

CHCS Webinar HIT Provisions of the Stimulus Package: Opportunities for Medicaid

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Responses to Unanswered Questions

Answers were provided by the webinar's three presenters:

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Notes:

- The following answers have been assembled by our expert panel based on their resources and expertise. New decisions and analyses are being made by the federal government rapidly, affecting these answers over time. Current information on HIT opportunities of the American Recovery and Reinvestment Act (ARRA) can be found at: <http://www.hhs.gov/recovery/index.html>.
- Where more than one answer to a question appears, responders are identified.

Questions and Answers¹

Funding Determination and Administration

1. *What is the breakdown of Medicare vs. Medicaid funding?*

A: The ultimate breakdown of Medicare vs. Medicaid funding will be based on the number of providers that apply and qualify for the incentives. The Congressional Budget Office's (CBO) latest estimates indicate \$23.9 billion for Medicare provider incentives and \$12.7 billion for Medicaid provider incentives. We anticipate that Medicare dollars for eligible professionals will be greater than Medicaid dollars, given the ARRA threshold requirements for Medicaid, yielding a smaller pool of eligible providers (both individuals and institutions):

- 30% of patient volumes are receiving Medicaid assistance;
- 20% of patient volumes are receiving Medicaid assistance for pediatricians; and
- 10% of patient volumes are receiving Medicaid assistance for children's hospitals and acute-care hospitals.

2. *I have heard different total HIT incentive dollar amounts: \$20 billion vs. \$34 billion. Can you explain what is included in these different estimates?*

A: The variance in funding characterizations made at the time of the webinar is tied to the CBO scoring for the Medicare and Medicaid incentives in the ARRA (see endnote). The

¹ See CHCS Terms of Use, http://www.chcs.org/info-url3959/info-url_show.htm?doc_id=363119.

breakdown of outlays can be found in both House and Senate cost estimates for the conference agreement Title IV Health Information Technology under division B (i.e., direct spending for mandatory programs distinct from discretionary spending shows estimated outlays from 2009 through 2019) and in the updated CBO estimate referenced above. These estimates likely include the administrative funding allowances along with the actual incentive payments. They also include the disincentives that start in 2016.

As currently estimated, the positive funding for providers (i.e., costs to Centers for Medicare and Medicaid Services (CMS)) includes \$36.6 billion in outlays, and savings totaling \$17.1 billion, which reduces the expenditure to \$19.5 billion, close to the often-referenced \$20 billion.¹

3. *Will state Medicaid programs be required to administer the Medicaid incentives for providers?*

A: For states that choose to accept the funding, it should be noted that the ARRA amends the provisions of the Social Security Act that set out Medicaid payments to states, most notably the federal matching rates. These payments are all contingent on an approved state plan. This likely must be amended to provide necessary assurances to the Secretary/CMS that payments will meet program requirements – such as assuring that payments are made to eligible providers, that recipients are meaningful users when applicable, and that providers are responsible for the remaining payment.

Nothing in the provisions indicates that the program is mandatory, and there are several circumstances under which a state might not offer it. This could happen, for example, if a state:

- Determines that it does not want to offer the incentive program;
- Decides that it does not have the resources to administer the program;
- Does not amend its plan; or
- Does not provide adequate assurances to Health and Human Services (HHS) and CMS.

As a practical matter, most states likely will pursue the funding unless they determine they have very few eligible Medicaid physicians, or that CMS' administrative and audit requirements are too onerous. In more rural states, it is unclear whether many physicians will qualify for the Medicaid percentage patient threshold, as the population is not as concentrated as in urban areas.

Since the incentives are not available until 2011, CMS likely will issue guidance on how states must amend their plans and provide required assurances for administering the incentives.

4. *Why are the incentives for pediatrics only 2/3? Don't pediatricians above the 30% threshold have access to the full grant funding?*

A: Although there is not a stated explanation for the 2/3 incentive, it is likely based on the lower qualification threshold for pediatricians of 20% of their patient volumes (which is 2/3 of the 30% threshold for other eligible professionals). If this were the rationale, then one might

hope that meeting the 30% threshold would yield a higher payment; however, nothing in the statute explicitly addresses this.

