Expanded Support for Medicaid Health Information Exchanges

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ONC-SIM Resource Center Learning Event Open to All States

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Agenda

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- Possible Activities
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- HIE Architecture Specifics
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- How to Incorporate into State Planning
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Learning Objectives

- To communicate the implications of State Medicaid Director Letter 16-003 and its impact on interoperability and Health Information Exchange
- To educate on the current and ongoing oversight activities for the HITECH 90/10 funding
- To have a dialogue on the implications of this updated guidance and to provide further policy clarifications as needed

Background

- CMS investments in Medicaid HIE demonstrably (and with statistical significance):
  - Over $200 million to date
  - Reduce the number of EPs who take Meaningful Use exemptions
  - Increase the number of EPs who report with no exemptions

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

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

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.

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. 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

HIE Architecture Specifics

Provider Directories

- **Definition** – A system that supports management of healthcare provider information, both individual and organizational (Source: IHE).
  - Information about the provider**:** Can include demographics, physical addresses, credential and specialty information, and electronic endpoints to facilitate trusted communications with a provider.
  - Information about the provider's relationships:
    - Affiliation with other organizations and providers.
    - Health Information Exchange (HIE) and members
    - Integrated Delivery Networks and care delivery members.
    - Hospitals, their practitioners, and their sub-organizations.

Provider Directories

- Enable HIE
- MMIS funding has always been available for Medicaid provider directories but the directory only supports Medicaid in most instances
- This new option would allow for the inclusion of non-eligible providers in a statewide HIE's provider directory, funded in part by Medicaid with HITECH funds

Provider Directories

- **Scenario 1: Health Information Exchange.**
  - A provider is preparing to transition their patient to a long-term care facility and uses a provider directory to look up the electronic endpoint (e.g., Direct Address or query endpoint) for where to send the summary of care record.

- **Scenario 2: Electronic Prescribing.**
  - A hospital is about to generate and transmit a discharge prescription electronically, and it uses a provider directory to look up the pharmacy to which it will send the prescription.

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)

Care Plan Exchange

Scenario 1: Unidirectional Exchange of a Care Plan during a complete handoff of care form the sending Care Team (e.g. Hospital setting) to a receiving Care Team (e.g. Home Health Agency and PCP)

Scenario 2: Exchanging a Care Plan between Care Team Members and a Patient

- Setting 1: Hospital or ED where Patient is discharged from sends Care Plan to Care Team in non-acute care setting
- Setting 2: Care Team including Patient in Acute Care Setting creates harmonized Care Plan for exchange with a second Care Team in a non-acute care setting
- Setting 3: Patient receives Care Plan in their personal health record application or patient system.

Care Plan in Stage 3

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

HISP Services

- Definition: 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.

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 supports 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 major distinction from previous permitted funding options, is that Medicaid HITECH funds can be used for more than interfaces for EPs- now it can be used for the Public Health infrastructure more broadly to allow EPs to meet 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

Financial Impact

- 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.

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

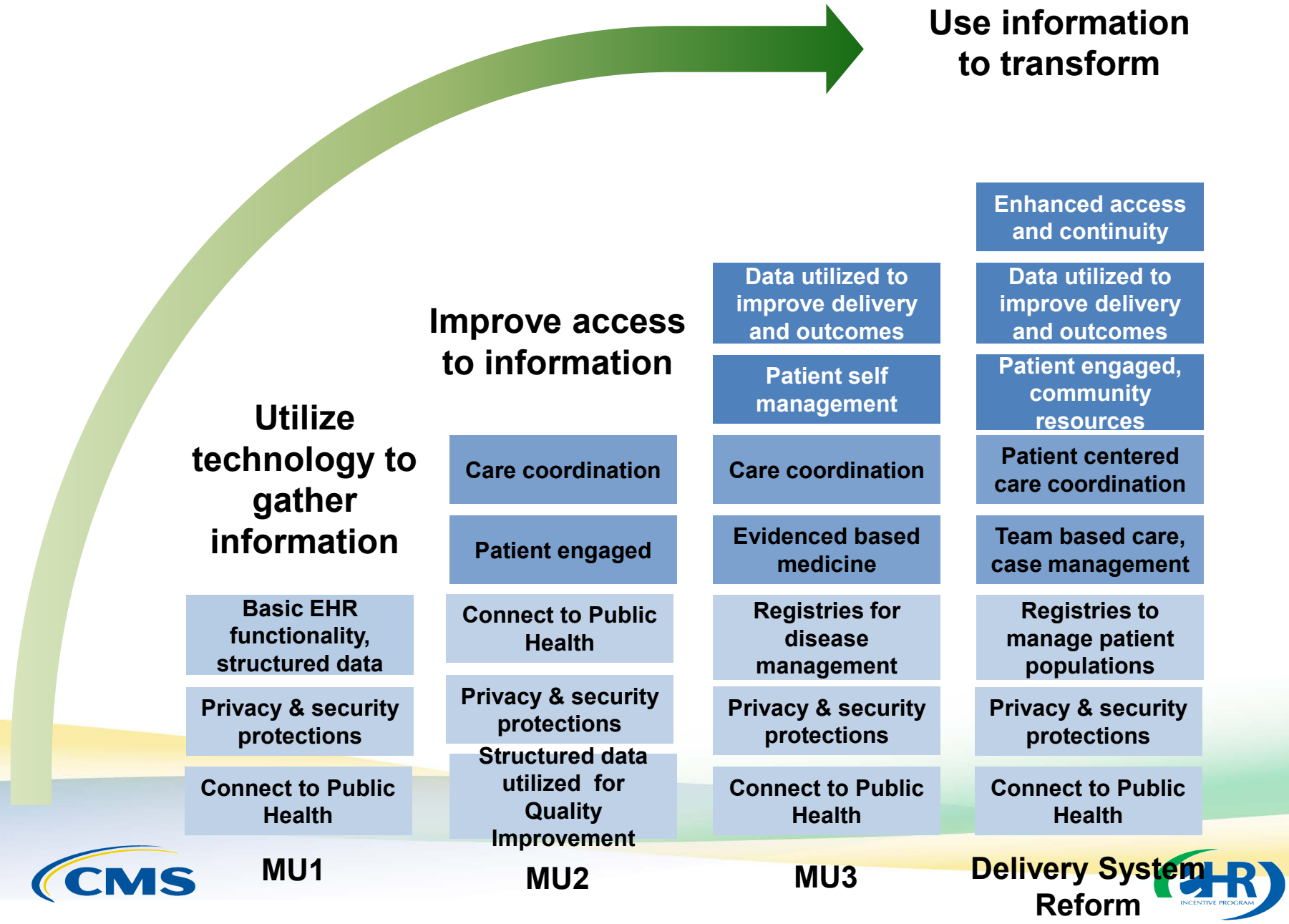
Federal/State Program	**Medicaid Share (%/$)**	**Federal Share ($/%)**	**State Share ($/%)**	**TBD Share (duplicate this column as many times as necessary) ($/%)**	**Total Program Cost ($)**
Medicaid EHR Incentive Program					

