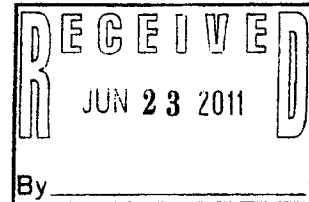


Department of Health & Human Services  
Centers for Medicare & Medicaid Services  
Consortium for Medicaid and Children's  
Health Operations  
233 North Michigan Avenue, Suite 600  
Chicago, Illinois 60601



June 16, 2011

Thomas Betlach, Director  
Arizona Health Care Cost Containment System  
801 East Jefferson Street, MD 4100  
Phoenix, Arizona 85034



Dear Mr. Betlach:

Thank you for Arizona's State Medicaid Health Information Technology Plan (SMHP), submitted to the Centers for Medicare & Medicaid Services (CMS) on March 22, 2011, and the Health Information Technology Implementation Advance Planning Document (HIT IAPD), submitted to CMS on May 20, 2011.

The SMHP and HIT IAPD documents were submitted to CMS for review and approval to proceed with certain activities authorized under Section 4201 of the American Recovery and Reinvestment Act of 2009 (the Recovery Act), Pub L. 111-5, and our regulations at 42 CFR Part 495, Subpart D. The Social Security Act, as amended under Section 4201 of the Recovery Act, as well as our final regulation, will allow the payment of incentives to eligible professionals and eligible hospitals for the adoption and meaningful use of certified electronic health record (EHR) technology.

CMS approves the State's SMHP effective on the date of this letter. Our approval of the State's SMHP is subject to provisions in regulations at 42 CFR Part 495, Subpart D. As a condition of this approval, issues we have identified and included in Enclosure A must be addressed in a revised, red-lined SMHP and submitted to CMS for our review and approval by July 18, 2011. When submitting the revised SMHP, please include a change control document specifying where in the SMHP the State has addressed the required changes. We are also providing additional comments and recommendations in Enclosure B to assist you with planning and implementation activities, and to help further improve the SMHP. Any of these comments and recommendations that the State chooses to adopt should be notated in submission of a revised SMHP in the future.

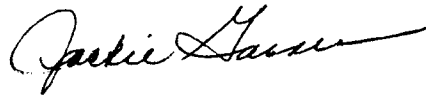
CMS also approves the State's HIT IAPD. CMS is approving total funding for activities described in the State's approved SMHP and HIT IAPD in an amount not to exceed \$6,236,500 (Federal share \$5,612,850) as described on pages 25-26 of the approved HIT IAPD. Approval of funding for this phase of the HIT IAPD will expire on September 30, 2013. Additionally, CMS is approving the carryover of PAPD funds totaling \$1,935,702 (Federal share \$1,742,132) as described on pages 25-26 of the HIT IAPD.

Please refer to Enclosure C for additional information about State responsibilities concerning activities described in the HIT IAPD.

I wish to congratulate you and your staff on the successful completion of initial HIT planning activities. CMS appreciates Arizona's commitment and dedication to implementing this important new program that will lead to improved healthcare for populations served by the Medicaid Program.

If there are any questions concerning this information, please contact Mr. Richard H. Friedman at (410) 786-4451, or via email at [Richard.Friedman@cms.hhs.gov](mailto:Richard.Friedman@cms.hhs.gov).

Sincerely,

A handwritten signature in cursive script, appearing to read "Jackie Garner".

Jackie Garner  
Consortium Administrator

**Enclosure A**

**As a condition of approval of the SMHP, the following issues must be addressed in a revised SMHP and submitted for CMS review and approval.**

1. Page 77 and throughout: Please provide more information on the provider web portal and how it will be integrated into or used by the State's systems.
2. Page 98, Section 4.3.7.1: Physician assistants (PAs) must practice in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC), but that does not mean the "practices predominantly/needly individual" requirements automatically apply. For example, if a PA practices in an RHC that is so led by a PA, the PA can meet either the Medicaid patient volume requirements OR the practices "predominantly/needly individual" requirements. Please correct.
3. Page 99, Section 4.3.7.2: "A Medicaid encounter is one that is not claimed by another provider." This goes beyond Federal guidance. For example, a mid-level practitioner (nurse practitioner or PA) may not be the billing provider, whereas a physician might be, but both the mid-level practitioner and the physician could have claim to the encounter for purposes of establishing patient volume in such cases.
4. Page 102, Section 4.3.7.4.3: Please review the frequently asked question (FAQ) on the CMS website about group practice patient volume as a proxy for an eligible professional's patient volume. CMS presents several examples of how this would apply. Not all individuals have to use the group's patient volume, but the numbers included can't be duplicated. Please contact CMS for more help on this.
5. Page 105, Section 4.3.7.5.2: The average length of stay (ALOS) should be available on (and consistent with) the Medicare Cost Report.
6. Pages 122 and 134, Section 4.6.3.1, 3<sup>rd</sup> paragraph: How often will the EHR Payment Analyst manually review the submitted documentation?
7. Page 124, Section 4.6.3.6 Licensure and Sanctions Test:
  - a. How will the State verify that providers are properly licensed/qualified providers? If Arizona intends to utilize existing provider enrollment methods, have the existing vulnerabilities been adequately addressed?
  - b. Since existing processes will be used to determine provider eligibility, then the program is vulnerable to potentially paying Federal dollars to persons or entities who should not receive Federal dollars. Even though the National Level Repository (NLR) checks for exclusions, CMS's concern is that the State does not request all the appropriate disclosures (for managing employees and ownership in this case), and the State appears to be limited in its ability to verify the exclusion status of key persons against available databases. Also, the NLR is only checking the Department of Health and Human Services Office of Inspector General (HHS OIG) List of Excluded Individuals and Entities (LEIE) for the enrolling provider--