5. *Are the tribes eligible for broadband funding?*

A: Yes. Section 6001 (e) states that “eligible applicants shall – (1)(A) be a state or political subdivision thereof ...an Indian tribe (as defined in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C.450(b)) of native Hawaiian organization.”ⁱⁱ

6. *Isn't it true that states can receive a 100% Federal Medical Assistance Percentage (FMAP) for the HIT incentives and 90% for the administration of the incentive dollars?*

A: Yes. Section 4201 (a)(1) F (i and ii) indicates a 100% match for the incentive payments and 90% for reasonable administrative expenses, as long as the state is meeting the conditions in subsection (t)(9).ⁱⁱⁱ

7. *Are there funds available in ARRA for state Medicaid agencies to upgrade their MMIS (Medicaid Management Information System) /IT infrastructure?*

A: Funds are not explicitly available for upgrading the MMIS/IT infrastructure. However, existing resources for design and implementation already provide a 90% match rate, and some states are considering how MMIS and Medicaid Information Technology Architecture (MITA) can help support a sustainable infrastructure for health information exchange (HIE, the target of one of the three HIT promotion grants in the Health Information Technology for Economic and Clinical Health (HITECH) Act).

8. *What can Medicaid programs do right now in the absence of specific guidance on Medicaid from the federal government?*

A: Each state will be responsible for creating a statewide HIT roadmap and developing its Medicaid incentive program. Even without federal guidance, states should be encouraging electronic health record (EHR) adoption, and conducting an environmental assessment of hospital and provider readiness to adopt and meaningfully use EHRs. States that are proactive will be in the best position to apply for grants and establish and implement their Medicaid incentive programs to drive early adoption. State Medicaid programs can also apply for MMIS funds to design and develop HIE interfaces for sharing administrative data.

9. *How do Medicaid providers get initial EHR purchasing funding through the incentive program?*

A: None of the specific processes for applying for these incentives have been determined. The Medicaid provider must pay 15% of the net average allowable costs (to be determined by the Secretary) and must demonstrate for first-year payments...“that it is engaged in efforts to adopt, implement, or upgrade certified EHR technology.”

In addition, there will be a methodology, to be established by the Secretary, by which providers will need to demonstrate that they qualify for Medicaid incentives (i.e., that they meet the patient population thresholds and have waived their right to the Medicare incentives).

This is an area of policy and process development that providers will be watching closely and will likely have a chance to inform.

10. *Our state has a Regional Health Information Organization (RHIO) — public/private group — in the beginning stages. Can ARRA funding go directly to the group as a state-designated entity for any HIE grant?*

A: If your RHIO meets the criteria set out in the HITECH Act for state grants to promote HIT (Section 3013(f)) and is a state-designated entity, it can apply directly for ARRA funding. Alternatively, some RHIOs may have the resources and structure to apply for grants to become regional extension centers. This application would not require a state designation.

11. *What opportunities exist for multi-state collaborative (e.g., groupings of federally qualified health centers that cross boundaries, or individual agencies that cross multiple states) purchases of HIT? Would this require multiple state agreements?*

A: There is no direct reference to collaborative or group purchasing. Nothing would support or prohibit the effort, and it could make EHRs more affordable, reducing the 15% component for providers able to purchase through a collaborative. There may be some state marketing or acquisition laws to navigate, but such purchasing collaboratives already exist through certain provider associations, so they should be navigable.

12. *Under the HITECH Act, what will occur with the existing e-prescribing incentives under Medicare?*

A: Although we did not find a clear reference to the eRx incentives from the Medicare Improvement for Patients and Providers Act (MIPPA), several leading industry groups, including the Certification Commission for Healthcare Information Technology (CCHIT), indicated that Medicare providers cannot receive both incentives in the same year. The eRx payments are slated for five years (from 2009-2013), with disincentives starting in 2012. Since the certified EHR technology reference in the ARRA Medicare and Medicaid incentives requires eRx, physicians implementing EHR this year or next year could be eligible for eRx incentives prior to the EHR incentives. All eligible Medicare physicians *not* using eRx in 2012 will be subject to the disincentives.