*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.

Foundation for Delivery System Reform



How to Incorporate into State Planning

State Medicaid Health IT Plan (SMHP), SIM, and Related Resources

What is an SMHP?

- SMHP supports MMIS and HITECH/HIE IAPD funding requests.

SMHP: Where are we?

- Almost half way through the program
- Most states have done a good job of keeping their SMHP's up to date
- Significant changes in HIT across the nation
- 2016- Last year for providers to start in the program

Five sections of the SMHP

- As-Is
- To Be
- Oversight of EHR Incentive Program
- Audit Strategy
- HIT Roadmap

SMHP: As-Is

- New Environmental Scan to look at data less than 1 year old
- Outline the current landscape, including updated participation status
- Grant updates
- SMA's use As-Is to help with strategic planning enterprise wide

SMHP: To-Be

- Broader perspective (i.e. Medicaid Program Management, State Population Health Management)
- Align goals with HIE goals
- SLR goals beyond incentive program
- SMA goals and what is needed to reach those goals

SMHP: Oversight of the EHR Incentive Payment Program

- Broader perspective (i.e. Medicaid Program Management, State Population Health Management)
- What has changed since initial roll-out?
- Lessons Learned and incorporating change
- Interoperability between HITECH and T-MSIS; Medicaid and CHIP, and the NLR

SMHP: Audit Strategy Section

- Identify how lessons learned about audit findings are being incorporated into the process
- Have processes changed?
- What are the current processes?

SMHP: HIT Roadmap

- Updated narrative pathway showing As Is and To Be to fulfill the agency's mission
- Align benchmarks with HIE IAPD
- What is the process to determine how many expected vs participated and how many dropped off?
- Roadmaps and various phases of HITECH implementation to be reached with milestones and forecasted dates on when the milestones will be met

Alignment with SIM Planning

- SIM team should be aware of SMHP content and requirement for new environmental scan.
  - IAPDs frequently include initiatives that address HIT infrastructure to support SIM initiatives.
- Environmental scan can be used for support both Medicaid and SIM HIT planning, particularly related to HIT.
- SMHP should include SIM-related HIT content and activities, including alignment and leveraging MMIS and HITECH/HIE.
- SIM initiatives can also inform the SMHP and IAPD processes to make sure that timing and alignment of efforts are compatible

Communication and collaboration are key!

Other Planning

- SIM HIT Plans should be considered active rather than static documents ***and as a critical part of the overall SIM Operational Plan.***
- SIM HIT plans should address timing and alignment with SMHPs and IAPDs.
- State HIE planning, whether addressed through SIM, through Medicaid HITECH staff, or through other governance approaches, should also be informed by all of the activities mentioned here.
- ***SIM planning external stakeholder engagement should be aligned with and leveraged for SMHP updating and SMHP updating should be aligned with and leveraged for SIM planning.***

Key Planning Takeaways

1. You need to do an update to your SMHP this year.
2. SMHP updates include environmental scans, which is an opportunity to investigate the expanded care areas (LTSSS and BH) that states generally did not focus on in their initial scans.
3. The SIM Operational Plan for HIT and the Medicaid SMHP need to align and be cross-leveraged as Medicaid is a core piece of all state SIM plans.
4. States can use 90/10 to do the environmental scan.

Questions

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For states with questions:

- Contact your Regional CMS Medicaid HITECH lead for support or www.medicaidhitechta.org
- ONC is a partner is supporting the HIEs as well