
Dr. Tom	Physician	34	100	34
Dr. Sue	Pediatrician	19	100	19
Dr. Bob	Pediatrician	20	100	20
Total		123	400	31

The pediatricians are part of a group and if you aggregate all the Medicaid encounters and divide by the number of All Encounters you arrive at the group volume of  $123/400 = 31\%$  Medicaid Patient Volume. The group was able to maximize their benefits. Each provider would attest to 123 Medicaid encounters and 400 for all encounters allowing all providers in the group to attest to 30% Medicaid volume. Note, it is appropriate when using group encounter methodology to include all licensed professionals regardless of eligibility for the program. Dieticians are excluded from participation; however, their encounters can be used in calculating group volume.

The practice was able to maximize their benefit by:

- Use of all provider encounters.
- Although not program eligible, Ms. Leigh's encounters are able to be used in the group methodology.
- Dr. Tom could have attested as an individual and received the same year 1 incentive of \$21,250 because he has more than 30% Medicaid Patient Volume.
- Dr. Sue would have not been eligible individually, but can attest and receive the full incentive of \$21,250 in her first year of participation based on the group methodology.

- e. Dr. Bob could have attested individually and received \$14,167 as a Pediatrician in the first year of the program but by utilizing the group methodology, he is eligible to receive \$21,250.
- Example #2: Dr. Pete is part of a large group practice with multiple locations consisting of providers that serve some Medicaid and providers that are enrolled but see no Medicaid patients. If the practice calculates the patient volume individually they have wildly varying results from 100% to 10% and would only be eligible for 70% of the clinics professionals. The practice includes professionals that are eligible for the program and some that are not. If the practice calculates the combined total of the group's patient volume based on Payee Tax ID and reaches 30% or more Medicaid utilization, then it is acceptable to use the entire practices patient volume when attesting. This is the easiest method for HFS to validate.

#### *4.5.1.4.3 Groups – Additional Considerations*

When state adjudicators review the first group provider for eligible encounters and find that the eligible encounter data does not meet the required threshold:

- All providers in the group are rejected or denied
- Each provider receives an email notifying them of the state action
- If “Registration Rejected” or “Registration Denied”:
  - The eligible encounter data becomes editable for all providers of the group, including start date and encounters, both total and eligible.
  - The first provider of the group to edit and save the data to correct it forces all other providers' eligible encounter data to be read-only.

When a group provider is approved, then no provider within that group can be denied or rejected for patient volume eligibility.

When patient volume reporting period “Start Date” is updated by the first provider, all existing providers receive an email asking them to revalidate their membership in the group during the new reporting period.

When “Medicaid Encounters” or “All Encounters” is updated, the System will send an email to all providers of the group asking them to revalidate the update.

If the first provider updates the “Include Organizational Encounters” button = YES changes to NO, then the group ceases to exist and the System:

- Dis-enrolls all providers of the group for group eligibility
- Removes all group eCQM data that exists for each dis-enrolled provider
- Sends an email to each ex-provider that notifies them of the following:
  - The group no longer exists.
  - All eligibility information for the group has been removed.
  - All eCQM information for the group has been removed.
  - The group may be recreated by another provider.
  - Each provider will have to rejoin the recreated group.

- All group eCQM data will have to be resubmitted if the group is recreated.
- Each provider should validate whether the MU reporting period, if created, still applies and the MU reporting period start date is now editable.

If the group is a FQHC, then the provider who first saves the group must select “Render Care in FQHC/RHC”=YES.

- FQHC will default to FQHC=YES for all group providers and no longer be modifiable.
- If the first (FQHC) provider later changes FQHC=NO, then the system will identify all Physician Assistants (“Practice as a Physician Assistant”=YES) and do the following:
  - Remove the group eligibility information.
  - Make the MU reporting period dates editable for this provider.
  - Send an email to the Physician Assistants that they can no longer participate as a group provider for purposes of eligibility or eCQM reporting. The PA may still attest as an individual provider in an FQHC setting but not for this group.

If a provider loses group affiliation because of a change in eligible encounter reporting period, or chooses to drop from the group, then the system will:

- Remove any group eCQM data that has been submitted for that provider.
- Make the MU reporting period dates editable for this provider.
- Wipe the group affiliated eligible encounters. The provider may use the same eligible encounter reporting period or another but must use a single practitioner’s practice encounters.

If a member of a group is rejected for MU Core or Menu objective compliance, then only that member of the group is rejected and must re-attest.

#### **4.5.1.4.4 No-Cost Encounters**

Providers have the option to include zero-pay claims in their patient volume calculation. If the provider chooses to include zero-pay claims in the calculation, they should be included in the total Medicaid encounters number and must also be separately identified during attestation.

#### *4.5.1.4.5 Out-of-State Encounters*

If Medicaid patients from bordering states are served or if a practice location is in a border state, the Medicaid patient volume from the state or location(s) can be utilized only if that additional encounter volume is needed to meet the Medicaid patient volume threshold. If an EP aggregates Medicaid patient volume across states, HFS may audit any out-of-state encounter data before making the incentive payment. The EP must maintain auditable records for the duration of the HFS Medicaid EHR Incentive Payment program.

#### 4.5.2 Methodology for Determining Eligible Hospital Patient Volume

To calculate Medicaid patient volume, an EH must divide:

- (2011-2014) The total HFS Medicaid encounters and out-of-state Medicaid encounters in any representative 90-day period in the preceding fiscal year or twelve (12) months preceding attestation by:
- (2015\* – on) The total HFS Medicaid encounters and out-of-state Medicaid encounters in any representative 90-day period in the preceding calendar year or twelve (12) months preceding attestation by:
- The total encounters for all payers in the same 90-day period.
  - Total number of inpatient discharges in the representative 90-day period plus total number of emergency department visits in the same 90-day period.
  - Note that the emergency department must be part of the hospital.

*\*In 2015 only, the “preceding calendar year” may be considered the 15-month period from October 2014 - December 2015*

##### 4.5.2.1 Definition of an Eligible Hospital Medicaid Encounter

To calculate eligible hospital patient volume, a Medicaid encounter is defined as an inpatient discharge or an emergency room visit 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 billable service was provided.

Exception – a children’s hospital is not required to meet Medicaid patient volume requirements.

## 4.6 Data Sources for Patient Volume Verification

Illinois runs SQL queries in the MMIS data warehouse to verify patient volume. Medicaid encounters are compared to the Medicaid encounters attested to by the provider. The state will also work with the provider to ensure the provider has drawn data from an appropriate group NPI or TIN.

## 4.7 FQHC/RHC Practice Predominantly Verification

The Illinois Medicaid EHR Incentive 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 is at a FHQC/RHC. The EP must also have a minimum 30 percent patient volume attributable to serving needy individuals.

To verify encounter totals, EPs at FQHCs are required to upload 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 adjudicator 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.

#### **4.8 AIU Verification**

Providers attesting to adoption, implementation or upgrade (AIU) of certified EHR technology in their first year will have to submit documentation to demonstrate their AIU. Documentation can be imported into eMIPP via an upload documents tab. Examples of acceptable documentation include the following:

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

#### **4.9 MU Verification**

The State will verify Meaningful Use through a number of automated system validations, as well as by pre-payment and post-payment audits. The auditing procedures are not public, but are submitted in a separate attachment to this document.

#### **4.10 State Specific Changes to MU**

Illinois requested an extension of the 2017 program year EP attestation deadline. The standard deadline of one month following the Medicare deadline (March 31<sup>st</sup>) is normally used for Illinois' attestation deadline. In discussions with provider groups in the bi-weekly EHR Incentive Workgroup meetings, discussions with Regional Extension Center staff assisting the State with outreach, and internal discussions with State key staff and management, Illinois may determine to request an extension to the deadline.

In requesting the extension of the 2017 program year tail period, the following reasons were cited:

- The Medicare EH deadline was extended to March 16th, resulting in some providers focusing their efforts elsewhere.
- Technical issues occurring during the system migration to a cloud environment delayed the providers ability to attest in early January 2018.
- Federal documentation modifications with four CQMs (137,74,153,155) prevented the State from implementing these CQMs correctly in our attestation application.

The request for an extension of the 2017 attestation deadline was approved by CMS on March 26, 2018.

Other than requesting the Medicaid EP attestation deadline extension, Illinois has not proposed any changes to the definition of Meaningful Use as it has been defined in federal legislation.

## 4.11 Certified EHR Technology Verification

The adjudication process for first-year registrations requires the provider to upload one of the following items as proof that they have purchased an EHR system:

- Contract
- Software license
- Receipt or proof of acquisition
- Purchase order

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 will automatically verify the program year of the certification as appropriate for the attestation. Post-payment audits include verification of the provider's Certified Electronic Health Record Technology.

## 4.12 Collection of MU Data

Illinois providers may submit their meaningful use data via eMIPP in three ways: manually attest 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 and is stored in eMIPP.

As QRDA becomes more familiar to Illinois providers, it is expected that this method will become the most prevalent method of providing meaningful use data.

## 4.13 Data Collection and Analysis Alignment

Illinois is following recommendations by CMS and the ONC for collecting MU data, including CQMs from Medicaid providers participating in the EHR Incentive Program.

The Stage 3 and Modifications to MU 2015-2017 final rule references reporting alignment several times. A mention of intent to implement changes with the quality reporting programs through the annual Medicare payment rules, such as the Physician Fee Schedule (PFS) and the Inpatient Prospective Payment Systems (IPPS) rules, appears on page 62767 of the rule. The IPPS final rule requires hospitals to report 4 of the 28 hospital IQR program electronic clinical quality measures (eCQMs) that align with the Medicare EHR Incentive Program. The Stage 3 rule later encourages CQM data submission through electronic submission for Medicare participants in 2017 and requires this electronic submission in 2018 for demonstrating MU.

A few pages later (p 62722), the rule declares an attempt to "streamline the criteria for meaningful use. We intended to do this by...Aligning with other CMS quality reporting programs using CEHRT, such as PQRS and Hospital IQR for clinical quality measurement." On page 62790, the rule states that CMS' proposed set of priorities are "efforts to align the EHR Incentive Program with the National Quality Strategy and with

CMS quality measurement and quality improvement programs like PQRS, CPCI, Pioneer ACOs and Hospital IQR and HVBP programs”.

Additional excerpts describe CMS’ attempts to require full year EHR reporting, largely to assist in alignment with other CMS reporting programs.

Illinois has implemented an application (eMIPP) capable of accepting QRDA files from the provider’s EHR system. By providing this capability and by complying with these final rules, Illinois continues to pursue improved methods of aligning clinical quality measures of other programs with the CQMs of the Medicare and Medicaid EHR Incentive Programs.

## **4.14 MU Stage Change Process**

### *4.14.1 IT Change Process*

Illinois has contracted with the Michigan Department of Health and Human Services for joint application development of the eMIPP web application. As part of this service, Project Management Body of Knowledge (PMBOK) management strategies have been enacted to handle project task execution. For the purposes of project coordination between the two States and the vendor, the processes listed in table (Figure 35) below have been implemented.

**IT Processes**

Process	Description
Initiating	This process group defines the project objectives and grants authority to proceed. For the Michigan team, the initiating processes are largely incorporated into the proposal development process, during which required partners are identified. This SOW acts as a project charter and preliminary scope statement.
Planning	This process group refines the project objectives and scope; and plans the tasks, activities, and steps necessary to meet the project's objectives. The planning processes start during proposal development and is completed following contract award/amendment.
Executing	This process group puts the project's plans into motion. This is where the bulk of the work for the project is performed.
Monitoring and Controlling	This process group measures the performance of the project's executing activities and reports these performance results to project managers and stakeholders. Output is used to refine, improve, or change project management (including plans and schedules) as necessary to meet the project's objectives.
Closing	This process group documents the formal acceptance and approval of the project's product and brings all aspects of the project to a close.