13. *If a state is already in the process of allocating dollars to EHRs, is it less eligible for these funds?*

A: Since many of the grant programs have matching requirements, states already allocating dollars may very well be in a *better* position to receive funds, assuming they are able to maintain some continued investment. Given that the two main grants intended for states (HIE and

revolving loan funds) also require a level of planning, these states will be helped by the time and thought in which they likely have already invested.

14. *Do the Medicare/Medicaid incentives apply to health centers that have already implemented electronic health records (pre-ARRA)?*

A: The incentives will support all eligible providers regardless of whether they already have adopted EHRs or they begin during the eligible time periods. All providers will be required to meet the meaningful use criteria, which could require health centers to upgrade their systems or expand the ways in which they use EHRs.

15. *Can states construct purchasing alliance strategies with HIT vendors, providing steerage or “recommended” vendors to be given more favorable funding? The interoperability problems of HIT may be further complicated without some vetting processes.*

A: It is unlikely that states could give more favorable funding to certain vendors other than all those that meet the certification requirements under meaningful use. Nothing would stop a state from vetting EHR vendors and establishing purchasing alliances or strategies that might make certain vendor solutions more affordable, but they could not require purchase of such solutions as a criterion for the ARRA incentives. Federal and state policies usually avoid unnecessary constraint or intervention in competitive markets. The certification requirements for the EHRs are intended to promote interoperability.

16. *What are the HIT opportunities for Medicaid HCBS Waiver providers?*

A: Those who qualify as providers under the ARRA and who are being paid pursuant to funding under an HCBS waiver would not be treated any differently than other eligible providers. If they do not meet the ARRA definition of providers, then they probably would not be eligible.

17. *What would you tell small physician practices trying to access these funds?*

A: (Tony Rodgers) First, they should consider their readiness to adopt a certified EHR. If they are already using a certified EHR, then they are well positioned to qualify for either the Medicaid or Medicare incentive program. For other practices, the state can apply for grants to provide technical support and assistance for EHR installation and implementation. Small practices should contact their governor's office or state Medicaid agency to learn about state plans for such technical assistance, as well as incentives and grants. They also should find out who will be leading their state's HIT efforts. States are strongly encouraged to include a broad stakeholder base – including small practices – in developing and implementing their statewide HIT strategic plans, creating their Medicaid provider incentive programs, and driving EHR adoption. If states are not engaging small practices via survey, assessments, and/or policy dialogue, practices should encourage them to do so.

A: (Richard Baron) Small physician practices need to wait until it is clearer how the funds are flowing. They should understand, though, that the funds will pay only for “meaningful use.” That means they should get started now with EHR adoption, because if they have not comprehensively adopted, they will not be eligible for the funds.

18. *Shannah pointed out that practitioners cannot receive incentive payments from both Medicaid and Medicare. Is this also true for hospitals?*

A: It appears that hospitals can receive incentives under both incentive programs because the computation of the Medicaid share stipulates that patients cannot be double-counted (presumably dual eligibles in the numerator to determine the Medicaid share).

19. *Are government agencies treated as not-for-profit and eligible for these incentives?*

A: Governmental entities are not treated as not-for-profit, but some of the stimulus dollars – the HIE funds and the revolving loan funds – are directed to government agencies.

Use of Funds

20. *How can the Medicaid incentives be used for initial purchases — if one has to prove they are meaningful users?*

A: Meaningful use does not apply in the first year of incentive payments if “...the Medicaid provider demonstrates that it is engaged in efforts to adopt, implement or upgrade certified EHR technology.” (4201(a)(6)(C)(i)(I))

21. *What do you believe is the impact on MMIS development? How do we use these opportunities to transform MMIS legacy systems and mindsets?*

A: (Shannah Koss) Insofar as MMIS systems are evolving to support more than bill payment, increased adoption of EHRs and enhanced automated HIE should support improved care management and oversight. Increased interoperability should also facilitate information exchange with providers to offer new channels for communication and administrative and clinical support. Although the ARRA did not add funding for MMIS systems, these systems could play an important role in helping to advance HIE and support meaningful use.

