

Expanded Support for Medicaid Health Information Exchanges

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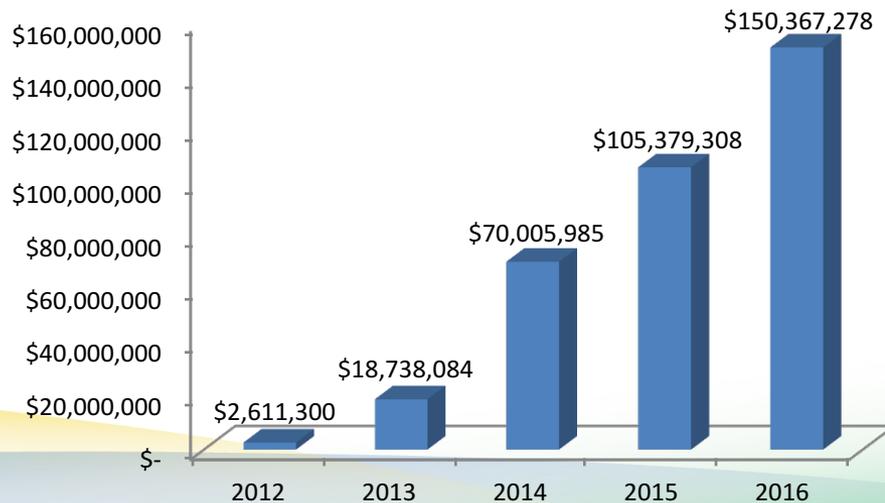


Agenda

- Background
- State Medicaid Director's Letter 16-003 of 2/29/2016
- How it works
- Possible Activities
 - Support for HIE Architecture
 - Support for HIE On-Boarding
- Interoperability Standards
- CMS Oversight
- Questions?

Background

- Since 2012, \$350 million has been approved by CMS for Medicaid HITECH support for HIEs supporting EPs and EHs under current guidance
- Potential \$45 million increase from 2015 to 2016, though not a yearly increase that is necessarily sustainable till 2021.



Background

- The guidance of how to allocate the matching funds for interoperability and Health Information Exchange (HIE) activities was based on the State Medicaid Director's letter of May 18, 2011*.
- Matching funds were limited to supporting HIE for Eligible Professional and Eligible Hospitals, that is, Eligible Providers (EPs) who were eligible for EHR incentive payments – a smaller subset of Medicaid providers that excluded post-acute care, substance abuse treatment providers, home health, behavioral health, etc.
- That guidance was issued when Meaningful Use Stage 1 was in effect. Meaningful Use Stage 2 and Stage 3, however, later broadened the requirements for the electronic exchange of health information

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

Bridging the Healthcare Digital Divide: Improving Connectivity Among Medicaid Providers

Connecting All Parts of the Health System

That's why today, we are announcing an initiative to bring interoperable technology to a broader universe of health care providers, including long-term care, behavioral health providers, substance abuse treatment centers, and other providers that have been slower to adopt technology. This announcement will help to bridge an information sharing gap in Medicaid by permitting states to request the 90 percent enhanced matching funds from CMS to connect a broader variety of Medicaid providers to a health information exchange than those providers who are eligible for such connections today. This additional funding will enhance the sustainability of health information exchanges and lead to increased connectivity among Medicaid providers.

Doctors and other clinicians need access to the right information at the right time in a manner they can use to make decisions that impact their patient's health. The free flow of information is hampered when not all doctors, facilities or other practice areas are able to make a complete circuit. Adding long-term care providers, behavioral health providers, and substance abuse treatment providers, for example, to statewide health information exchange systems will enable seamless sharing of a patients' health information between doctors or other clinicians when it's needed. This sharing helps create a more complete care team to collaborate on the best treatment plans and goals for Medicaid patients.