FIGURE 35

A seven-phased process was implemented to organize activities and tasks associated with identifying requirements, designing, developing and testing software. These phases contain major work packages that must be accomplished to move systematically through the project life cycle. These phases roll up into three logical phases. The three-phase roll-up provides an easily understandable, top-down structure that facilitates grouping of activities with similar resource requirements and closely related deliverables. Figure 36 below shows the relationship between the three-phase roll-up and the seven phases of the delivery framework.

**Project Framework Phase Relationships**

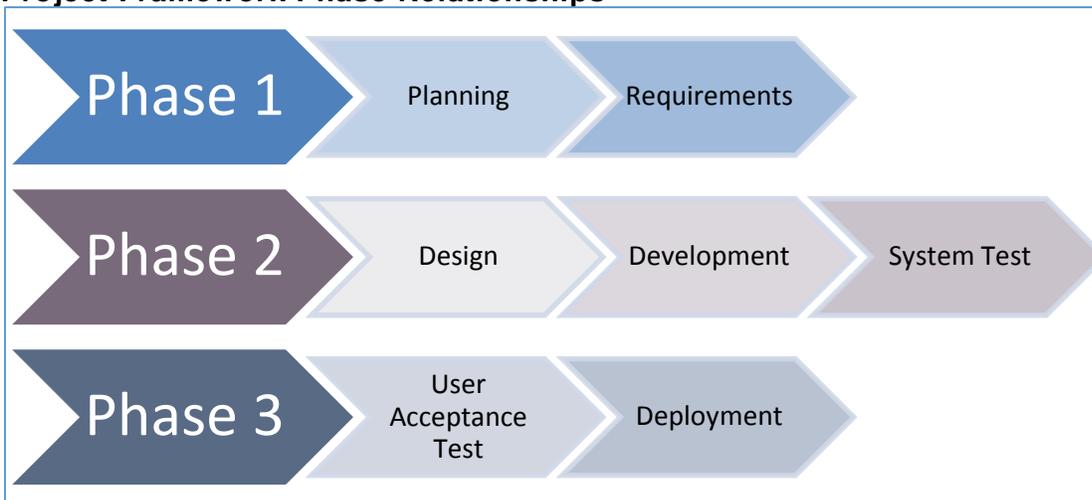


FIGURE 36

Generally, 4 to 5 major eMIPP application deployments are scheduled each calendar year with the capability to conduct additional deployments if necessary. For the major releases, planning and requirements phase (phase 1) may last up to 4 weeks, the design phase (phase 2) may last another 4 to 7 weeks and the user acceptance testing (phase 3) requires an additional 3 to 4 weeks.

#### *4.14.2 Fiscal Change Process*

Changes in legislation, staffing, outreach, training, or system support also require fiscal modifications for the program. The State drafts an Implementation Advanced Planning Document (IAPD) which details the monetary requests for federal funding. Funding is broken down by administrative costs, contractual costs and projected payments. Completed templates detail the fiscal obligation breakdown by federal responsibility (90%), state responsibility (10%) and total (federal and state combined). At the State level, all budget changes are reviewed and approved by state budget staff, and federal finance staff. Once all state approvals have been acquired, a draft IAPD is sent to federal CMS for approval. The state works with federal staff to complete any additional requirements. All significant changes in finance require the completion and federal approval of an IAPD prior to implementation.

#### *4.14.3 Communication Change Process*

Providers may receive notifications regarding program changes in several different ways. Significant changes in policy will be posted as a “provider notice” on HFS’ provider notice site. State staff will also notify registered/attesting providers of program news via an email blast. The State’s REC’s routinely distribute information regarding program updates and/or changes to providers.

State EHR program staff established a Medicaid EHR Incentive workgroup meeting bi-weekly, in which any provider may participate via phone conference to ask questions. The State uses this meeting to disseminate program information (payment and enrollment statistics, program news, deadlines, CMS announcements, etc.) and to solicit information from providers.

The State also has multiple options to allow providers to obtain assistance. They may call the program help desk, which is coordinated at the first-level by our REC’s (see section 4.21) or providers may send an email to [HFS.EHRIncentive@Illinois.gov](mailto:HFS.EHRIncentive@Illinois.gov), an account monitored by State staff. Additional support is available to assist with IMPACT/eMIPP authentication or authorization issues.

### **4.15 IT System Changes Required by the EHR Incentive Program**

Illinois’ current agreement with Michigan was completed in 2013. Since adopting the eMIPP application and associated hardware, no significant changes have been necessary. Program stage changes are handled using the process described above in 4.14.1 (IT Change Process).

## 4.16 Timeline for System Modifications

Illinois' eMIPP system has been operational since November 2013. Changes to software deployments must be targeted for the 4-5 major deployments scheduled each year. As indicated, the timeline for planning, designing, testing and implementation of changes via a normal deployment will take anywhere from 11-15 weeks. Minor releases are completed as necessary to resolve application errors or as an emergency deployment to shorten implementation timeframes.

## 4.17 NLR Readiness

The State has been exchanging transactions with the National Level Repository (NLR) since 2011. In 2013, these actions were transitioned to the current configuration with eMIPP.

## 4.18 Acceptance of Registration Data

The process to accept registration data from the National Level Repository (NLR) and import the information into the State Level Repository (SLR) has been in production in Illinois since 2011. In 2013, the process was integrated into the Michigan-Illinois joint software – hardware solution as described in 4.17 (NLR Readiness) above.

Once B6 transactions are received from the NLR, the registration data is imported into eMIPP databases the same day. B7 responses are issued by the State and received by the NLR the following day. Once the registration data is received, an automated email is sent to the provider to inform them they can begin their attestation.

## 4.19 Web Information

Providers seeking program information may visit the Illinois Medicaid EHR Incentive Program's website:  
<https://www.illinois.gov/hfs/MedicalProviders/eMIPP/Pages/default.aspx>

The site includes information on registration and enrollment, auditing, ILHIE, eligibility, payment process, DPH information and other helpful material including a provider manual (toolkit).

## 4.20 MMIS Modifications

The eMIPP application was integrated into the Agency's existing IMPACT application, combining Provider Enrollment and eMIPP under the same web login process, effective October 1, 2016. Providers were notified of the change through our normal communication methods – system broadcasts, emails, REC notices and at meetings/conference calls.

No other significant changes to MMIS regarding the Illinois Medicaid EHR Incentive Program are expected at this time. Previous changes to MMIS were minor, pertaining

to provider data extracts. Future changes will be handled via the change processes for both MMIS and eMIPP.

## 4.21 Call Centers/Help Desk Support

Providers may call the main Illinois Medicaid EHR Incentive Program help desk at 1-855-MUHELP1 (or 1-855-684-3571). Providers outside Chicago may email [info@ILHITREC.org](mailto:info@ILHITREC.org). These help desks are primarily handled by the REC's. The help desks can provide direct assistance or result in additional assistance from State staff or can obtain on-site assistance if necessary. Providers are notified of the following options for assistance:

### Help Desk Options

Issue	Contact
Providers with general questions about IMPACT or provider enrollment	Email: <a href="mailto:IMPACT.Help@Illinois.gov">IMPACT.Help@Illinois.gov</a> Phone: 877-782-5565 (select option #1)
Providers that are <i>having trouble logging in</i> to the IMPACT system	Email: <a href="mailto:IMPACT.Login@Illinois.gov">IMPACT.Login@Illinois.gov</a> Phone: 888-618-8078
eMIPP questions or EHR Incentive Program policy questions: EHR Help Desk	Email: <a href="mailto:hfs.ehrincentive@illinois.gov">hfs.ehrincentive@illinois.gov</a> Phone: 217-524-7322
CHITREC (within Chicago)	Phone: 1-855-MUHELP1 or 855-684-3571 Email: <a href="mailto:info@CHITREC.org">info@CHITREC.org</a>
IL HITREC (outside Chicago)	Email: <a href="mailto:info@ILHITREC.org">info@ILHITREC.org</a>

For all other issues, please email HFS at [hfs.ehrincentive@illinois.gov](mailto:hfs.ehrincentive@illinois.gov)

## 4.22 Appeal Process

Illinois Medicaid EHR Incentive 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 Vendor filing a written, signed request for appeal with the Department's Bureau Hospital and Provider Services within 30 calendar days after the date of the Department's Denial Notification.

The request for appeal shall include:

1. 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 Bureau of Hospital and Provider Services shall conduct an informal review of the request for appeal, including a review of all documentation listed above. If the Department's initial decision set forth in the Denial Notification is affirmed, the Office of Inspector General will issue a "Notice to Deny" providing the Vendor with the opportunity to request a formal hearing with the Bureau of Administrative Hearings within 10 days of the Notice.

This request for hearing must be received by the Department within 10 days after the date on which the Notice to Deny is received by Vendor. If such a request is not received by the Department within 10 days, or is received but later withdrawn, the Department's decision to deny shall be a final and binding administrative determination.

Upon timely request for hearing, the Bureau of Administrative Hearings shall conduct an administrative hearing in accordance with Sections 104.220 through 104.295, as applicable.

#### **4.23 Separation of HITECH and MMIS FFP**

HFS uses a reporting category in their accounting system which links each HFS expenditure to a federal grant, e.g. 100% HIT incentive payments, as well as 90% for HIT Administrative match. HITECH payments are tracked and reported separately on the CMS 64 as per the HITECH Act.

#### **4.24 EHR Incentive Payments – Frequency of Payments**

EHR incentive payments are made to eligible hospitals and eligible professionals on a weekly basis.

#### **4.25 Direct Payments to Provider or Assignee without Deduction or Rebate**

The Medicaid Questions on the CMS EHR Incentive Program Final Rule (November 10, 2010) states, "We believe that payments under the Medicare and Medicaid EHR Incentive Programs will be treated like all other income. The incentive payment legal authorities do not supersede any State or Federal laws requiring wage garnishment or debt recoupment. Therefore, if there is a legal basis for the State or Federal government to net or recoup debts then we believe such authority would apply to incentive payments, just as it applies to all other income."

The State of Illinois will recoup any outstanding Medicaid debts with incentive payment monies and pay out the remainder to providers. A small fee may be deducted for paper checks. The great majority of providers will receive their full payment electronically within three weeks of having their attestation approved.

## 4.26 Payment to Entity Promoting Adoption of CEHRT

Section 495.10(f) of the Final Rule allows EPs to “reassign the incentive payment to their employer or to an entity with which they have a contractual arrangement allowing the employer or entity to bill and receive payment for the EPs covered professional services”. HFS will not be making payments to state-designated entities as allowed for in Section 495.10(f)(2)(ii). The CMS Registration transaction to the State will include not only the EPs TIN, but also the payee TIN and NPI entered into the CMS Registration & Attestation (R&A) System by the provider. As indicated above, HFS will validate the payment assignment at the state level, as the national level is not able to validate the payee TIN/provider TIN combination. The HFS MMIS Provider Extract interface file contains the valid individual and group NPIs, names, State provider IDs and TINs associated with the provider who is registering at the state level. The provider will have the opportunity to assign his/her incentive payment to an entity. If the provider/payee combination is not present on the HFS MMIS Provider Extract interface file, eMIPP will notify the provider that an invalid provider/payee combination was received. The provider will be required to either change the payee to a valid NPI/TIN combination currently enrolled with HFS and recognized by HFS’ MMIS, or to set up the new payee with HFS in order to proceed with the request for the incentive payment to be paid for the provider/payee combination. As part of the EHR Incentive Program’s existing enrollment process, HFS requires an established business relationship prior to HFS accepting the provider/payee combination.