not the other names. Arizona should review *Best Practices for Medicaid Program Integrity Units' Collection of Disclosures in Provider Enrollment*, issued in August 2010 to all State Program Integrity directors (found here - <https://www.cms.gov/FraudAbuseforProfs/Downloads/bppedisclosure.pdf>).

8. Page 131: What is the process for making hospital-based determinations for eligible professionals? Will this be automated? If not, please describe how the manual process will be managed to avoid delays.
9. Page 131: How will the provider be notified if the State determines that the provider is ineligible?
10. Page 149, Audit Strategy: Please expound on the "risk-based audit strategies" and "Specific data element variances" referred to as the structure of the risk-based strategy.
11. Pages 149-158, Audit Strategy: In the next iteration of the SMHP, please provide a more detailed audit strategy. The State needs to identify high risk providers and audit triggers that support a risk-based audit approach. For example, are there patient volume triggers? Hospital based indicators? Eligibility factors? Please review the SMHP template, Section D (The State's Audit Strategy) and provide additional detail following the suggested criteria.

**Enclosure B**

**The following comments and recommendations will assist with planning and implementation activities and help further improve the SMHP. Any comments or recommendations that the State chooses to adopt should be notated in submission of a revised SMHP.**

1. General: The State should clarify where interfaces will occur between the Medicaid Management Information System (MMIS) and other systems used for implementation of this program.
2. General: Please clarify how other Medicaid information technology (IT) projects would impact the EHR Incentive Program and the Health Information Exchange (HIE). What impact will the Health Insurance Exchange (HIX) and eligibility systems projects have on the EHR Incentive Program? How will the State ensure that there will not be duplication of effort between systems?
3. General: It appears there are several eligibility determination systems. How will the State manage the data from all the different eligibility determination systems and keep it updated and synchronized?
4. General: Due to the State's high penetration of managed care, the State may wish to consider the patient panel method of collecting encounter information for verifying patient volume. This is not required, but rather suggested for State consideration.
5. Pages 35-39: Please provide more detail on the IT compatibility of the EHRs used by Tribal Clinics and the Veterans Administration (VA) health system with the State's systems. What are the estimated time lines of this interoperability, if any? Will the interoperability prevent the State from EHR compliance? How will the State deal with any delays?
6. Page 77: Will the provider web portal (or other State web sites) alert providers to changes in law or regulations?
7. Pages 79: Please clarify the architecture plan to integrate data management services to connect the many systems of care. Does this include parts of the MMIS, other State databases and any all-payer claims database? The SMHP describes several system interfaces but only shows one database in the MMIS. Are there other databases in other systems that will interface, such as the immunizations system?

**Enclosure C**

**General HIT IAPD Information**

All costs identified in this HIT IAPD are understood to be estimated costs only. Allowable costs relating to the Medicaid EHR Incentive Program are determined by CMS regulations and policy described in this HIT IAPD approval notice. Only actual costs incurred are reimbursable. The State must provide adequate support for all costs claimed in addition to providing detailed records and proper audit trails.

This approval does not include the projected provider incentive payments. Upon receipt of this HIT IAPD approval, please coordinate with the State's budget office to include the incentive payments on Form CMS-37, Medicaid Program Budget Report in the appropriate Administrative Section. The State will need to work with the CMS Regional Office Financial Management Group (FMG) staff to submit a supplemental CMS-37 that reflects this IAPD award. The State should be sure to update the 37.12 budget narrative to reflect their expected budgetary needs by quarter.

As required in regulations at 42 CFR 495.340, the State must submit a HIT IAPD update no later than 60 days after the occurrence of project changes including but not limited to any of the following: (1) a projected cost increase of \$100,000 or more; (2) a schedule extension of more than 60 days for major milestones; (3) a significant change in planning approach or implementation approach, or scope of activities beyond that approved in the HIT IAPD; (4) a change in implementation concept or a change to the scope of the project; or, (5) a change to the approved cost allocation methodology. As required in regulations at 42 CFR 495.342, the State must submit an annual HIT IAPD 60 days from the HIT IAPD approved anniversary date.