



***CHCS Webinar:***

# **HIT Provisions of the Stimulus Package: Opportunities for Medicaid**

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Thursday, April 23, 2009

3:30 – 5:00 p.m. EDT

For audio, dial: (866) 699-3239; Meeting/Event Number: 711 442 661  
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# CHCS Mission

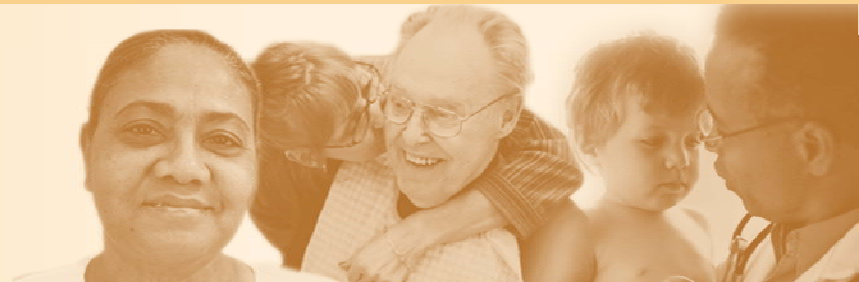
To improve health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.

## ► Our Priorities

- Improving Quality and Reducing Racial and Ethnic Disparities
- Integrating Care for People with Complex and Special Needs
- Building Medicaid Leadership and Capacity

## National Reach

- 47 states
- 160+ health plans



# Overview of Today's Webinar

- Opportunities for Medicaid to Invest in HIT
- How State Medicaid Programs Can Leverage HIT Stimulus Opportunities
- Supporting Practices in EHR Adoption: A Physician's Perspective


# Potential Roles for State Medicaid Agencies

- **Policy drivers**
  - ▶ Creating transformation through contracts, incentives, reimbursement, provider networks, etc.
- **Neutral conveners**
  - ▶ Leading public-private payer collaborations
  - ▶ Avoiding anti-trust concerns
- **Purchasers**
  - ▶ Reducing fragmentation and redundancy in purchasing decisions
  - ▶ Implementing value-based purchasing
- **Leaders in QI**
  - ▶ Implementing HIT and training to practices
  - ▶ Creating alignment across QI efforts

# Shannah Koss

## Health Information Consultant

- Over 20 years of senior leadership experience in health regulation, HIT, and health industry strategy.
- Consults on a wide array of Medicare, self-insured employer, care management, and HIT industry issues.
- Most recently, vice president of HIT at Avalere Health.
- Previous positions with I-trax Inc., Voxiva, Inc., and IBM.
- Began her career at the White House Office of Management and Budget in progressively senior health oversight positions over 10 years. Specialty in FDA, Medicare, HIT, and regulatory reform.
- M.P.P. from Harvard's Kennedy School of Government, B.A. from the University of Chicago.



# The American Recovery and Reinvestment Act of 2009

Opportunities for Medicaid to  
Invest in HIT

Shannah Koss, Principal  
Koss on Care LLC

# Topics

- Key HIT components in the ARRA
- What is happening in state Medicaid programs today?
- Challenges and opportunities
- Considerations for states and primary care physicians

Acknowledgement – Foundation of Research and Education AHIMA State-level HIE Consensus project

# ARRA HIT Components

- Medicaid recovery provisions
- Health and Information Technology for Economic and Clinical Health Act (HITECH)
  - Overview
  - Grants and loan programs
- Medicare and Medicaid EHR incentives
- Other ARRA HIT funding
  - HRSA construction and equipment funding includes HIT for community health centers (\$1.5B)
  - Commerce/Agriculture broad band support for unserved or underserved medical and healthcare providers (\$2.5B)

# HITECH

- Codifies the Office of the National Coordinator for HIT
- Creates two federal advisory committees on HIT policy and standards
- Creates many new HIE/T funding programs including:
  - HIE planning and implementation
  - Regional Extensions centers
  - Grants to establish EHR loan programs
- Increases privacy protections
  - Addresses gaps in HIPAA – Business Associates, RHIOs, PHRs and breach reporting
  - Additional enforcement, EHR monitoring and reconsideration of minimum necessary