## 4.27 Process to Verify Capitation Rate Not Exceeded by Incentive Payments

The Final Rule further requires that the State ensure that existing fiscal relationships with providers to disburse incentive payments through Medicaid managed care plans does not result in payments that exceed 105 percent of the capitation rate. HFS acknowledges that providers can leverage both MCO and FFS encounters to qualify for the incentive payment. However, HFS pays all incentive payments directly to individual providers and not through the MCOs or other entities. Since these payments are not disbursed through (or to) Medicaid managed care plans, the payments will not be included in the “105% of the capitation rate” calculation.

## 4.28 EH Calculations and EP Payments Consistent with Statute and Regulation

Illinois has made no changes to hospital calculations and EP Incentive payments that would differ with Statutes and Regulations. Any errors found in payment calculations can later be corrected with an adjustment.

## 4.29 Role of Contractors

Illinois has an IGA (Inter-government agreement) with the State of Michigan to provide services related to the application development of the eMIPP web application shared by the two states (and others). The eMIPP application allows providers to attest, and also contains the necessary administrative functions to allow Illinois to adjudicate and process incentive payments. Michigan has contracted with a software/hardware vendor to provide assistance with these application development services.

Illinois also has a grant agreement with two Regional Extension Centers (CHITREC and IL HITREC) to provide outreach functions for the program. These functions include enrolling additional providers into the incentive program, providing help/desk functions and providing general support for the provider community, holding webinars related to program activities and assisting the state with their knowledge of the program.

### **4.30 Illinois 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 federal CMS (e.g., the development and support of the R&A System), ONC or other federal organizations.

HFS is dependent upon federal CMS for the review and approval of all SMHPs and IAPDs submitted to request federal funding for the Illinois Medicaid EHR Incentive Program. HFS relies on federal CMS to maintain the R&A 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.

HFS is dependent upon federal CMS and the ONC for the distribution and clarification of the Final Rule regarding the Illinois Medicaid EHR Incentive Program and MU criteria. HFS is dependent upon the ONC for the certification requirements of EHR systems so that Illinois providers can ascertain an AIU certified EHR system.

HFS has considered the effect of the Medicare and Medicaid Extenders Act of 2010 relative to the PIP Program. As a result of this legislation, EPs will not be required to submit additional documentation regarding the Net Allowable Cost of implementing EHR systems.

## **5 EHR INCENTIVE PROGRAM AUDIT STRATEGY**

The revised Audit Plan was submitted on August 10, 2016. This audit plan brings the program up to date through Stage 2 legislation. This standalone document was approved by CMS on October 11, 2016.

## 6 HIT ROADMAP

### 6.1 Illinois Healthcare Transformation from “As Is” to “To Be”

HFS continues to transform its Medicaid Enterprise by advancing its use of shared technology and business processes; and to achieve its mission of providing quality healthcare coverage at sustainable costs for the people, families and communities of Illinois.

Illinois is in the process of modernizing its 35-year-old MMIS, and other systems that comprise its Medicaid Enterprise. In 2013 HFS entered an Intergovernmental Agreement (IGA) with the State of Michigan Department of Health and Human Services (MDHHS) to begin a feasibility study to determine the viability and practicality of a shared Medicaid Enterprise between the two states. The resulting Illinois Michigan Program Advanced Cloud Technology (IMPACT) project is a multi-phase initiative to deliver to HFS a state-of-the art federally certified MMIS through a cloud-enabled service as well as Medicaid Enterprise modules for:

- Electronic Medicaid Incentive Payment Program (eMIPP) module (11/2013)
- Provider Enrollment (PE) module (07/2015)
- Core which includes several subsystems (~2020)
  - Benefits Administration
  - Claims/Encounters
  - Customer Relationship Management
  - Document Management Portal
  - Eligibility/Enrollment
  - Financial Services
  - Managed Care/Contracts Management
  - Prior Authorization
  - Third Party Liability Electronic Database (TED)

With a goal to accomplish HFS’ mission of empowering individuals enrolled in MCOs to improve their health while containing costs and maintaining program integrity, HFS developed the MCO State Quality Strategy (Quality Strategy). The Quality Strategy establishes a framework for ongoing assessment and identification of potential opportunities for health care coordination and improvement and ensuring the delivery of the highest quality and most cost-effective services possible. The Quality Strategy was developed with input from provider groups, advocates, MCOs and HFS staff and was reviewed by CMS. The quality strategy has five (5) goals identified below:

#### Five Goals of Quality Strategy

GOAL 1	Ensure adequate access to care and services for Illinois Medicaid recipients that is appropriate, cost effective, safe and timely.
GOAL 2	Ensure the quality of care and services delivered to Illinois Medicaid recipients.
GOAL 3	Ensure integrated care delivery – right care, right time, right setting right provider.
GOAL 4	Ensure consumer safety, satisfaction, access to, and quality of care and services delivered to Illinois Medicaid recipients in select managed care programs.
GOAL 5	Ensure efficient and effective administration of Illinois Medicaid managed care programs.

## **IMPACT**

The Illinois IMPACT project is a three-phase initiative to support the transformation of healthcare delivery in Illinois.

- Phase 1 of IMPACT included the launch of Electronic Health Records (EHRs) electronic Medicaid Incentive Payment Program (eMIPP) in November 2013. eMIPP provides incentive payments to eligible professionals, eligible hospitals, and critical access hospitals to adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. As part of that effort, Illinois launched MyHFS.illinois.gov, a secure provider web portal for authorized users to access and submit Medicaid information.
- Phase 2 of IMPACT included the launch of Provider Enrollment (PE) in July 2015, allowing hundreds of thousands of Illinois health care providers to seamlessly manage their enrollments in the cloud-enabled provider system.
- Phase 3 of IMPACT is the full implementation of the MDHHS cloud-enabled MMIS, currently scheduled for full implementation in 2020.

## **Other Completed Projects**

In addition to the IMPACT program, other systems have been replaced with new systems that meet federal requirements, increase efficiency by automating and expediting state agency processes, provide a more convenient and consistent user experience, are more convenient for providers, and ensure participants receive timely and high-quality Medicaid services. This section includes a few of the key projects as outlined below:

- The HFS EHR Electronic Provider Incentive Payment (ePIP) system went live in 2011. This is the official web site for the Illinois EHR Incentive Program that provides incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.
- The HFS ICD-10 project was launched in 2011 to meet DHHS requirements to modify the standard medical data code sets for coding diagnoses and inpatient hospital procedures. This modification included concurrently adopting the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for diagnosis coding and the International Classification of Diseases, 10th Revision, Procedural Coding System (ICD-10-PCS) for inpatient hospital procedure coding. HFS continued work on this project to meet the revised October 2015 deadline.
- The HFS 5010 project was launched in 2012 to upgrade the standards for electronic health care transactions from Version 4010/4010A1 to Version 5010. These electronic health care transactions include claims, eligibility inquiries and remittance advices (RAs) functions.
- The Health-e-Illinois Plus (HEAplus) system went live October 2013 and provides an Integrated Eligibility System (IES) through a single point of entry for self-service customers and State workers from HFS and DES.
- The Electronic Medical Incentive Provider Payment E-MIPP system implementation occurred November 15, 2013.

- Phase 1 of the Integrated Eligibility System (IES) was implemented in 2015 to determine eligibility for medical programs, Supplemental Nutrition Assistance Program (SNAP), formerly known as “food stamps” and cash assistance, primarily for Temporary Assistance for Needy Families (TANF).
- Phase 1 of the PBMS was implemented on April 1, 2015 which encompassed drug rebate functionality.
- The Provider Enrollment system implementation occurred July 20, 2015.
- In 2015 in collaboration with the Department of Human Services (DHS), HFS implemented Phase 1 of a new integrated eligibility system. This system determines eligibility for medical programs, Supplemental Nutrition Assistance Program (SNAP), formerly known as “food stamps”, and cash assistance, primarily for Temporary Assistance for Needy Families (TANF).
- A new PBMS was implemented in March of 2017 as part of the third phase of the IMPACT initiative. The new PBMS is a state-of-the-art, real time point of sale claims adjudication system. It enhances the Department’s Pharmacy Program by providing improved functionality that was not available in the legacy claims processing system. The new system contains the following functionality:
  - Expanded provider portal that contains improved prior authorization request functionality, including the ability to search for prior authorization status as well as claim submission functionality;
  - Enhanced prior approval review process that uses diagnosis and other information collected from pharmacy and medical claims data to systematically approve select drugs in defined circumstances;
  - Enhanced third party liability claims processing functionality, reducing the need for pharmacies to request third party liability overrides;
  - Enhanced override capabilities eliminating the need for most paper claims;
  - Enhanced functionality and provider messaging;
  - Improved Payor Sheet format; and
  - Enhanced claims processing functionality.

The PBMS will continue to collect encounter pharmacy claims from the MCOs.

- Under Medicaid Reform and the HFS Care Coordination Innovations Projects managed care has been central to HFS planning and expansion of its Medicaid managed care programs up through FY15. These expansion efforts sought to deliver better Medicaid services with the promise of reduced costs and transition a minimum of 50% of the Medicaid eligible participants into risk-based managed care programs. As a result of the Care Coordination Innovations efforts, at the beginning of FY 2015, just over 50 percent of Illinois’ Medicaid participants were enrolled in a capitated, risk-based managed care program. Enrollment in a managed care program is expected to be at approximately 80 percent by the end of calendar year 2018.

## Concept of Operations

CMS recently reaffirmed its guidance to states to focus on a Concept of Operations (COO) when assessing current capabilities and outlining future goals. In its April 2011 Medicaid Information Technology (IT) Supplement, CMS stated:

“States should develop a concept of operations and business work flows for the different business functions of the state to advance the alignment of the state’s capability maturity with the MITA Maturity Matrix (MMM). These COO and business workflows should align to any provided by CMS in support of Medicaid and Exchange business operations and requirements. States should work to streamline and standardize these operational approaches and business work flows to minimize customization demands on technology solutions and optimize business outcomes<sup>1</sup>”.

CMS further clarified the COO requirements in the Medicaid Enterprise Certification Toolkit (MECT) version 2.0 released March 2016. CMS has required the COO as a key artifact for review during the Project Initiation Milestone review and the MMIS Certification Milestone review. This document includes a COO section for each business area to support this review process.

The illustration below represents a high-level view of COO planning. It includes the three architectures of MITA, and how capability improvements can be made in each area to reach increasing levels of MITA maturity.