A: (Tony Rodgers) At a minimum, the state's MMIS architecture and system environment will need to accommodate exchange of administrative and eligibility data. In some cases, state Medicaid agencies will choose to build onto their MMIS an EHR or continuity of care record system for Medicaid providers to access and use. States would be well served to follow the MITA framework, data architecture principles, and planning process guidelines to integrate EHR technologies and clinical databases into their MMIS environment.

However, I expect most states will focus on creating interfaces with EHR systems, rather than developing their own EHRs. States that choose to support MMIS to EHRs interfaces will need to meet federal data exchange and security standards. If the Medicaid agency chooses to store and distribute its own electronic continuity of care document/record information, it will need to ensure that it meets federal data standards definitions, and exchange standards.

The availability of future Medicaid funding for operations and management is one reason state Medicaid programs may choose to build EHR functionality into their MMIS environment. That said, states will need to move to a true service-oriented architecture and be capable of managing system processes that are internet-based rather than mainframe-based. This will require a whole new way of strategically planning Medicaid HIT in the future.

22. *From the perspective of a Medicaid health plan, what is the most significant opportunity in ARRA related to HIT/EHR?*

A: (Shannah Koss) Although dollars won't go directly to health plans, they stand to benefit enormously from improved quality, efficiency and population-based health data. More timely information and improved care coordination offer cost savings around managing hospital discharge and readmission, and better managing chronic care services. Plans can help states and providers prepare for the adoption and incentives, particularly in determining Medicaid patient case load.

A: (Tony Rodgers) A smart state Medicaid program will include its MCOs in strategic HIT planning, and explore opportunities to collaborate with the MCOs on grants and Medicaid incentive program implementation.

Medicaid health plans can participate in and reap the benefits of HIT/EMR in three primary ways. First, they can be a data partner with the state. Interfacing MCO medical management (prior authorization, clinical alerts, and critical path guideline and protocols) and case management systems with EHR can significantly reduce administrative overhead and help providers meet MCO quality standards. EHRs offer MCOs near real-time quality data reporting, medical record review and online provider messaging. Second, MCOs can directly use EHRs to support their disease management, chronic care management and case management programs. Third, MCOs can identify providers who qualify for Medicaid incentives, or who could benefit from assistance in adopting EHRs.

In the long run, widespread adoption of EHRs by Medicaid providers will open the door for MCOs to deliver value-added web services to providers and members, and even create virtual medical homes for their members.

Meaningful Use

23. *When and where are the hearings on meaningful use?*

A: Initial National Committee on Vital and Health Statistics (NCVHS) hearings occurred on April 28 and 29; public submission of written testimony was due April 30. NCVHS is a federal advisory committee statutorily established to advise the Secretary of HHS; it will do based on the hearings. In the meantime, CMS staff are likely developing criteria or gathering additional information on how to develop criteria. Given the significance of this qualifying aspect, there likely will be more opportunities for public input.

24. *Why are there different criteria or a phased implementation for Medicaid “meaningful use”?*

A: There are several reasons for this. For providers who receive incentive payment for initial adoption in the first year, the timing of the installation could create a very steep learning curve in year two that will make meeting all aspects of meaningful use challenging. The three components of meaningful use – certified EHR technology, information exchange, and reporting measures (as presented on slide 6 of Shannah Koss’s presentation) – are intended to foster the use of EHRs in support of improved health care. Which health care improvement goal is the focus of meaningful use could, and perhaps should, vary for Medicaid providers given distinct health reform priorities across state Medicaid programs. Finally, given some of the added burdens of the safety net providers, which Medicaid disproportionately supports, phased adherence to meaningful use criteria may also be warranted.

25. *Understanding that Medicaid providers may experience more challenges integrating electronic systems into their practices, wouldn’t it further reinforce existing disparities in care to institute differential requirements for their demonstration of meaningful use?*

A: There is a risk that existing disparities could persist a bit longer, but unrealistic expectations of what can be accomplished in a given timeframe could foster sustained barriers if providers opt out. In addition, different does not have to be less. It arguably would be in all providers’ interests, and likely to advance adoption and meaningful use more readily, if there were some flexibility in the aspects of meaningful use applied over time.