# HITECH Grants

- Planning and implementation grants to facilitate and expand HIE within the state and nationwide
  - State or qualified state designated entity recipients
- HIT regional extension center grants to establish centers that give technical assistance and disseminate best practice for HIT adoption
  - 50% up to 4 -year funding to qualified non-profits
- Competitive grants for states and tribes to establish EHR loan programs
  - Loan entity must contribute \$1 for every \$5 Federal
  - Support up to 10-year EHR loans for purchase, certification, training and enhanced security

# Medicare and Medicaid EHR Incentives

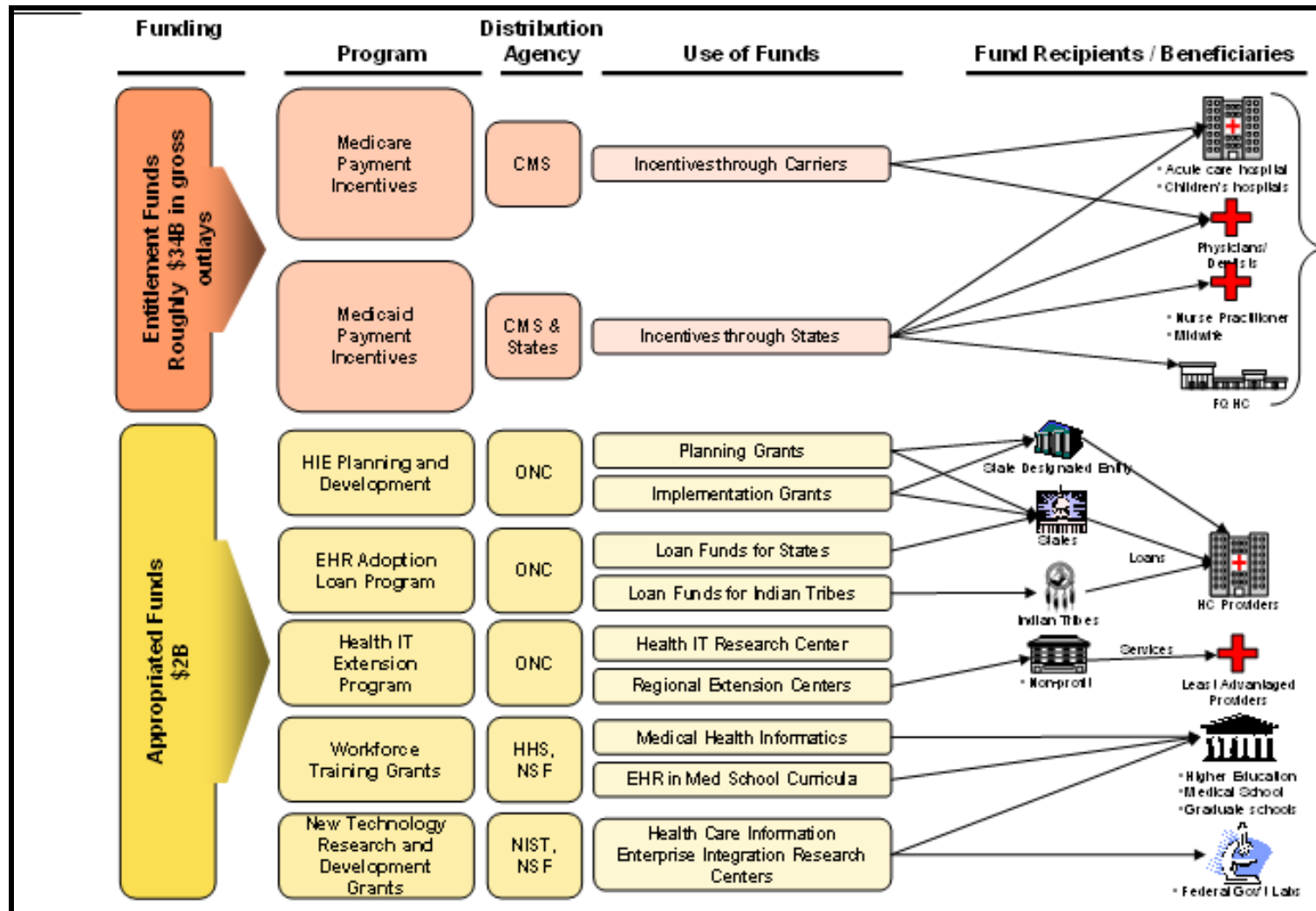


- Medicare - Independent physicians who treat Medicare patients will be eligible for EHR incentive payments starting in 2011 through 2015 if they are "meaningful users" of certified EHRs.
- Medicaid – Medicaid providers, including independent physicians, that meet a threshold percentage of Medicaid patients are eligible for more generous EHR incentives
  - Incentives can cover initial EHR purchases
  - Incentive payments can only be made for 5 years and no later than 2021
- Providers may only receive incentives under one program – Medicaid recipients must waive their right to Medicare incentives

# EHR “Meaningful Use”

- HHS must define three criteria by which “meaningful use” will be determined:
  - Certified technology – using technology in a meaningful manner that includes eRx
  - Information exchange – technology is connected in a manner that improves quality and promotes care coordination
  - Reporting measures – submits information for the incentive period on selected clinical quality and other measures
- Given the differences between the Medicaid and Medicare incentives there is a reasonable argument for either different criteria or a phased implementation for Medicaid

# HIT ARRA Funding Provisions\*



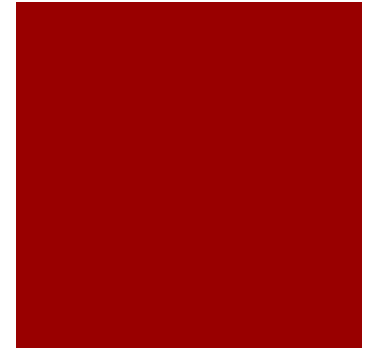
\*Graphic created by Manatt Health Solutions

# Stimulus Funding Implications for Providers



- Several resources will emerge in support of EHR purchase, technical assistance and training, connectivity and incentives for “meaningful use”