Andy Slavitt, Centers for Medicare & Medicaid Services (CMS) Acting Administrator,
Karen DeSalvo, National Coordinator for Health Information Technology (ONC) and Acting Assistant Secretary for Health

<https://blog.cms.gov/2016/03/02/bridging-the-healthcare-digital-divide-improving-connectivity-among-medicaid-providers/>

State Medicaid Directors Letter 16-003*

- The CMS Medicaid Data and Systems Group and ONC Office of Policy have partnered to update the guidance on how states may support health information exchange and interoperable systems to best support Medicaid providers in attesting to Meaningful Use Stages 2 and 3:
- This updated guidance will allow Medicaid HITECH funds to support all Medicaid providers that Eligible Providers want to coordinate care *with*.
- Medicaid HITECH funds can now support HIE onboarding and systems for behavioral health providers, long term care providers, substance abuse treatment providers, home health providers, correctional health providers, social workers, and so on.
- It may also support the HIE on-boarding of laboratory, pharmacy or public health providers.

*<https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16003.pdf>

State Medicaid Directors Letter

The basis for this update, per the HITECH statute, the 90/10 Federal State matching funding for State Medicaid Agencies may be used for:

*“pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information under this title, subject to applicable laws and regulations governing such exchange.”**

*<http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/hitechact.pdf>

How it works:

- This funding goes directly to the state Medicaid agency in the same way existing Medicaid HITECH administrative funds are distributed
 - State completes IAPD (Implementation Advanced Planning Document) to be reviewed by CMS
 - States complete Appendix D (HIE information) for IAPD as appropriate
- This funding is in place until 2021 and is a 90/10 Federal State match. The state is still responsible for providing the 10%.
- The funding is for HIE and interoperability **only**, not to provide EHRs.
- The funding is for implementation **only**, it is not for operational costs.
- The funding still must be cost allocated if other entities than the state Medicaid agency benefit
- **All providers or systems supported by this funding must connect to Medicaid EPs.**

Possible Activities



HIE Architecture

Several HIE modules and use cases are specifically called out for support:

Provider Directories: with an emphasis on dynamic provider directories that allow for bidirectional connections to public health and that might be web-based, allowing for easy use by other Medicaid providers with low EHR adoption rates

Secure Messaging: with an emphasis on partnering with DirectTrust

Encounter Alerting

Care Plan Exchange

Health Information Services Providers (HISP) Services

Query Exchange

Public Health Systems

Any requested system must support Meaningful Use for a Medicaid EP in some manner. So, for example, the content in the Alerting feed or Care Plan must potentially help an EP meet an MU measure.

HIE On-Boarding

State Medicaid Agencies may use this enhanced funding to on-board Medicaid providers who are not incentive-eligible, including public health providers, pharmacies and laboratories.

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

So, for example:

- Long term care providers may be on-boarded to a statewide provider directory
- Rehabilitation providers may be on-boarded to encounter alerting systems
- Pharmacies may be on-boarded to drug reconciliation systems
- Public health providers may be on-boarded to query exchanges
- EMS providers may be on-boarded to encounter alerting systems
- Medicaid social workers may be connected to care plan

Such on-boarding must connect the new Medicaid provider to an EP, and help that EP in meeting MU

Interoperability Standards

- Medicaid systems must adhere to Medicaid Information Technology Architecture (MITA)*, which requires adherence to seven conditions and standards:
 - Modularity Standards
 - MITA Condition
 - Industry Standards Condition
 - Leverage Conditions
 - Business Results Condition
 - Reporting Condition
 - Interoperability Condition

*<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-information-technology-architecture-mita.html>

Interoperability Standards

December 4, 2015, CMS Final Rule on, “Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems,” published describing “industry standards,” as aligned with ONC standards:

§433.112 FFP for design, development, installation or enhancement of mechanized processing and information retrieval systems.

* * * * *

(b) CMS will approve the E&E or claims system described in an APD if certain conditions are met. The conditions that a system must meet are:

* * * * *

(12) The agency ensures alignment with, and incorporation of, industry standards adopted by the Office of the National Coordinator for Health IT in accordance with 45 CFR part 170, subpart B: the HIPAA privacy, security and transaction standards; accessibility standards established under section 508 of the Rehabilitation Act, or standards that provide greater accessibility for individuals with disabilities, and compliance with Federal civil rights laws; standards adopted by the Secretary under section 1104 of the Affordable Care Act; and standards and protocols adopted by the Secretary under section 1561 of the Affordable Care Act.

