Expanded Support for Medicaid Health Information Exchanges

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Disclosures

Thomas Novak is an employee of the Office Of The National Coordinator For Health IT. The conflict of interest was resolved by peer review of the slide content. He declares no other conflicts of interest or financial interest in any product or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

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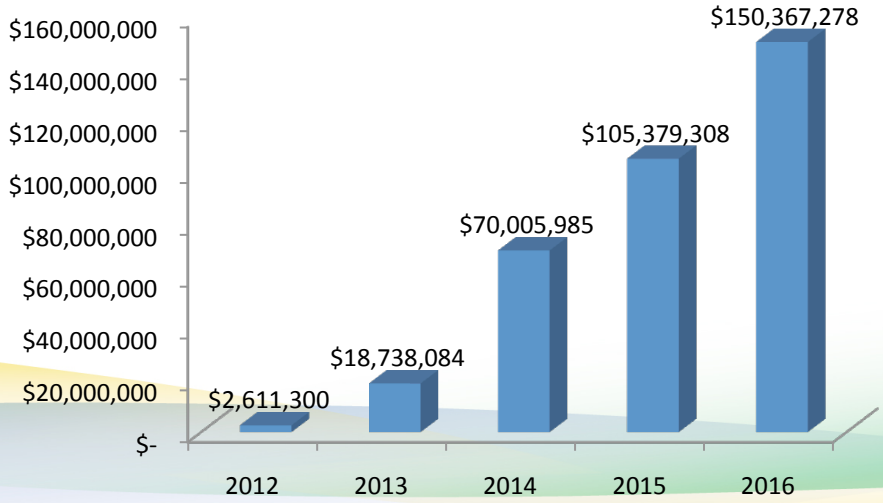
Learning Objectives

Following this presentation, attendees should be able to:

1. Describe the history of Medicaid's funding of health information exchange (HIE).
2. Describe the scope of the new funding.
3. State what kinds of HIE architecture can be supported.
4. Describe what the HIE on-boarding process involves.

Background

- Health Information Exchange support originally limited to smaller universe of providers per previous SMD letters
- 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 – which focused on adoption – 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 or EHs.**

Two Kinds of Work Supported

Health Information Exchange On-Boarding

- Adding new Medicaid provider types to HIEs: long term care, behavioral health, substance abuse treatment providers, labs, pharmacies, EMS, public health, home health, etc.
- Technical: Establish Secure Connections, Align Encryption Standards, Coordinate Certificate, Build Interfaces
- Administrative: Establish Consent Models, Business Associate Agreements, Contracts

Health Information Exchange Architecture

(not an exhaustive list)

- Provider Directories
- Secure Messaging
- Encounter Alerting
- Care Plan Exchange
- Query Exchange
- Health Information Service Providers (HISP)
- Public Health Systems

Any requested system or initiative must support a Meaningful Use objective for a Medicaid EP or EH.

CMS

EHR INCENTIVE PROGRAM

HIE On-Boarding

Workflow • Workflow • Workflow

- On-Boarding should begin with planning, workflow analysis, business process modeling to ensure HIE adoptions ***helps*** coordinate care in a manner helpful to providers (covered under SMD 10-016*)
- On-Boarding doesn't end with establishing the connection. Establish connection. Send test data. Send some production data. State establishes benchmarks for implementation. Be thorough and thoughtful.

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

* https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD10016.pdf

HIE Architecture Specifics

Provider Directories

- White pages connecting providers for sending structured data (summary of care, problem list, medication history, care plans) and other secure messages.

Build *really good* provider directories

- As long as system lets the EP or EH complete HIE objective, other Medicaid providers can access it however is best. Web-based providers directories for Medicaid providers without EHRs is ok. Or for Medicaid providers with lesser EHRs, options like FTP sweeps or flat file transfers ok, as long as MU objective met for EPs & EHs
- Establish bi-directional connections to public health as source of truth for licensure, sanctions, board certification, etc.

Provider Directories

- MMIS funding has always been available for Medicaid provider directories but MMIS funding limited states to supporting in-house provider directories. This new option allows for the inclusion of all Medicaid providers in a statewide HIE's provider directory, so long as such connections help Eligible Providers with Meaningful Use. ***Be Strategic***. MMIS has operational support at 75% that HITECH does not.

Secure Messaging

- Definition: ability to send and receive secure information electronically between care providers to support coordinate care. May also be used between patients and their providers. Sometimes called "point-to-point" exchange or "push" exchange
- Secure messaging may support the following MU measures:
  - Transitions of Care
  - View, Download or Transmit
- Direct: National standard for secure messaging
  - Role in CEHRT – Products are certified using Direct; required for Stage 2 but providers do not need to use Direct for Stage 3 MU
  - DirectTrust – A trust community that enables providers in one HISP to communicate with providers from another HISP without one-off data sharing agreements