- Purchase support is available through loan programs and the Medicaid incentives
- Regional extension centers should provide support for implementation and training
- Incentive dollars for Medicare can be as high as \$44K, for Medicaid as high as \$65K (covering 85% of allowable costs, pediatricians at 2/3 the rate)

# Medicaid Economic Realities



- Staffing freezes and cuts
- Reduced operating budgets
- Health reform and HIE/T initiatives cut back or on hold
- Increased application volumes and increased enrollment
- Safety net providers and vulnerable populations at risk
- Governors and legislatures considering how Medicaid financing plays a role in addressing budget shortfalls

# How are States Responding?

- Broad range of responses based on politics, policy, leadership and past HIE/T progress
- Some states are at a standstill waiting for the governor and legislature to decide on the state's general ARRA response
- Other states have completed a detailed analysis with an eye toward leveraging every possible resource to advance health reform, HIT and HIE
- Challenge for the states and the Feds is planning versus expediency



# Considerations in Your State



- Who has the lead or should have the lead?
  - State agency or state designated entity?
- Is there a road map? What are the leading health improvement/reform goals?
- Is it a coordinated effort e.g., a public-private partnership that includes all state programs or are there potentially competing/conflicting activities and applicants?
- How to navigate economic challenges and funding opportunities?
- Can you afford to pursue or not to pursue stimulus dollars?

# Provider Considerations

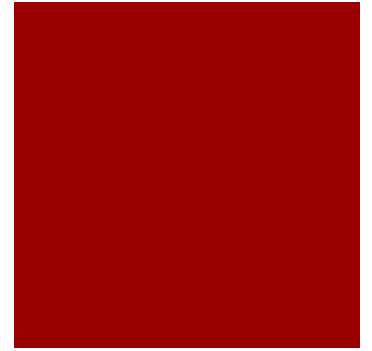
- Your current technology adoption status
- Meaningful use – monitor and perhaps engage in the policy discussion
- Medicare vs. Medicaid incentives or disincentives
  - Doing nothing may expose your practice to reduced payment starting in 2016
- How EHR adoption may support changing market expectations

# For more information:

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## Questions?