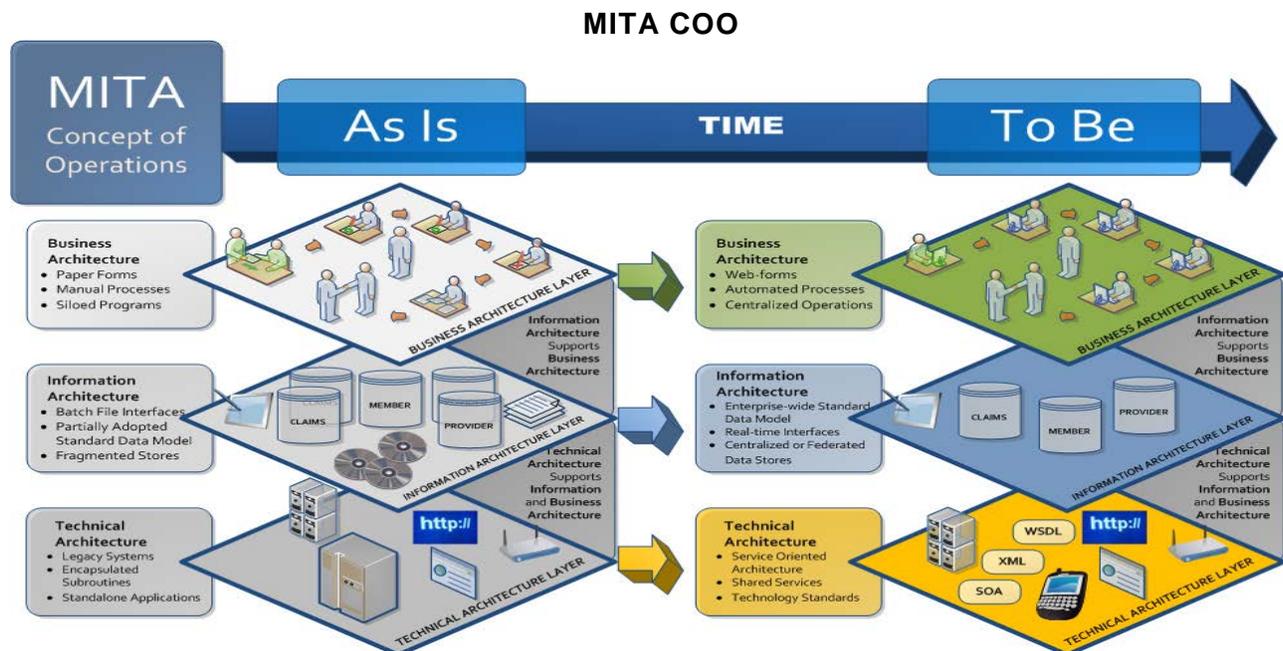


FIGURE 37

<sup>1</sup> Source: <http://www.cms.gov/Medicaid-Information-Technology-MIT/Downloads/Enhanced-Funding-Requirement-Seven-Conditions-and-Standards.pdf>

### 6.1.1 Moving from “As Is” to “To Be”

The HIT Roadmap is meant to translate the gaps identified from the As Is and To Be HIT Landscape, into actionable tactical steps that HFS will take to successfully implement the Medicaid PIP Program and fulfill Illinois’ HIT and HIE goals and objectives. The Roadmap is not meant to be a static document but should be seen as a living document that will continue to evolve as the HIT and HIE strategic business direction and technology environment continue to develop over time.

It should be noted that the State of Illinois has recently passed significant Medicaid Reform Legislation (See Section 2 Current HIT Landscape Assessment – The As Is Environment). It is expected that this reform which includes coverage, process and technology mandates, will influence the State’s Vision for Medicaid HIT.

#### **Business Relationship Management “To Be” Summary**

HFS focus will include improvements to the sharing of data, test and track software, consolidate redundant systems, automate and promote self-service for business partners and manage stakeholder satisfaction.

HFS goals for Business Relationship Management are as follows:

- Improve agreement administration through standard processes and automation where feasible
- Improve business process and defragment this process
- Review the policy for how MOUs are put into place
- Streamline internal and external communication protocols to speed up process
- Develop policy that standardizes the method of data exchange across agencies
- Acquire or develop a tracking tool for business relationships
- Improve functionality that supports workflow management
- Implement functionality that supports a robust testing system, including:
  - Ability for agencies or trading partners to submit files electronically for testing
  - Automation of testing process with data exchange business partners
  - Create robust tools to view EDI transactions

#### **Care Management “To Be” Summary**

HFS will continue to develop its care management business area by:

- Improving and expanding their EDW, data content
- Enabling advanced, accurate, efficient and robust analytical capabilities
- Improving and expanding member and provider outreach
- Improving planning

HFS will automate where feasible to increase efficiency and effectiveness of operational processes and communication with stakeholders.

HFS’ goals for the Care Management business area include:

- Create participant-specific health education materials for self-care and needed follow-up to improve health status, based on clinical findings
- Continue to increase automation wherever feasible, including the 278 transaction
- Continue to improve waiver indicator accuracy

## **Eligibility and Enrollment Management “To Be” Summary**

### ***Member***

HFS will continue to focus on member eligibility and enrollment business areas by improving the timeliness of data updates, access to data, and the exchange of data between systems. HFS will automate, where feasible, to increase the efficiency and effectiveness of operational processes.

Goals for the member Eligibility and Enrollment Management business area include:

- Continue to improve collaboration with other agencies and entities to improve data quality across programs and systems
- Continue to automate manual processes (check wages, social security, etc.)
- Continue to improve electronic audit trails
- Reduction/elimination of disparate systems
- Automated eligibility determination
- Real-time access to current data
- More robust search capabilities
- Reduction/elimination of multiple records for the same participant
- Participant online web portal

### ***Provider***

HFS will continue to focus on provider eligibility and enrollment business areas by replacing manual tasks with automation, where feasible, improve the use of and access to data, and on the communication to providers.

Goals for the provider Eligibility and Enrollment Management business area include:

- Fully implement use of HIPAA standards
- Integrate provider enrollment and claims systems
- Improve provider data quality across programs and systems
- Continue to collaborate with other divisions and entities to improve provider data quality across programs and systems
- Continue to improve electronic audit trails
- Create more robust search capabilities
- Adopt a document storage system
- Allow for free-form notes

## **Financial Management “To Be” Summary**

HFS will focus on many of the common, aforementioned themes to improve efficiencies as they relate to processing time, interoperability, data exchange and centralization, real-time updates versus batch processing, standardization of data and formatting,

elimination of manual processes, existing siloes and stand-alone processes, and establish better collaboration between business units.

Goals for the Financial Management business area include:

- Automate where feasible
- Improve format standards, accessibility, consistency, and robust quantity of data
- Utilize a single centralized online data store with image capability
- Improve reporting utilization, standards and accessibility across both internal and external entities and departments
- Improve notification and alerts to stakeholders for cost settlement activities
- Incorporate provider enrollment, claims, payment and void and tax and levy data with in a centralized system to ensure correct financial information
- Increase cost avoidance and reduce pay and chase
- Streamline policy and processes

### **Member Management “To Be” Summary**

HFS will focus on automation, standardization and streamlining of information in order to improve the quality of data collected. Improved data will naturally translate into more proactive, targeted and effective communications.

HFS has a health benefits hotline. Inquiries are tracked and sent to Bureau of Professional and Ancillary Services, (BPAS). Resolution information is entered in a monitored SharePoint site.

Goals for the Member Management business area include:

- Provide program integration through collaboration with other entities
- Ensure comprehensive and real time information is available online to participants
- Increase process standardization across departments and agencies
- Continued improvement in automating manual processes, where appropriate
- Increase data quality
- Create a robust audit trail
- Improve member outreach in quality and frequency
- Enable assessment of member outreach
- Increase pro-active member outreach
- Streamline the grievance and approval process
- Develop single system to document all calls/contacts and outcomes with participants
- Capture and retain participant’s names and alias
- Continue to improve internal communication regarding member outreach
- Continue improvement in identifying and targeting various participant populations for outreach
- Develop ability to measure effectiveness of outreach activities
- Automate the appeals request process
- Provide functionality that supports online submission of supporting documentation

- Use XML for correspondence
- Adopt technology that supports video conferencing for hearings that includes all involved parties on one screen
- Develop ability to track and monitor status of hearings by HFS staff
- Retain history and view changes made to appeals in a user-friendly online format

### **Operations Management “To Be” Summary**

HFS will once again focus on automation and standardization of data for all lines of business including: Fee for Service (FFS), Pharmacy, and Encounters. Improvements will centralize on one imaging system, with robust pricing for claims and use of data centric methodologies to increase the efficiency.

Goals for the Operations Management business area include:

- Automate manual tasks and processes wherever feasible
- Increase system capability so expected claims volume won't overload the system
- Provide a more robust pricing system
- Create table-driven logic vs program hard-coding
- Create more robust search capabilities
- Aggregate prescriptions for an individual and automate reporting to physicians about contraindications of medications being prescribed so that, even if a provider did not prescribe the medication, he or she is aware of the individual's entire medication regime
- Continue to improve coordination between MMIS and DHS systems
- Provide interface data exchange between all relevant systems for those that don't exist
- Improve exchange of data between systems to improve data quality and accuracy
- Automate the ability to reprice claims or force automatic rebill for rate changes, system issues and holds
- Allow claims exceeding \$9 million to be processed
- Create a participant web portal
- Eliminate/reduce disparate systems
- Create a fully NCCI-compliant system
- Provide single sign-on functionality
- Provide functionality that supports electronic submission of attachments
- Generate error codes using HIPAA error codes incorporating state specific error codes as needed
- Have capability to create free-form notes
- Provide an electronic reconciliation process
- Create a more robust audit trail
- Create a more robust system to process capitation payments
- Create a more robust test environment that is online and real-time and includes ability to turn edits on and off

- Provide a process for obtaining information on best practices from other states and programs, and allow for integrating quality forums
- Provide functionality that allows a provider to choose method of RA (paper, electronic, or both)
- Reduce the number of providers who receive paper checks
- Reprocess any claim on demand

### **Performance Management “To Be” Summary**

HFS will focus on the quality of data collected, improved communication and in the sharing of data between internal and external users. Enhancements to integrate and improve the systems are needed to increase efficiency and accuracy.

Goals for the Performance Management business area include:

- Ability to allow participants to validate EOBs online through the applicant portal.
- Utilization of laymen’s description of codes (CPT, HCPCS, etc.) making the REOMBs linguistically and culturally appropriate.
- Functionality that supports implementation of this process in the MMIS
- Build program integrity requirements into new programs as they are developed and implemented
- Continue to improve communication across programs and agencies

### **Plan Management “To Be” Summary**

HFS will focus on strategic objectives to improve the quality of life for participants. Moving forward, HFS’ data processing and information technology resources must be robust, flexible, supportive and functional, allowing for continuous quality improvements.

Goals for the Plan Management business area include:

- Provide program integration through collaboration with other entities and systems
- Establish links to external systems to identify clinical care guidelines, cutting edge strategies, and best practices, including States that receive enhanced Federal match for initiatives
- Explore options to standardize and automate where feasible
- Improve analytical tool’s capacity, including data pulls and definition, and correction to support in the design of new programs and enable reporting and analysis
- Establish epidemiologic approach to identify emergent trends, risk status, and unmet needs
- Incorporate industry-standard payment rates for comparison purposes, through an automated process and within the MMIS
- Provide the ability to organize all legislation and rules, so that HFS staff may understand where the policy changes need to be made in a timely process, as well as functionality that supports organizing legislation and rules in the MMIS
- Provide functionality that support an enhanced audit history and versioning

- Provide functionality that supports an enhanced audit history, versioning, and a simpler process to pull data for auditors
- Implement the ERP (Enterprise Resource Planning) system to replace PAAS
- Implement a governance process for managing change requests

### **Provider Management “To Be” Summary**

HFS will focus on functionality to support inquiry and update capability. Expand levels of provider support to include focused training sessions and webinars, real-time on-line assistance, customer service call centers, and power point presentations. Implementation of a centralized and robust data repository will increase the outreach and reporting capabilities.