Encounter Alerting

- Encounter alerting provides real-time electronic notification when patients are admitted to, discharged from, or transferred from a hospital using Admission, Discharge, and Transfer (ADT) messages
- Encounter alerting notifies primary care providers and care coordinators about health care encounters (e.g., ED visits, hospital admissions) and assists with follow up care coordination
- **Potential Meaningful Use Objectives** - Health Information Exchange Objective Measure 1

Care Plan Exchange

- Sending an electronic care plan between providers (physical and behavioral health, for example)
- MU alignment:
  - Summary of Care
  - Health Information Exchange
  - View, download, transmit

Care Plan Exchange

- A Care Plan (including Home Health Plan of Care (HHPoC)) is a consensus-driven dynamic plan that represents a patient's and Care Team Members' prioritized concerns, goals, and planned interventions. It serves as a blueprint shared by all Care Team Members (including the patient, their caregivers and providers), to guide the patient's care. A Care Plan integrates multiple interventions proposed by multiple providers and disciplines for multiple conditions.
- A Care Plan represents one or more Plan(s) of Care and serves to reconcile and resolve conflicts between the various Plans of Care developed for a specific patient by different providers. The Care Plan also serves to enable longitudinal coordination of care.
- 2015 Edition Certification Health IT Final Rule introduces new criterion for Care Plan 170.315 (b)(9)
  - New criterion requires a Health IT Module to enable a user to record, change, access create and receive care plan information in accordance with the HL7 C-CDA Release 2.1 Implementation Guide (Standard)

HISP Services

Health Information Service Providers are entities that provide secure messaging services, using Direct, to providers and consumers.

- **Value**: Think of a HISP as an e-mail service provider. You need them behind the scenes to make sure your messages are being sent and received properly and securely on your behalf.
- HISP Services are offered by EHR publishers, HIEs, for profit service providers, etc.
- They are usually offered as a paid subscription or by a per transaction rate.

HISP Services

- **Health Information Service Providers (HISPs)** serves as a health data intermediary providing the secure communication across organizations and providers
- Message senders can create a message in standardized message format and routing with secure transport protocols to the appropriate recipient.
- Message senders and recipients receive a unique email address used for HISP secure messaging and must be connected to a HISP or use technology with the same functions as a HISP
- States may need to review the HIE governance and policies to determine if non-covered entities can be HISP users
- **Meaningful Use Objective** – Health Information Exchange Measures 1, 2 and/or 3

Health Information Service Provider Examples	
• Regional Health Information Organization (RHIOs) services • State-level HIE	• Within Certified Electronic Health Record Technology (CEHRT) • Network of networks

Query Exchange

- Query exchange – used by providers to search and discover accessible clinical data on a patient. This type of exchange is often used when delivering unplanned care.
- Can support MU "Transitions of Care" measure (by meeting other technical requirements and assuming numerators and denominators can be measured by providers)
- Requires trust relationships to be established between participants before data may be exchanged. Governance organizations, often called Health Information Organizations (HIOs), provides the trust relationships (provides policy, agreements, technical security infrastructure, etc.)

Public Health Systems

The public health systems that support Eligible Providers in achieving Meaningful Use may now be supported:

- Immunization Registries
- Syndromic Surveillance Registries
- Specialty Registries
  - Prescription Drug Monitoring Programs (non-MMIS)
  - Other diseases/conditions that are state priorities (homelessness, lead exposure, etc.)
- Architecture for the registries can now be supported, not just connections

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.

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					

*https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/medicaid_hit_iapd_template.pdf

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.

What states are already building?

Under Review:

- Create a specialized public health registry that goes beyond typical registry functions and includes social determinants of health; such as housing status, risk stratification, and information on a patient's attributed entities such as home care providers or relationships with managed care organizations.
- Create an obstetrics and prenatal registry to meet requirements around assessments and reporting, and more importantly, bring data around infant mortality and low birth weight into the hands of researchers and officials to better inform new policies.
- Connect ambulatory providers, with an emphasis on connections between Federally Qualified Health Centers and behavioral health providers. This missing connection to the previous interoperable landscape now will drive better coordination of care among Medicaid recipients.

Colorado:

- On-board behavioral health providers onto the state Health Information Exchange.
- Create an advanced directive registry to ensure that end of life decisions are respected and adhered to in a manner compliant with all state and federal laws.
- Create a registry of the costly and complex super-utilizers. This approach allows for aggressive case management for those suffering from multiple chronic conditions.

What states are already building (continued)

Puerto Rico:

- Create a Zika registry as a specialized public health registry. This model of registry needs to support linkages to electronic lab results with results pushed to ordering clinician. Also, longitudinal tracking of pregnancy is appropriate and most existing registries do not have such functionality. This effort is being done as a model for other states with potential high exposure to Zika.
- On-boarding of labs to the health information exchange. In many states there are a limited number of labs processing Zika tests. The two labs in Puerto Rico that process these tests were previously not connected to the health information exchange and are now to be connected.
- On-boarding of providers to the Zika registry. The state is to provide very aggressive workflow analysis and business process modeling as the process for testing, tracking samples, and receiving notifications of results is incorporated into the on-boarding process, as well as the establishment of the technical connections.