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# Anthony Rodgers

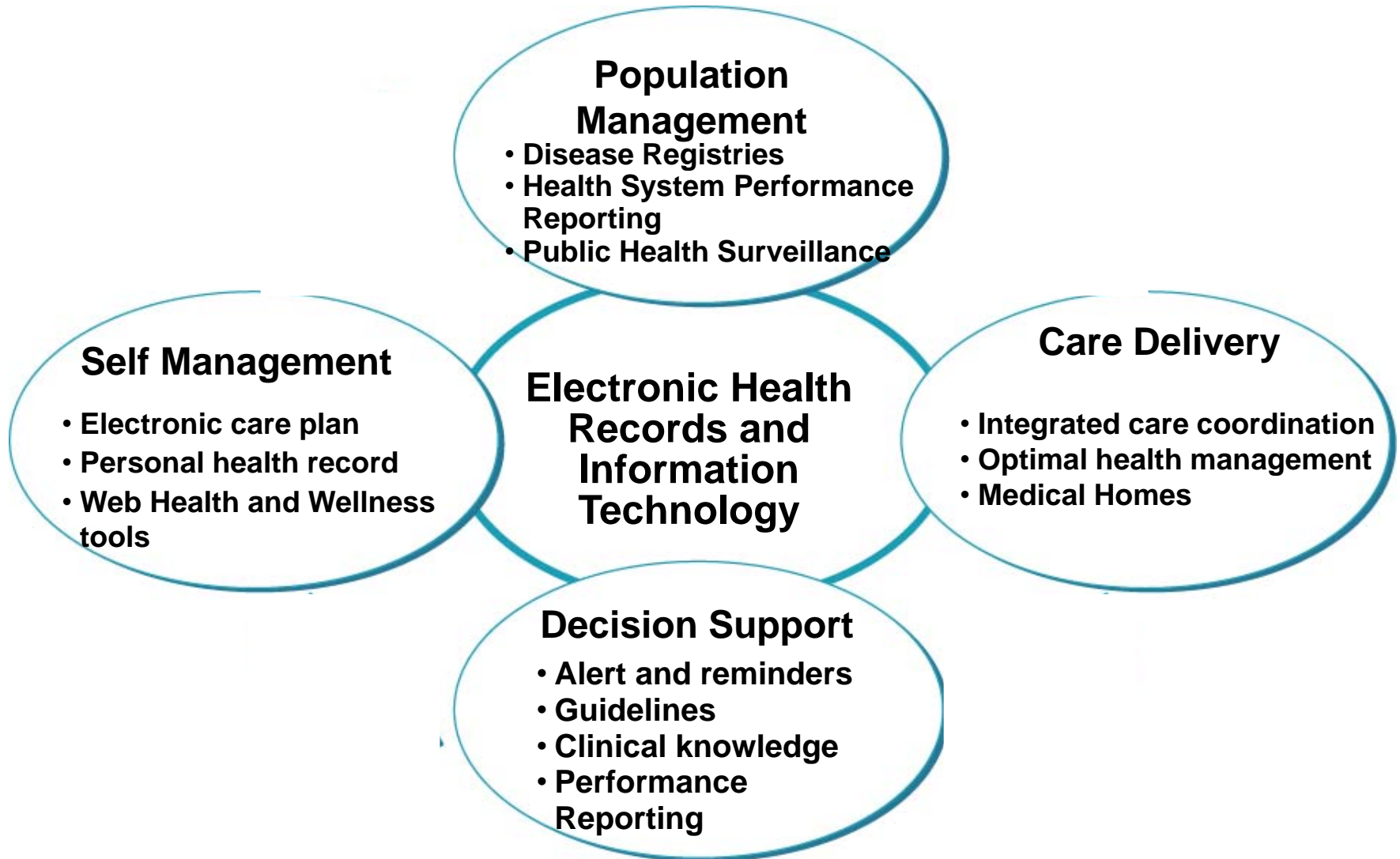
Director, Arizona Health Care Cost Containment System (AHCCCS)

- Over 30 years of health care executive management experience in public hospital systems, health plans and Medicaid Programs.
- An expert on non-profit organization governance.
- Responsible for health coverage for over one million Arizonans; appointed to current position in 2003.
- Chair of the Multi-State Collaboration on Medicaid Health System Transformation, and a member of the National Quality Forum.
- Holds visiting professor appointments at Arizona State University and the UCLA School of Public Health.
- M.S. in public health, B.A. in economics and political science from UCLA.