Goals for the Provider Management business area include:

- Integrate provider enrollment and claims systems
- Functionality that allows HEDIS measure results to be viewed for an applicable provider
- Develop ability to attach or scan correspondence and documentation received from providers
- Develop a comprehensive/historical record of all provider communication
- Improve communications with sister agencies
- Provide functionality that supports providers viewing edits and why the edit is triggered
- Provide functionality that allows providers to enter a provider number that can display groups of their claims data (i.e., rejected claims, paid claims, etc.)
- Provide functionality that allows providers to be able to submit a query to get claims history (detail) off a database
- Create automated database for Bureau of Administrative Hearings (BAH) case tracking system
- Develop CASE system to interface with MMIS (include LTC)
- Develop electronic application to perform site visits

## **6.2 Illinois Expectation for EHR Adoption**

The SMA plans to enhance EHR provider adoption and detailed our vision and goals in our Implementation Advance Planning Document (IAPD) approved by CMS in December 2017:

**Vision:** The Illinois Medicaid EHR Incentive Program shall promote and provide guidance for meaningful use implementations while also helping establish and expand the structure and methods for improving the exchange of healthcare information.

- Goal 1:** Encourage, promote and enable provider attestations for all payment years and stages.
- Goal 2:** Reduce lag times for tests leading to production data transmissions with Public Health registries.
- Goal 3:** Improve Public Health expertise for Meaningful Use.

**Goal 4:** Establish and expand the structure and methods for improving the exchange of healthcare information.

### 6.3 Annual Benchmark for Goals

The EHR program team is motivated to pay as many eligible providers as possible. The SMA plans to enhance provider EHR adoption and MU rates annually with specific focus on dental providers who have attested for AIU but not MU. Dental providers, as an eligible provider type, have lagged behind the other eligible provider types comparatively in attesting for MU.

Listed below is a historical view and break-out of the Eligible Provider's participation in the Illinois EHR Incentive Program.

FFY2012		
Provider Type	Count	Amount
Certified Nurse Midwife	31	\$658,750
Dentist	63	\$1,338,750
Nurse Practitioner	173	\$3,676,250
Physician		
<i>Pediatrician</i>	34	\$481,678
<i>Non-Pediatrician Physician</i>	1073	\$22,801,250
Physician Assistant practicing in FQHC/RHC led by a PA	6	\$127,500
<b>TOTALS:</b>	<b>1380</b>	<b>\$29,084,178</b>

FIGURE 37

FFY2013			
Provider Type	AIU	MU	Amt
Certified Nurse Midwife	46	14	\$1,096,500.00
Dentist	153	3	\$3,276,750.00
Nurse Practitioner	298	59	\$6,834,000.00
Physician			
<i>Pediatrician</i>	69	0	\$977,500.23
<i>Non-Pediatrician Physician</i>	1238	15	\$26,350,000.07
Physician Assistant practicing in FQHC/RHC led by a PA	13	0	\$16,732,250.00
<b>TOTALS:</b>	<b>1817</b>	<b>91</b>	<b>\$55,267,000</b>

FIGURE 38

FFY2014				
Provider Type	AIU	MU1	MU	Amount
Certified Nurse Midwife	24	4	44	\$977,500.00



Dentist	226		27	\$6,222,000.00
Nurse Practitioner	228	7	249	\$7,276,000.00
Physician				
<i>Pediatrician</i>	19	2	54	\$617,692.00
<i>Non-Pediatrician Physician</i>	986	45	1581	\$35,364,248.00
Physician Assistant practicing in FQHC/RHC led by a PA	8		14	\$271,999.00
<b>TOTALS:</b>	<b>1491</b>	<b>58</b>	<b>1969</b>	<b>\$50,729,439.00</b>

FIGURE 39

FFY2015				
Provider Type	AIU	MU1	MU	Amt
Certified Nurse Midwife	18	4	70	\$1,062,500.00
Dentist	219	1	57	\$5,159,500.00
Nurse Practitioner	202	58	349	\$8,498,583.33
Physician				
<i>Pediatrician</i>	7	6	36	\$388,183.00
<i>Non-Pediatrician Physician</i>	642	111	1901	\$32,162,583.00
Physician Assistant practicing in FQHC/RHC led by a PA	4	0	13	\$195,500.00
<b>TOTALS:</b>	<b>1092</b>	<b>180</b>	<b>2426</b>	<b>\$47,466,849.33</b>

FIGURE 40

FFY2016				
Provider Type	AIU	MU1	MU	Amount
Certified Nurse Midwife	23	5	66	\$1,156,000.00
Dentist	133	3	29	\$3,136,500.00
Nurse Practitioner	213	59	351	\$8,763,500.00
Physician				
<i>Pediatrician</i>	12	4	47	\$493,021.00
<i>Non-Pediatrician Physician</i>	452	74	2188	\$29,701,829.00
Physician Assistant practicing in FQHC/RHC led by a PA	131	9	65	\$3,527,500.00
<b>TOTALS:</b>	<b>964</b>	<b>154</b>	<b>2746</b>	<b>\$46,778,350.00</b>

FIGURE 41

FFY2017				
Provider Type	AIU	MU1	MU	Amount
Certified Nurse Midwife	12	1	80	\$956,250.00
Dentist	255	3	52	\$4,160,750.00
Nurse Practitioner	372	3	469	\$13,506,500.00



Physician				
<i>Pediatrician</i>	7	0	40	\$325,849.00
<i>Non-Pediatrician Physician</i>	574	51	2307	\$32,896,416.00
Physician Assistant practicing in FQHC/RHC led by a PA	9	13	512	\$8,432,000.00
<b>TOTALS:</b>	<b>1229</b>	<b>71</b>	<b>3460</b>	<b>\$60,277,765.00</b>

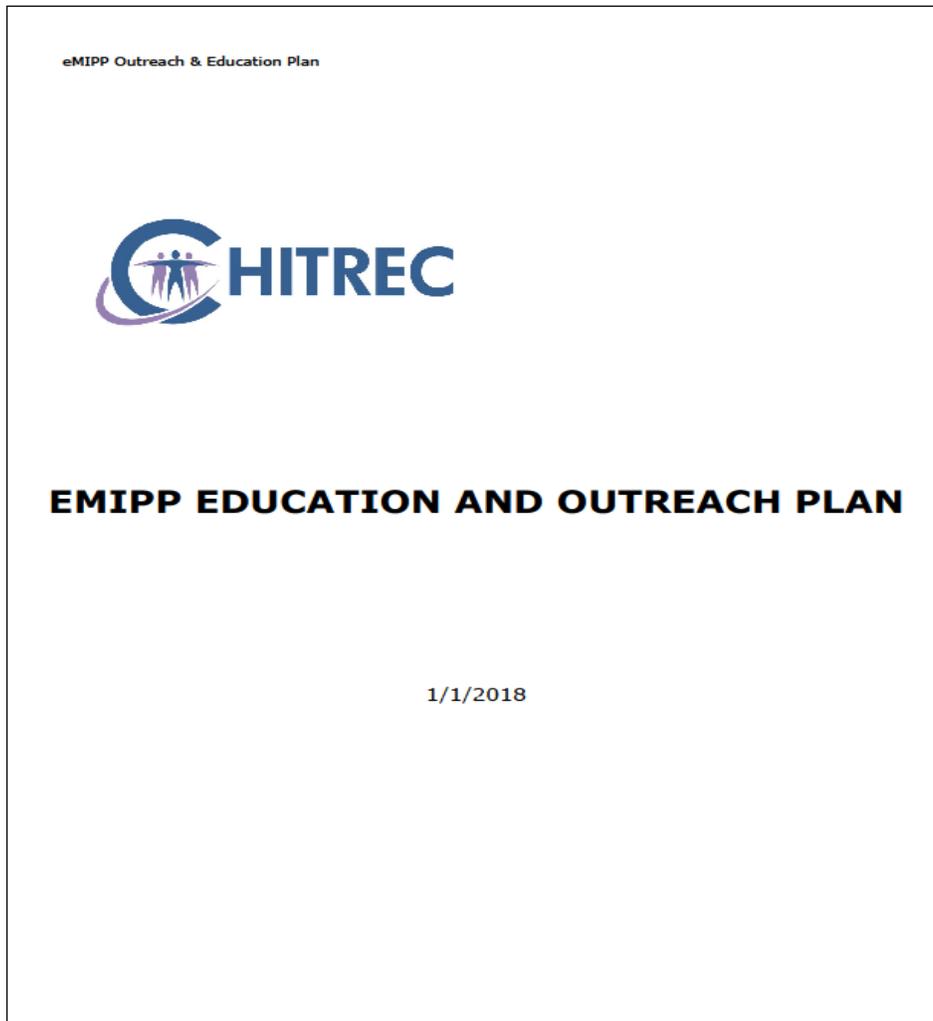
FIGURE 42

\*Data as of 3/15/2018.

\*\*Adjustments and/or recoupments to date have been applied to totals.

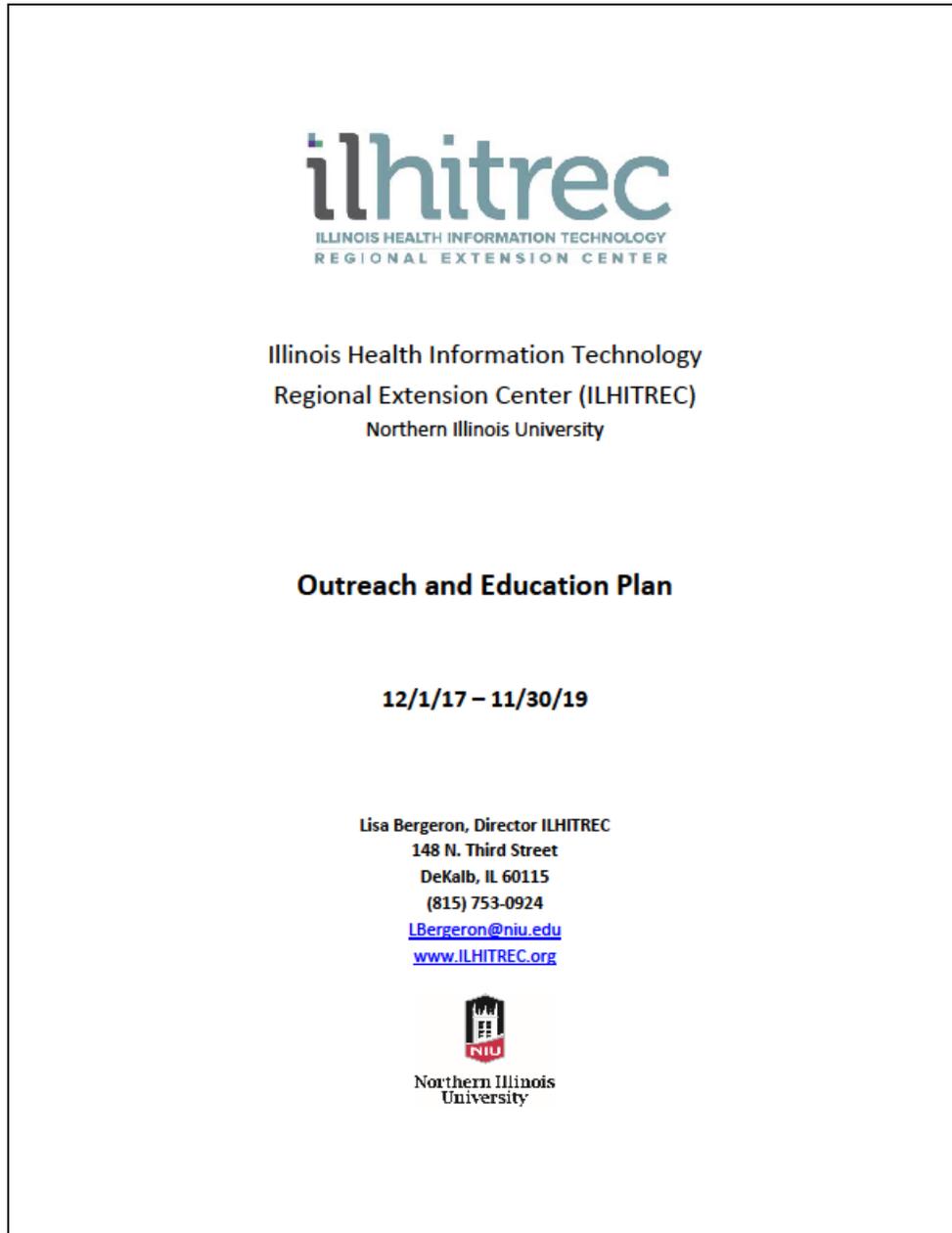
## APPENDIX A: REC OUTREACH AND EDUCATION PLANS

### A.1 CHITREC Outreach and Education Plan



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## A.2 IL HITREC Outreach and Education Plan



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## APPENDIX C: SAMPLE HOSPITAL PAYMENT CALCULATION

The spreadsheet below is an example of the hospital payment calculation worksheet that will be used to determine payment amounts and shared with hospitals to estimate their own payment amount.