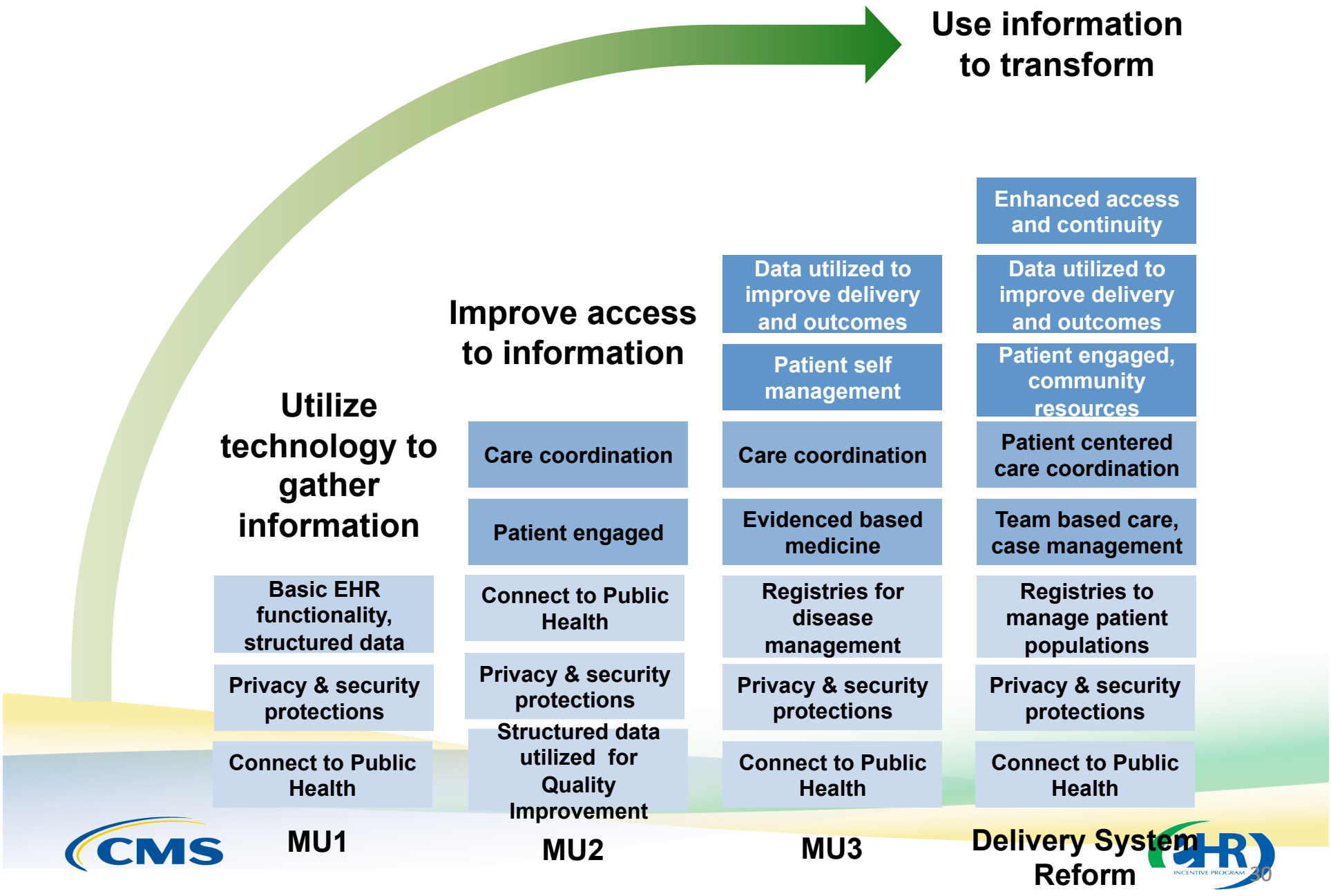
Other state under review:

- Encounter Notification Services: Building statewide architecture alerting hospitals whenever a patient is admitted, discharged or transferred to better coordinate population health and case management.
- Statewide image exchange in efforts to reduce unnecessary tests and limit unnecessary cumulative radiation exposure. Cloud based technology allows for better management and transfer of large image files.
- CQM collection. Leveraging existing open-source technology to align and standardize quality indicators received by vendors of electronic health systems and aggregated in the health information exchange.

Room for Innovation

- Care Plans can (and do, under HRSA), have fields for screening for food insecurity, housing, legal assistance. CEHRT asks for care team. Summary of Care includes care team.
- “Medicaid Providers” to be on-boarded might include social workers, home health aides, Adult Authorities on Ageing (AAAs), EMS providers, correctional health providers, non-acute care hospitals, even caregivers in some states. If connecting them helps eligible providers coordinate care for MU, we can support.
- Specialty Registries in MU2 are intentionally broad by definition. States are looking at Zika registries, lead registries, advanced directive registries, pre-natal registries, LTSS assessment registries, school-based healthcare registries, HIV registries, Hepatitis registries, and so on.

Foundation for Delivery System Reform



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