Interoperability Standards

What's in 45 CFR Part 170?

- Transport standards (e.g. Direct)
- Functional standards (e.g. clinical decision support)
- Content exchange standards (e.g. CCDA)
- Implementation specifications for exchanging electronic health information
- Vocabulary standards for representing electronic health information

CMS Oversight

Cost allocation requirements from SMD 11-004* remain in place:

CMS will work with States on an individual basis to determine the most appropriate cost allocation methodology.

- HITECH cost allocation formulas should be based on the direct benefit to the Medicaid EHR incentive program, taking into account State projections of eligible Medicaid provider participation in the incentive program
- Cost allocation must account for other available Federal funding sources, the division of resources and activities across relevant payers, and the relative benefit to the State Medicaid program, among other factors
- Cost allocations should involve the timely and ensured financial participation of all parties so that Medicaid funds are neither the sole contributor at the onset nor the primary source of funding. Other payers who stand to benefit must contribute their share from the beginning. The absence of other payers is not sufficient cause for Medicaid to be the primary payer.

Sample Cost Allocation Plan

Federal/State Program	Medicaid Share (%/\$)	Federal Share (\$/%)	State Share (\$/%)	TBD Share (duplicate this column as many times as necessary) (\$/%)	Total Program Cost (\$)
Medicaid EHR Incentive Program					

CMS Oversight

- New funding must connect Medicaid providers to EPs and map to specific MU measures (to be described by the state)
- Implementation benchmarks to be defined by the state
- States should assume data will be requested regarding MU implications of new systems and newly on-boarded providers
- For new systems without defined data standards (Encounter Alerting, Care Plan Exchange), the systems must still support some MU measure to be defined by the state.

CMS Oversight

Existing guidance on other activities that can be supported remains in place:

- Personal Health Records
- System and resource costs associated with the collection and verification of meaningful use data from providers' EHRs
- System and resource costs to develop, capture, and audit provider attestations
- Evaluation of the EHR Incentive Program (Independent Verification (IV) & Validations (V) and program's impact on costs/quality outcomes)
- Data Analysis, Oversight/Auditing and Reporting on EHR Adoption and Meaningful Use
- Environmental Scans/Gap Analyses
- SMHP updates/reporting; IAPD updates
- Developing Data Sharing & Business Associate Agreements (legal support,
- Ongoing costs for Quality Assurance activities Multi-State Collaborative for Health IT annual dues Staff/contractual costs related to the development of State-Specific meaningful use and patient volume criteria Medicaid Staff Training/Prof. Development (consultants, registration fees, etc.)

Described at <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/smd10016.pdf>

CMS Oversight

(cont'd)

- System and resource costs associated with the National Level Repository (NLR) Interface
- System and resource costs associated with State interfaces of a Health Information Exchange (HIE)--(e.g., laboratories, immunization registries, public health databases, other HIEs, etc.)
- Creation or enhancement of a Data Warehouse/Repository (should be cost allocated)
- Development of a Master Patient Index (should be cost allocated)
- Communications/Materials Development about the EHR Incentive Program and/or EHR Adoption/meaningful use
- Provider Outreach Activities (workshops, webinars, meetings, presentations, etc).
- Provider Help-Line/Dedicated E-mail Address/Call Center (hardware, software, staffing)
- Web site for Provider Enrollment/FAQs
- Hosting Conferences/Convening Stakeholder Meetings
- Business Process Modeling

Questions

For states with questions:

- Email questions to: CMS.AllStates@briljent.com
- Contact your Regional CMS Medicaid HITECH lead for support or see www.medicaidhitechta.org
- ONC is a partner is supporting the HIEs as well thomas.novak@hhs.gov