# How State Medicaid Programs Can Leverage HIT Stimulus Opportunities

Anthony Rodgers, Director  
Arizona Health Care Cost  
Containment System  
April 23, 2009

# Electronic Health Records System Transformation Enabler

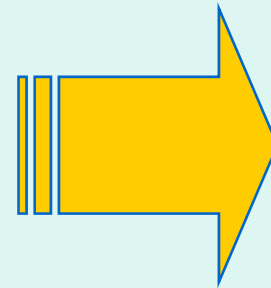


# Return on Investment: Wide Spread Adoption of Electronic Health Information (EHI) Technologies Can Better Outcomes and Lower Cost

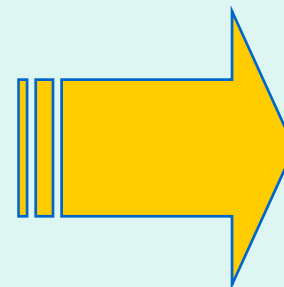
Improving Health Care Quality and  
Cost Performance

## *ROI of EHI at Point of Care:*

- Improved Patient Safety
- Reduced Complications Rates
- Reduced Cost per Patient Episode of Care
- Enhanced cost & quality performance accountability
- Improved Quality Performance



Better  
Outcomes



Lower  
Costs

## Potential Return on Investment to Arizona Medicaid from HIT Initiatives at Statewide Scale

Areas of Cost Avoidance and Savings	Year 2010	Year 2011	Year 2012
<b>Hospital Cost</b>	\$635,000	\$1,056,000	\$1,408,000
<b>Medicaid Health Plan Medical Risk/Administrative Cost</b>	\$23,081,000	\$57,702,000	\$248,120,000
<b>Laboratory Cost</b>	\$1,840,000	\$2,573,000	\$2,573,000
<b>Pharmacy Cost</b>	\$8,500,000	\$15,500,000	\$32,100,000
<b>Total</b>	<b>\$34,056,000</b>	<b>\$76,831,000</b>	<b>\$284,201,000</b>

**Federal Share of Three Year Total Savings: \$ 260,758,080**

# Prerequisites to Success

- Comprehensive state level roadmap or strategic plan with specific measurable goals and accountabilities,
- Public and private health care leadership engagement,
- Key stakeholder involvement,
- Political will,
- Aligned financial incentives (Medicare, Medicaid, commercial health plans),
- Long term view for E-Health,
- Adequate capital for health information system infrastructure development and operating funds.

# How CMS Can Help States Maximize the Investment of HITECH Stimulus Funding

- **Provide general guidance** to state Medicaid/CHIP programs, including a national roadmap for widespread adoption of EHR and health information exchange in Medicaid/CHIP.
- **Establish a Medicaid specific regulatory framework and approval processes** for state plan amendments for participating in Medicaid HIT including:
  - Policy framework for “Meaningful use of EHR” in Medicaid
  - Requirements for Medicaid health information exchange between states
  - Payment policies related to telemedicine and telehealth adoption
  - Medicaid HIT Grants and Loan Programs
- **Prioritize and develop grant opportunities** that build statewide infrastructure that support Medicaid.

# How CMS Can Help (cont.)

- **Provide Medicaid agencies with continuous technical assistance, education, and support tools,**
- **Work closely with ONC to develop and implement coordinated** policy and financial incentives between federal agencies, especially Medicare, HHS, AHRQ, and Social Security Administration,
- **Recognize and incentivize states** that are “front runners” or who have best practices.

# How States Can Maximize the Investment of HITECH Funds

- Establish an E-Health lead for the state as the primary contact point for federal and state coordination.
- Identify the accountable organizations and state agencies for coordinating and maximizing HIT for Arizona.
  - Regional technical support centers
  - Regional Health Information Exchanges
  - HITECH projects and initiatives key stakeholders
- Update the state's roadmap for E-health.
- Provide the legislative and policy framework for health information exchange and EHR deployment.
- Establish accountability processes for use of federal funds by public and private sector initiatives.