For instance, the HIE aspect of meaningful use is often outside of any individual provider’s realm of control (i.e., infrastructure may or may not exist to support needed connectivity to core components of the care continuum, and HIE participation across providers likely will vary). Acknowledging this as part of the criteria and evolving the applicability of the criteria could foster evolving and enhanced use. This could entail connectivity to pharmacies and labs, followed by hospitals (large then small), followed by specialists (at least for primary care).

Behavioral Health

26. *Is any of this money designated for individuals with mental illness?*

A: Specific patient populations are not the target of the funding, but mental health providers serving them can be eligible.

27. *How can community-based behavioral health agencies take advantage of HIT offerings?*

A: If agencies have qualifying professionals, those providers may take advantage of the provider incentives. A broader issue is how behavioral health agencies can leverage the emergence of a more robust HIT infrastructure, and encourage providers to take advantage of the incentives and become meaningful users of EHRs.

Behavioral health agencies should inform the HIT adoption plan and speak to the information and connectivity needs of their provider communities.

28. *Will community mental health centers and outpatient behavioral health clinics qualify for the EHR incentive program?*

A: The incentives target individual providers and hospitals and, as such, eligible professionals within all types of centers and clinics can qualify. Funding and assistance from the regional extension centers and the revolving loan funds could also support these organizations.

29. *Can state-operated psychiatric hospitals be eligible for EHR grants?*

A: Psychiatric hospitals are part of the definition of “eligible hospitals” under the Medicare incentives section. There is no distinction between public and private hospitals in either the ARRA or the referenced definition of eligible hospitals. The Medicaid incentives apply to children’s hospitals and acute-care hospitals, with no direct reference to psychiatric hospitals. If a state-run psychiatric hospital meets the definition of these hospitals, it would be eligible.

Other

30. *Who establishes the HIT regional extension centers? Are they set up by the state, the feds or a private entity (e.g., non-governmental organization)?*

A: HHS will establish the application requirements and process for those eligible and, likely through a standard grant approval process, will select grant awardees. The statutory characterization of the centers states: “Regional centers shall be affiliates with any United States-based non profit institution or organization, or group thereof, that applies and is awarded financial assistance under this section.” Awards will be based on merit.

Given the aggressive statutory deadline of May 18 for HHS notice describing the program and criteria for determining qualified applicants, guidance is likely in late spring or early summer.

31. *What are your thoughts on balancing protected health information (PHI)/patient privacy/permission issues with the desire to share as much information as possible with providers?*

A: (Shannah Koss) Privacy and security are critical issues that have been at the forefront of HIT since the Clinton health reform discussions. The passage of HIPAA and the added privacy and security protection in the ARRA establish a comprehensive framework for supporting needed protection. The key to how this is implemented and to our ability to improve both individual care and population health is in the ability to readily share needed information with appropriate protections.

There is no simple answer. The ARRA added a new layer of requirements that could be more burdensome than helpful, but also calls on the Secretary of HHS to examine what minimum necessary exchanges will truly support health care improvement and coordination. This is the right question to be asking, although perhaps too soon to answer. It is also the hope that with stepped-up enforcement, individuals and organizations responsible for protecting PHI will be more vigilant.

A: (Tony Rodgers) The federal government is responsible for setting the framework and standards for the exchange and use of PHI in EHR. Medicaid agencies have significant authority to facilitate or allow the exchange of health information among providers. Even so, it is important that the Medicaid agency ensures that HIE between EHRs and the ultimate use of electronic health information meets both federal and state standards. There are new HIPAA notification requirements and penalties for breach of personal health information.

Electronic patient consent software applications can be built into the exchange process, leading to HIE audit trails documenting with whom and when data was shared. Medicaid programs should make sure that these security and privacy software applications are engineered into the HIEs.

32. *How do you expect the HIE initiatives to sustain funding beyond the initial start-up costs, i.e. will the providers and physicians who are contributing and sharing data also be asked to pay for the costs of sustaining the HIEs?*

A: As discussed during the webinar, most HIEs are grappling with this very question, with several different models of sustainable funding emerging. Some of these have all beneficiaries contribute to sustainability, but want the contribution to be commensurate with the benefits (in this case, what the providers receive in terms of efficiency and increased revenue). As we move up the adoption curve and providers see increased benefits, they likely will be asked to support the ongoing funding. Health plans are generally viewed as the primary beneficiaries of anticipated cost savings, and thus often viewed as the larger bearers of HIE costs. Finally, some

states are looking very closely at how the 90% and 75% FMAP for MMIS could serve as a sustainable funding resource for state HIEs.