Illinois Eligible Hospital Estimated EHR Incentive Calculator					
Medicare/Medicaid Hospital: Enter data in the white fields only from your Medicare Cost Reports.					
<b>Identification</b>					
Today's Date:	3/20/2018	End Date of the last full (12 mo) Medicare Cost Report (exempting partial cost reports)			
Payment Year:		Month:		Day:	
Hospital Name:		Year:			
CMS Certification Number (CCN):					
National Provider Identifier (NPI):					
<b>Step 1: Compute Growth Rate and Estimated Overall EHR Amount</b>					
<p>Compute the average annual growth rate by entering the actual discharge data for the current year and three years prior. The average annual growth rate will be auto-calculated by taking the discharge increase/decrease from the current year and dividing it by the discharges from the prior year (x 100). Average Annual Growth Rate will be calculated by averaging the three years growth rates.</p> <p>Example: 22,000 (Current Year) - 21,372 (Prior Year) = 628 (difference). Then, divide 628 by 21,372 (Prior Year) = 0.294 x 100 (for rate) = 2.94% (2552-96 Worksheet 5-3 Part 1 column 15, line 12 - Nursery Discharges) or (2552-10 Worksheet 5-3 Part 1 Column 15 line 14 - Nursery Discharges)</p>					
Cost Rpt Start Dt	Cost Rpt End Dt	Prior Year	Current Year	Increase/Decrease	Growth Rate
					0.00%
					0.00%
		NA		NA	0.00%
Enter (4) most recent full (12 mo) cost reports. Skip years that have partial or irregular reporting periods.				Total Increase/Decrease	
				Average Annual Growth Rate	0.00%
The current FY's total discharges are multiplied by the average annual growth rate to determine the new projected discharges. This step is repeated for each of the additional projected future Years 2 through 4.					
Projected Year	Total Discharges	Annual Growth Rate	New Projected Discharges		
Year 1 (Current year)		NA			
Year 2		0.00%			
Year 3		0.00%			
Year 4		0.00%			
<p>Compute the discharge related amount of \$200 per discharge if reporting year total discharges exceed 1,149 but capped at 23,000 each year. The last 3 of the theoretical 4 years of payment are adjusted by the average annual growth rate.</p> <p>* Note: If the number of discharges exceeds 23,000, then the number of discharges is 21,851 (23,000-1,149)</p>					
Year	Discharges	Allowed Discharges	Transition Factor	Calculation Summary	Total Overall EHR Initial Amount
Year 1			1.00	(\$2,000,000 +( * \$200)) *1	
Year 2			0.75	(\$2,000,000 +( * \$200)) *0.75	
Year 3			0.50	(\$2,000,000 +( * \$200)) *0.5	
Year 4			0.25	(\$2,000,000 +( * \$200)) *0.25	
<b>Overall EHR Amount:</b>					<b>\$0</b>
<b>Step 2: Compute Medicaid Share</b>					
Medicaid Inpatient Days:		[2552-96] Worksheet 5-3 Part 1, Column 5, Line 1 + Lines 6-10 or [2552-10] Worksheet 5-3 Part 1, Column 7, Line 1 + Lines 8-12			
Medicaid Managed Care Days:		[2552-96] Worksheet 5-3 Part 1, Column 5, Line 2 or [2552-10] Worksheet 5-3 Part 1, Column 7, Line 2			
Total Inpatient Bed Days:		[2552-96] Worksheet 5-3 Part 1, Column 6, Lines 1-2 + Lines 6-10 or [2552-10] Worksheet 5-3 Part 1, Column 8, Lines 1-2 + Lines 8-12			
Total Charges		[2552-96] Worksheet C Part 1, Column 8, Line 101 or [2552-10] Worksheet Part 1, Column 8, Line 200			
Charity Care Charges		[2552-96] Worksheet 5-10 Column 1, Line 30 or [2552-10] Worksheet 5-10, Column 3, Line 20			
Medicaid Inpatient Days + Medicaid Managed Care Days / (Total Inpatient Bed Days X ((Total Charges - Charity Care Charges)/Total Charges))			(+ ) / ( X (-) / )		
<b>Medicaid Share:</b>					<b>0.00000</b>
<b>Step 3: Compute Estimated Medicaid EHR Incentive Amount</b>					
Overall EHR amount X Medicaid Share =				\$0 X 0=	
<b>Estimated Medicaid EHR Incentive Amount</b>					<b>\$0</b>



**SAMPLE COMPLETED EH CALCULATION WORKSHEET**

Illinois Eligible Hospital Estimated EHR Incentive Calculator					
Medicare/Medicaid Hospital: Enter data in the white fields only from your Medicare Cost Reports.					
<b>Identification</b>					
Today's Date:	3/20/2018	End Date of the last full (12 mo) Medicare Cost Report (exempting partial cost reports)			
Payment Year:	2011	Month: 10			
Hospital Name:	Acme Hospital	Day: 1			
CMS Certification Number (CCN):	3301	Year: 2010			
National Provider Identifier (NPI):	123456789				
<b>Step 1: Compute Growth Rate and Estimated Overall EHR Amount</b>					
<p>Compute the average annual growth rate by entering the actual discharge data for the current year and three years prior. The average annual growth rate will be auto-calculated by taking the discharge increase/decrease from the current year and dividing it by the discharges from the prior year (then multiplying by 100). The final growth rate will be auto-calculated by averaging the three years of growth rates.</p> <p>Example: 22,000 (Current Year) - 21,372 (Prior Year) = 628 (difference). Then, divide 628 by 21,372 (Prior Year) = 0.294 x 100 (for rate) = 2.94% (2252-96), Worksheet S-3, Part 1, column 15, line 12 or (2252-10), Worksheet S-3, Part 1, Column 15, line 14</p>					
Cost Rpt Start Dt	Cost Rpt End Dt	Prior Year	Current Year	Increase/Decrease	Growth Rate
10/2/2009	10/1/2010	21,372	22,000	628	2.94%
10/2/2008	10/1/2009	20,743	21,372	629	3.03%
10/3/2007	10/1/2008	20,113	20,743	630	3.13%
10/3/2006	10/2/2007	NA	20,113	NA	NA
Enter (4) most recent full (12 mo) cost reports. Skip years that have partial or irregular reporting periods.				Total Increase/Decrease	9.10%
				Average Annual Growth Rate	3.03%
<p>The current FY's total discharges are multiplied by the average annual growth rate to determine the new projected discharges. This step is repeated for each of the additional projected future Years 2 through 4.</p>					
Projected Year	Total Discharges	Annual Growth Rate	New Projected Discharges		
Year 1 (Current year)	22,000	NA	22,000		
Year 2	22,000	3.03%	22,667		
Year 3	22,667	3.03%	23,354		
Year 4	23,354	3.03%	24,062		
<p>Compute the discharge related amount of \$200 per discharge if reporting year total discharges exceed 1,149 but capped at 23,000 each year. The last 3 of the theoretical 4 years of payment are adjusted by the average annual growth rate.</p> <p>* Note: if the number of discharges exceeds 23,000, then the number of discharges is 21,851 (23,000-1,149)</p>					
Year	Discharges	Allowed Discharges	Transition Factor	Calculation Summary	Total Overall EHR Initial Amount
Year 1	22,000	20,851	1.00	(\$2,000,000 + (20851 * \$200)) * 1	\$6,170,200
Year 2	22,667	21,518	0.75	(\$2,000,000 + (21518 * \$200)) * 0.75	\$4,727,700
Year 3	23,354	21,851	0.50	(\$2,000,000 + (21851 * \$200)) * 0.5	\$3,185,100
Year 4	24,062	21,851	0.25	(\$2,000,000 + (21851 * \$200)) * 0.25	\$1,592,550
<b>Overall EHR Amount:</b>					<b>\$15,675,550</b>
<b>Step 2: Compute Medicaid Share</b>					
Medicaid Inpatient Days:	17,500	(2552-96) Worksheet S-3 Part 1, Column 5, Line 1 + Lines 6-10 or (2552-10) Worksheet S-3 Part 1, Column 7, Line 1 + Lines 8-12			
Medicaid Managed Care Days:	1,350	(2552-96) Worksheet S-3 Part 1, Column 5, Line 2 or (2552-10) Worksheet S-3 Part 1, Column 7, Line 2			
Total Inpatient Bed Days:	50,000	(2552-96) Worksheet S-3 Part 1, Column 6, Lines 1,2 + Lines 6-10 or (2552-10) Worksheet S-3 Part 1, Column 8, Lines 1,2 + Lines 8-12			
Total Charges	\$5,000,000	(2552-96) Worksheet C Part 1, Column 8, Line 101 or (2552-10) Worksheet Part 1, Column 8, Line 200			
Charity Care Charges	\$1,000,000	(2552-96) Worksheet S-10 Column 1, Line 30 or (2552-10) Worksheet S-10, Column 3, Line 20			
$\frac{\text{Medicaid Inpatient Days} + \text{Medicaid Managed Care Days}}{\text{Total Inpatient Bed Days} \times ((\text{Total Charges} - \text{Charity Care Charges}) / \text{Total Charges})}$				$\frac{(17500 + 1350)}{(50000 \times ((5000000 - 1000000) / 5000000))}$	
				<b>Medicaid Share:</b>	<b>0.47125</b>
<b>Step 3: Compute Estimated Medicaid EHR Incentive Amount</b>					
Overall EHR amount X Medicaid Share =				\$15,675,550 X 0.47125 =	
<b>Estimated Medicaid EHR Incentive Amount</b>				<b>\$7,387,103</b>	

## Illinois Eligible Hospital EHR Incentive Calculation Instructions

Revised 6/19/2012

### Enter Identification Information

1. Provider will enter the Hospital Name, CCN, and NPI
2. Provider will enter the month, day and year of the end date of the last full Medicare Cost Report.
3. The payment year field will be automatically entered populated based on the Cost Report end date.
4. Today's date will be automatically entered by the spreadsheet.