# Creating a Medicaid EHR Incentive Program

- **Definition of Meaningful Use in Medicaid**
  - A clear set of definitions for each eligible provider
  - Create an auditable validation process
- **Approaches to incentive programs for Meaningful Use of EHRs in Medicaid**
  - Establish a voluntary program with a lot of provider education and assistance
  - Identify providers participating and track progress
  - Phase in of meaningful use requirements over two to three years
  - Payout incentive once a year
  - Provide other recognitions for physician EHR adoption
  - Establish measurable goals and quality outcomes that are consistent with the meaningful use of EHRs.
  - Focus on achieving improved quality of care and reducing unnecessary cost not on EHR transactions.

# Requirements for Meaningful Use of EHR in Medicaid

## Meaningful use of electronic health information by a Medicaid health care provider requires:

1. The consistent viewing and updating of a Medicaid patient's relevant electronic health information as part of the normal tasks of a patient examination or visit using a certified electronic health record.
2. An authorized Medicaid provider must be capable of viewing and exchanging health information with other Medicaid providers involved in the patient's care management.
3. Requires the exchange, display, and storage of medical, dental, and/or behavioral health information, patient histories, problems list, allergies, medication list, lab and diagnostic test results, and images, progress notes for the purpose of patient evaluation, diagnosis, treatment, and referral.
4. Utilization of E-prescribing and computerized order entry and results reporting functionality.
5. Utilization of basic clinical alerts, messaging, and clinical decision support.

# Requirements for Medicaid EHR Incentive Program

- **Requires Meaningful use of certified EHR system**
- **Hospital EHR incentive program participants**
  - **Acute Hospitals**
  - **Children Hospitals**
- **Eligible Non Hospital Based Provider EHR incentive includes:**
  - Physicians
  - Nurse Practitioners
  - Certified Nurse Midwife
  - Physician Assistants (practicing in rural clinic or FQHC)
  - Dentist
  - Community Health Centers and Rural Clinics
- **Establish process for attestation and validation** of provider eligibility and EHR eligible cost
- **Requires verification and approval** of incentive payments by Medicaid agency
- **All processes must be auditable** and transparent

# Role of Medicaid Managed Care Plans and Private Sector

- Participate in assessment and strategic planning process
- Help identify and support eligible providers that qualify for incentive program
- Provide technical assistance and support for providers
- Participate in the Medicaid incentive program validation process
- Integrate case management data and other MCO data into EHRs
- Integrate claims processing and other administrative processes (prior authorization, formularies, medical record audits) with EHRs to reduce provider overhead cost
- Participate in the quality reporting and auditing processes
- Include EHR standards and requirements in provider contracts