33. *Is there any sense that there will be additional federal appropriations to support HIT, beyond the ARRA funds?*

A: Yes, it is highly probable that there will be more funds. The health reform discussions continue to position HIT as part of the solution. The amount of federal funding for HIE infrastructure is still viewed as nominal, particularly given the public good nature of the infrastructure.

34. *If the stimulus package opportunities are voluntary and the state does not need to participate, what is the best way to stay updated on the direction a state is heading?*

A: (Shannah Koss) How to best stay informed will vary from state to state, but encouraging CMS to keep providers informed about the status of state activities is an avenue to pursue.

A: (Tony Rodgers) The best way is to identify who the state has designated to lead the HIT effort – this can be an individual, a state agency, or a public/private, non-profit organization. A state medical society or hospital association would also be a good resource for information.

It should be noted that Medicaid participation in the Medicaid provider incentive program is 100% federally funded, suggesting there is no financial reason why a state's Medicaid program would not want to participate.

35. *Must applications for provisions of the stimulus package be sent to the state for federal dollars?*

A: They must only for state-administered programs, specifically the Medicaid incentives and the revolving loan fund for certified EHR technology.

36. *Should leadership in creating changes in reimbursement policies happen at the state level, the federal level, or both?*

A: (Shannah Koss) It has and will continue to happen at both the federal and state levels. States arguably were the leaders and the laboratories for health reform prior to the recession. Some states feel the feds need to show leadership for more comprehensive reform, or at least eliminate some of the barriers to state reform efforts. Ideally, there should be a “meeting of the minds” on the fundamental reimbursement goals at both the state and federal levels (e.g., definitions of quality, minimum standards of care, and prioritization of services).

A: (Tony Rodgers) At both levels. The U.S. health care system is basically a local health delivery system. States are responsible for licensing hospitals and providers. So it makes sense that state leadership in driving HIT adoption is critical. The federal role is to provide guidelines and standards for HIE standards among federal health systems (VA, CDC, IHS, etc.) and states.

As a major funding resource of HIT, the federal government certainly wants a return on its investment. Medicare, the Federal Employees Health Benefit Program, VA, CDC, and Medicaid are major stakeholders in the success of the health system transformation through adoption and use of HIT. This will make reimbursement reform possible.

Reimbursement reform is a major policy focus of national health reform. The federal government has the primary leadership leverage in this effort. That said, states must also formulate policy around provider reimbursement. Reimbursement reform will have a significant impact on public and private health plan claims systems, financial accounting systems, quality reporting systems, fraud and abuse detection systems, and medical cost inflation. The key to a successful restructuring of reimbursement policy will be the alignment of public and private payers and the reduction of administrative burden on providers. That will take both state and federal leadership and private-sector coordination.

A: (Richard Baron) I believe this should be federal. A core part of this, to support data exchange, will have to be standards setting, and this will need to happen effectively across national companies doing business as providers of multiple clinical services (e.g., laboratories, pharmacies, direct clinical providers, hospitals, etc.). I don't see how we stay out of each other's way if states get involved in standards setting, and I don't see how reimbursement really "works" unless it is tied to adoption of HIT with embedded standards. I could imagine states predicating any financial support on "compliance with federal standards," but conflicting incentives will inevitably lead to fragmented standards setting.

¹ Figures found in the following documents: <http://www.cbo.gov/ftpdocs/99xx/doc9989/hr1conference.pdf>, http://www.cbo.gov/ftpdocs/100xx/doc10008/03-02-Macro_Effects_of_ARRA.pdf and <http://www.cbo.gov/ftpdocs/101xx/doc10106/health1.pdf>.

² Excerpt from Commerce and Agriculture Joint request for information and notice of public meetings footnote.

³ Note: Sections cited from the American Reinvestment and Recovery Act of 2009 can be found at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h1enr.pdf.