### STEP 1: Compute Growth Rate and Estimated Overall EHR Amount

1. Provider will enter the Cost Report Start and End date for each year reported. Each cost report should be a full cost report (12 months). Years involving irregular cost reports should not be reported; they should be skipped. If there are fewer than four full reportable years of data, please fill in all years for which a full cost report exists.
2. Provider will enter the actual discharges for the current year and three previous years.
  - A. Enter the amount listed on CMS Form 2552-96, Worksheet S-3, Part 1, Column 15, line 12 less Nursery Discharges or
  - B. Enter the amount listed on CMS Form 2552-10 Worksheet S-3, Part 1, Column 15, line 14 less Nursery Discharges
3. The Prior Year Discharge column will be automatically populated based on the Current Year Discharge column.
4. The Increase/Decrease will be automatically populated based on the Current Year and Prior Year discharge information.
5. The annual growth rate will be calculated based on the  $(\text{Increase/Decrease})/\text{Prior Year's discharges}$ . The growth rate will be rounded to four decimal places.
6. The three annual growth rates will be averaged (rounded to four decimal places).
7. New projected discharges will be estimated based on the product of the current year's discharges and the growth rate. The new projected discharges will be rounded to the nearest discharge (zero decimal places).
8. Allowed discharges will be calculated based on the initial 1,149 discharge subtraction.
9. Discharges exceeding 23,000 will be calculated as follows:  $23,000 - 1,149 = 21,851$  allowed discharges.
10. Each year's allowed discharges will be multiplied by \$200 and added to the \$2 million base payment.
11. The result of the calculation in the preceding instruction will be multiplied by the transition factor for the given year.
12. The transition factor will be 1.0 (Year 1), 0.75 (Year 2), 0.50 (Year 3) or 0.25 (Year 4).
13. The sum of this calculation for all four years is the Overall EHR Amount.

### STEP 2: Compute Medicaid Share

1. Provider will enter the Medicaid Inpatient Days
  - A. Enter the amount listed on CMS Form 2252-96, Worksheet S-3, Part 1, Column 5, Line 1 and Lines 6-10 or
  - B. Enter the amount listed on CMS Form 2252-10 Worksheet S-3, Part 1, Column 7, Line 1 and Lines 8-12
2. Provider will enter the Medicaid Managed Care Days
  - A. Enter the amount listed on CMS Form 2252-96, Worksheet S-3, Part 1, Column 5, Line 2 or
  - B. Enter the amount listed on CMS Form 2252-10 Worksheet S-3, Part 1, Column 7, Line 2
3. Provider will enter the Total Inpatient Bed Days
  - A. Enter the amount listed on CMS Form 2252-96, Worksheet S-3, Part 1, Column 6, Lines 1,2 and Lines 6-10 or
  - B. Enter the amount listed on CMS Form 2252-10 Worksheet S-3, Part 1, Column 8, Lines 1,2 and Lines 8-12
4. Provider will enter the Total Charges
  - A. Enter the amount listed on CMS Form 2252-96, Worksheet C, Part 1, Column 8, Line 101 or
  - B. Enter the amount listed on CMS Form 2252-10 Worksheet C, Part 1, Column 8, Line 200
5. Provider will enter the Charity Care Charges
  - A. Enter the amount listed on CMS Form 2252-96, Worksheet S-10, Column 1, Line 30 or
  - B. Enter the amount listed on CMS Form 2252-10 Worksheet S-10, Column 3, Line 20
6. The Medicaid Share is automatically calculated by dividing the sum of #1 and #2 by  $(\#3 \times (\#4 - \#5))/(\#4)$ . The Medicaid share will be rounded to five decimal places.

### STEP 3: Compute Medicaid EHR Incentive Amount

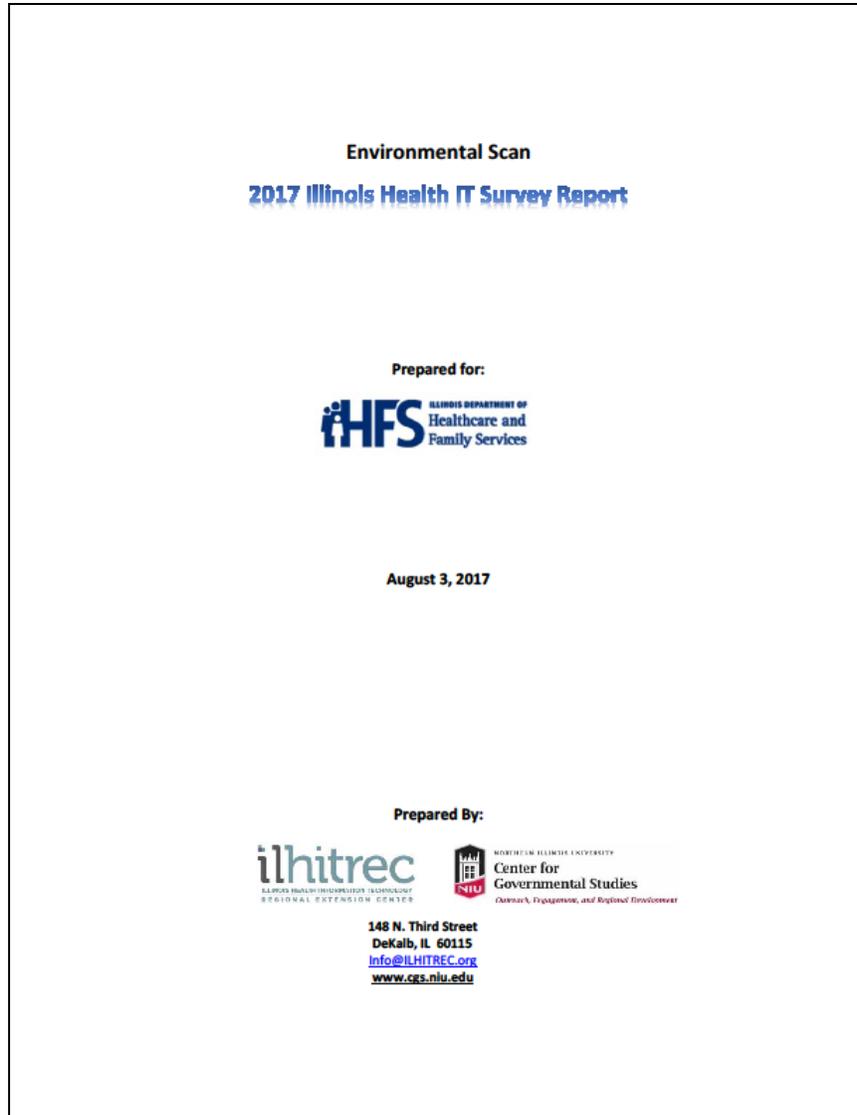
1. The Medicaid EHR Incentive Amount is automatically calculated by multiplying the Medicaid Share and the Overall EHR Amount. The amount will be rounded to the nearest dollar (zero decimals places).

## APPENDIX D: HFS MEDICAID EHR INCENTIVE WORKGROUP

Listed below are the members of the workgroup and the organizations that they are affiliated with.

Name	Organization
Julie Glen, Chairperson	Loyola University Medical Center
Dave Barnes	HFS/Medical Programs
Scotty McLaughlin	HFS/Medical Programs
Eric Watson	HFS/Medical Programs
Mecky Lang	HFS/Medical Programs
Jackie Alexander	HFS/Office of the Inspector General
Darren Barnes	SIU School of Medicine
Janet Baxter	AllianceChicago
Lisa Bergeron	Northern Illinois University/IL HITREC
Paula Dillon	Illinois Hospital Association
Cindy Eddings	Rush-Copley Medical Center
Carrie Galbraith	Illinois Critical Access Hospital Network
Cheryl Hoots	Illinois Primary Health Care Association
Dejan Jovanov	Illinois Department of Public Health
Lindsey Kane	Northwestern University/CHITREC
Amy Lee	Advocate Physician Partners
Susan Lorenz	Advocate Physician Partners
Shannon Mikesell	SIU School of Medicine
Lauren Russo	Rush University Medical Center
Ken Ryan	Illinois State Medical Society
Direndia Shackelford	Advocate Physician Partners
Brenda Simms	Northern Illinois University/IL HITREC
Sam Stathos	Cook County Health and Hospital Systems

## APPENDIX E: 2017 ILLINOIS ENVIRONMENTAL SCAN



*Right-click to open Acrobat Document object*

## APPENDIX F: LIST OF ACRONYMS

The following acronyms are used throughout this document:

Acronym	Definition
AIU	Adopt, Implement or Upgrade
ABCD III	Assuring Better Child Health and Development III
ABP	American Board of Pediatrics
ACA	Patient Protection and Affordable Care Act
ACO	Accountable Care Organization
ADHD	Attention Deficit Hyperactivity Disorder
ADT	Admit Discharge Transfer
AHS	Automated Health Systems
AHRQ	Agency for Healthcare Research and Quality
ALJ	Administrative Law Judge
AOA	American Optometric Association
AOBP	American Osteopathic Board of Pediatrics
AR	Accounts Receivable
ARRA	American Recovery and Reinvestment Act
AVRS	Automated Voice Response System
BCHS	Bureau of Comprehensive Health Services
BCP	Bureau of Claims Processing
BFO	Bureau of Fiscal Operations
BHIP	Behavioral Health Integration Project
BIP	Broadband Initiatives Program
BMC	Bureau of Managed Care
BMCHP	Bureau of Maternal and Child Health Promotion
BMI	Body Mass Index
BMI	Bureau of Medicaid Integrity
BPRA	Bureau of Program and Reimbursement Analysis
BRDA	Bureau of Rate Development and Analysis
BRFSS	Behavioral Risk Factor Surveillance System
BTOP	Broadband Technology Opportunities Program
CAH	Critical Access Hospital
CAI	Community Anchor Institutions
CBHA	Community Behavioral Healthcare Association
CCN	(Federal) CMS Certification Number
CDC	Centers for Disease Control and Prevention
CDPH	Chicago Department of Public Health
CFR	Code of Federal Regulation
CH&P	Community Health and Prevention Services
CHES	Chicago Health Event Surveillance System
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act
CHITREC	Chicago Health Information Technology Regional Extension Center



Acronym	Definition
CHPL	Certified HIT Product List
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare & Medicaid Services
(Federal) CMS	Centers for Medicare & Medicaid Services
(Illinois) CMS	Illinois Department of Central Management Services
CQM	Clinical Quality Measure
DATA	Dekalb Advancement of Technology Authority
DCEO	Illinois Department of Commerce and Economic Opportunity
DCFS	Illinois Department of Children and Family Services
DHS	Illinois Department of Human Services
DMP	Division of Medical Programs
DPSQ	Division of Patient Safety and Quality
DRA	Deficit Reduction Act
ECC	Electronic Claims Capture
ECP	Electronic Claims Processing
ED	Emergency Department
EDW	Enterprise Data Warehouse
EFT	Electronic Funds Transfer
EH	Eligible Hospital
EHR	Electronic Health Record
EMR	Electronic Medical Record
EP	Eligible Professional
EVE	Eligibility Verification and Enrollment
FFP	Federal Financial Participation
FFS	Fee-for-Service
FONSI	Finding of No Significant Impact
FQHC	Federally Qualified Health Center
FTP	File Transfer Protocol
HCCN	Health Center Controlled Network
HEDIS	Healthcare Effectiveness Data and Information Set
HFS	Illinois Department of Healthcare and Family Services
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act
HISPC	Health Information Security and Privacy Collaboration
HIT	Health Information Technology
HITEC	Health Information Technology Extension Center
HITECH	Health Information Technology Economic and Clinical Health Act
HITPO	Health Information Technology Project Office
HL7	Health Level Seven
HMO	Health Maintenance Organization
HRSA	Health Resources and Services Administration
IAPD	Implementation Advance Planning Document
IAPDU	Implementation Advance Planning Document Update
IARF	Illinois Association of Rehabilitation Facilities
IBPO-EC	Illinois Broadband Opportunity Partnership for East Central Illinois



Acronym	Definition
ICAHN	Illinois Critical Access Hospital Network
I-CARE	Illinois Comprehensive Automated Immunization Registry Exchange
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICD-10-PCS	International Classification of Diseases, 10 <sup>th</sup> Revision, Procedural Coding System
ID	Identification
IDOT	Illinois Department of Transportation
DPH	Illinois Department of Public Health
IDVA	Illinois Department of Veterans Affairs
IHA	Illinois Hospital Association
IHE	Integrating the Healthcare Enterprise
ILCS	Illinois Compiled Statutes
ILHIE	Illinois Health Information Exchange
IL-HITREC	Illinois Health Information Technology Regional Extension Center
I-NEDSS	Illinois National Electronic Disease Surveillance System
I/P	Inpatient
IRHN	Illinois Rural HealthNet
IRS	Internal Revenue Service
ISMS	Illinois State Medical Society
IT	Information Technology
LAN	Local Area Network
LIS	Low-Income Subsidy
LOINC	Logical Observation Identifiers Names and Codes
LTACH	Long-term Acute Care Hospital
LTC	Long-Term Care
MAC	Medicaid Advisory Committee
MAR	Management and Administrative Reporting
MARS	Management and Administrative Reporting Subsystem
MCO	Managed Care Organization
MDS	Minimum Data Set
MDW	Medical Data Warehouse
MEDI	Medical Electronic Data Interchange
MFCU	Medicaid Fraud Control Unit
MIPPA	Medicare Improvements for Patients and Providers Act
MITA	Medicaid Information Technology Architecture
MMCE	Medicaid Managed Care Entity
MMIS	Medicaid Management Information System
MPD	Master Provider Directory
MPI	Master Patient Index
MSIS	Medicaid Statistical Information System
MSP	Medicare Savings Programs
MTA	Medical Trading Area
MTG	Medicaid Transformation Grant
MU	Meaningful Use
NCQA	National Committee for Quality Assurance
NCPDP	National Council for Prescription Drug Programs



Acronym	Definition
NHIN	Nationwide Health Information Network
NICU	Neonatal Intensive Care Unit
NIU	Northern Illinois University
NPI	National Provider Identifier
NPES	National Provider and Plan Enumeration System
NTIA	National Telecommunications and Information Administration
OGC	Office of General Counsel
GOHIT	Illinois Governor's Office of Health Information Technology
OIA	Office of the Internal Auditor
OIG	Office of the Inspector General
OIS	Office of Information Systems
OME	Otitis Media with Effusion
ONC	Office of the National Coordinator for Health Information Technology
O/P	Outpatient
OSF	Order of Saint Francis
PA	Physician Assistant
PAAS	Programmatic Administrative Accounting System
PBM	Pharmacy Benefit Manager
PCCM	Primary Care Case Management
PCI	Partnership for a Connected Illinois
PCP	Primary Care Provider
PCS	Procedure Coding System
PHSA	Public Health Services Act
PICU	Pediatric Intensive Care Unit
PIP	Provider Incentive Payment
POS	Place of Service
PPCP	Priority Primary Care Provider
PPU	Provider Participation Unit
PQRS	Physician Quality Reporting System
PRS	Policy Review System
R&A	Registration and Attestation System
REC	Regional Extension Center
REV	Recipient Eligibility Verification
RHC	Rural Health Clinic
RHIO	Regional Health Information Organization
RLS	Record Locator Service
ROI	Return on Investment
RPR	Recipient/Provider Reference subsystem
RUGS	Resource Utilization Groups
RUS	Rural Utility Service
SAMHSA	Service Administration of Mental Health and Substance Abuse
SAMS	Statewide Accounting Management System
SBDD	State Broadband Data and Development
SEIU	Service Employees International Union
SHARP	Strategic HIT Advanced Research Project



Acronym	Definition
SHIECAP	State Health Information Exchange Cooperative Agreement Program
SHIP	State Health Improvement Plan
SMA	State Medicaid Agency
SMD	State Medicaid Director
SMHPU	State Medicaid Health Information Technology Plan Update
SNOMED	Systematized Nomenclature of Medicine-Clinical Terms
SS-A	State Self-Assessment
SSN	Social Security Number
TIN	Taxpayer Identification Number
TPL	Third-Party Liability
SUR	Surveillance and Utilization Review
UC	Urbana-Champaign
UC2B	UC Big Broadband
UDS	Uniform Data System
US DHHS	United States Department of Health and Human Services
USDA	United States Department of Agriculture
XML	Extensible Markup Language

## APPENDIX G: EHR INCENTIVE PROGRAM TASKS

The following table contains the task list for the continued evolution of the EHR Incentive Program.

### Task list

Activity	Start Date	End Date	Status
<b>PROJECT PLANNING TASKS COMPLETED</b>			
Implemented HITPO	10/2010	01/2011	Complete
Contracted with a vendor, Cognosante (f/k/a Fox Systems), to assist in SMHP and IAPD development	4/23/2010	5/03/2010	Complete
Developed State's Incentive Payment Vision Statement	2/04/2011	3/23/2011	Complete
Conducted EHR Assessment – Medicaid Providers (Environmental Scan)	8/01/2010	11/30/2010	Complete
Conducted EHR Assessment – Non-Medicaid Providers (Environmental Scan)	11/01/2010	11/30/2010	Complete
Developed EHR Business Gap Analysis	10/28/2010	12/23/2010	Complete
Developed SMHP to administer incentive payments for EHR meaningful use	12/1/2010	4/7/2011	Complete
Completed the MITA SS-A Update relating to PIP program implementation	7/20/2010	10/01/2010	Complete
Submitted Draft SMHP to federal CMS	4/7/2011	4/7/2011	Complete
Received comments from federal CMS; revised SMHP addressing comments; resubmitted to federal CMS	6/8/2011	7/1/2011	Complete
<b>Provider Incentive Program (PIP) Implementation</b>			
Submit IAPD for federal CMS approval	7/21/2011	7/21/2011	Complete
Develop Policy and Procedures required to support the PIP program	9/17/2010	10/19/2010	Complete
Define requirements for the system solutions	6/1/2011	7/1/2011	Complete
<b>IAPD/SMHP</b>			
Submit revised SMHP to federal CMS for approval, and annually thereafter	1/20/2012	Ongoing	Ongoing
Provide updated IAPD as necessary throughout the implementation and administration of the PIP program	1/20/2012	Ongoing	Ongoing
<b>EHR Incentive Program Implementation</b>			
Complete system specifications	8/31/2011	12/31/2011	Complete
Launch Illinois EHR Incentive Pgm website			Complete
Establish new policies for the program	9/17/2010	10/19/2010	Complete
Establish program procedures	9/17/2010	10/19/2010	Complete



Activity	Start Date	End Date	Status
Finalize Illinois Rules revisions required for the PIP program	9/17/2010	1/31/2011	Complete
Execute outreach and communication plan to support PIP program awareness in provider community and within HFS	10/20/2010	Ongoing	Ongoing
Implement System Updates	7/01/2011	9/30/2011	Complete
Test State/Federal R&A System Interface			Complete
Program Launch	09/2011	09/2011	Complete
Begin Accepting Attestations	Aug 2012 (EH) Dec 2012 (EP)	Aug-2012 (EH) Dec 2012 (EP)	Complete
Begin Issuing EHR Incentive Payments	March 2012	March 2012	Complete
Continued EHR Incentive Payments (Adopt/Implement/Upgrade [A/I/U])	March 2012	Ongoing	Ongoing
Audit Process Begins (first audits conducted)	August 2012	August 2012	Complete
Audits updated for Stage 2	4/1/2016	10/11/2016	Complete
Ongoing Post-Payment Audits	August 2012	Ongoing	Ongoing
Coordinate PIP Program for Phase 2 – Stage 1 Meaningful Use / Year 2 and Year 3 Payments			
Conduct Stakeholder discussions on shared HIE projects	1/20/2012	8/31/2012	Complete
CMS review and approval of MU Screens	4/5/12	2/20/2013	Complete
Define Stage 1 MU requirements	10/1/2012	12/31/2012	Complete
Complete system upgrades to collect, store, and report on MU measures.	11/1/2012	2/28/2013	Complete
Conduct MU User Acceptance Testing	11/01/2012	2/28/2013	Complete
Accept Provider Stage 1 MU Attestations	Dec 2012 (EH) Mar 2013 (EP)	Dec 2012 (EH) Apr 2013 (EP)	Complete
Phase 1 of eMIPP implementation	7/8/2013	11/18/2013	Complete
Phase 2 of eMIPP implementation	11/26/2013	03/28/2014	Complete
Flex rule implementation in eMIPP	10/5/2014	10/31/2014	Complete
Implement Modifications to Stage 1 and Stage 2 (2015-2017)\Stage 3 Final rule in eMIPP for 2015-2016 program years	10/1/2015	10/31/2015	Complete
Implement requirements of 2017 IPSP final rule in eMIPP	8/15/2016	12/15/2016	Complete
Implement Modifications to Stage 1 and Stage 2 (2015-2017)\Stage 3 Final rule in eMIPP for 2017 program year	6/3/2016	3/29/2017	Complete
Implement requirements of 2017 OPSP final rule in eMIPP	11/1/2016	12/15/2016	Complete
Tasks To Be Undertaken			
Implement requirements of 2018 IPSP final rule in eMIPP	9/4/2017	1/1/2018	Complete



Activity	Start Date	End Date	Status
Implement modifications to 2018 QRDAIII Implementation Guide	9/4/2017	1/1/2018	Complete
State determination of MU and tracking of MU	1/20/2012	Ongoing	Ongoing
Develop State's Vision for MU and Clinical Data	1/20/2012	Ongoing	Ongoing
Quarterly system updates to eMIPP			Ongoing
<b>ADT Tasks</b>			
Vendor shall provide to HFS a written implementation plan	3 weeks after contract execution		Approved by CMS. Preparing RFP for solicitations
Vendor shall provide to HFS a written training plan	6 weeks after contract execution		Approved by CMS. Preparing RFP for solicitations
Vendor shall provide written security risk assessment	1 month after contract execution		Approved by CMS. Preparing RFP for solicitations
Vendor shall provide first quarterly status report	3 months after contract execution		Approved by CMS. Preparing RFP for solicitations
Vendor shall ensure that all MCOs are connected and actively receiving ADT notification from the system	12 months after contract execution		Approved by CMS. Preparing RFP for solicitations
Vendor shall ensure Web portal is implemented	5 months after contract execution		Approved by CMS. Preparing RFP for solicitations
Vendor shall ensure that all Integrated Health are connected and actively receiving ADT notification from the system	12 months after contract execution		Approved by CMS. Preparing RFP for solicitations
Vendor shall ensure that all Vendor developed system reports to be used by HFS, MCOs, integrated health homes and providers are implemented	7 months after contract execution		Approved by CMS. Preparing RFP for solicitations
Vendor shall provide written report outlining how Illinois should improve HIE following system implementation	18 months after contract execution		Approved by CMS. Preparing RFP for solicitations