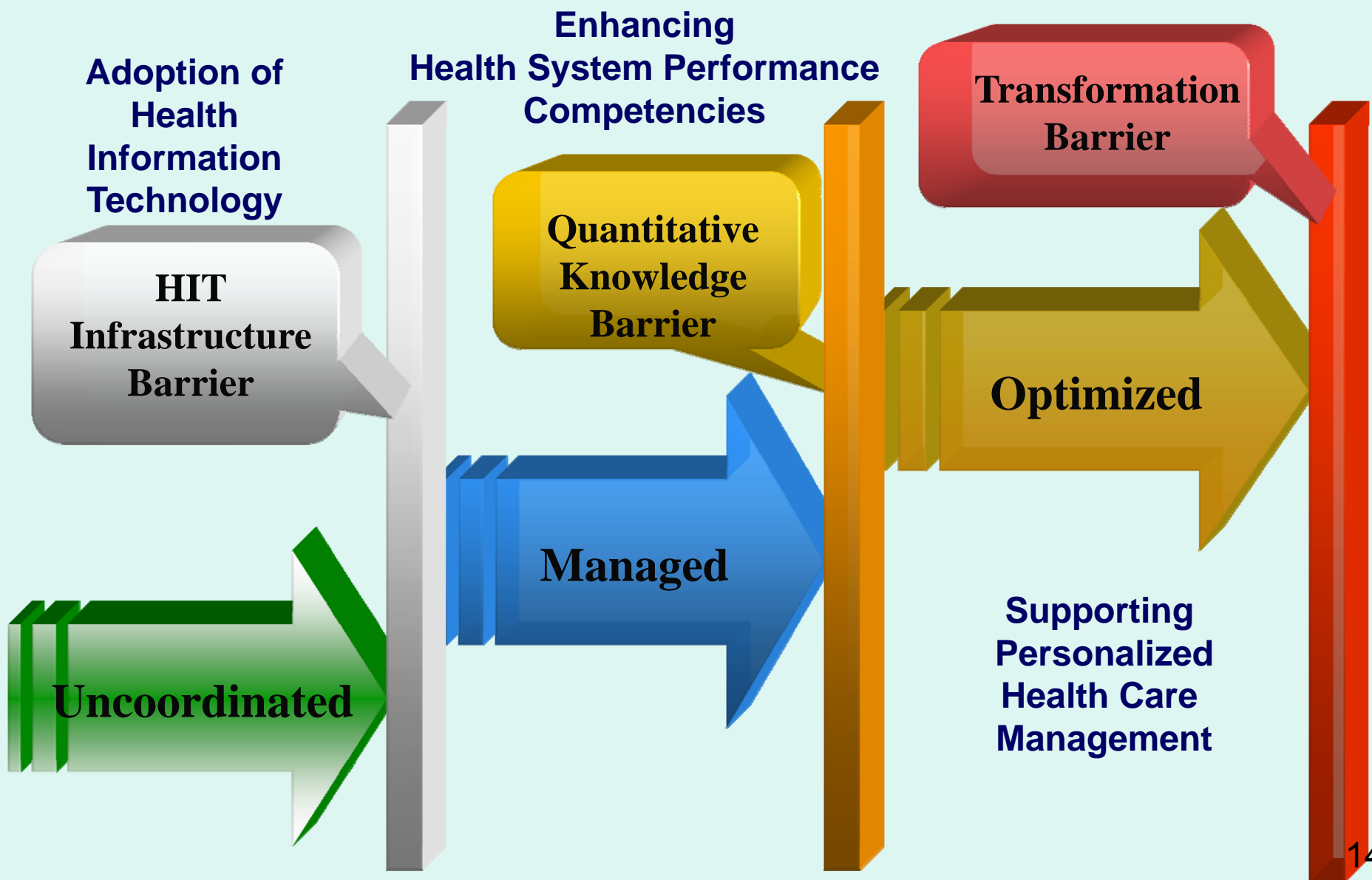
# Action Steps for State Medicaid Agencies

- **Step 1: Perform an environmental assessment** of the “as is” readiness of providers in the adoption of electronic health records within the Medicaid/CHIP provider networks.
- **Step 2: Develop a strategic plan** for Medicaid Health Information Technology Infrastructure with the goal of health system transformation.
  - Assure widespread stakeholder involvement
  - Establish the appropriate role for health plans and managed care organizations
  - Develop clear measurable outcome oriented goals
  - Assure coordination with private-sector initiatives
- **Step 3: Establish a defined role for Medicaid/CHIP** programs to play over the next three years in financing and deploying HIT.
  - HIE
  - EHRs
  - Incentive program administrator
  - Loan program administrator
  - Quality oversight and public reporting

# Action Steps for State Medicaid (cont.)

- **Step 4: Leverage current state regional HIE and EHR projects** to create statewide solutions.
- **Step 5: Develop the policy and regulatory framework** for health information exchange, loan programs, and Medicaid EHR incentive programs.
- **Step 6: Apply for various grants, loan programs and/or Medicaid incentive program** to financially support the HIT strategic plan.
- **Step 7: Develop internal and external business processes** for managing health information exchange, loan programs, incentive programs, and grant projects.

# Overcoming Barriers in Medicaid Health System To Achieve Health Care Transformation Maturity



# Projects Arizona Medicaid Will Leverage to Maximize HITECH Funding

**Arizona Medical Information Exchange**

**EHR Purchasing & Assistance Collaborative**

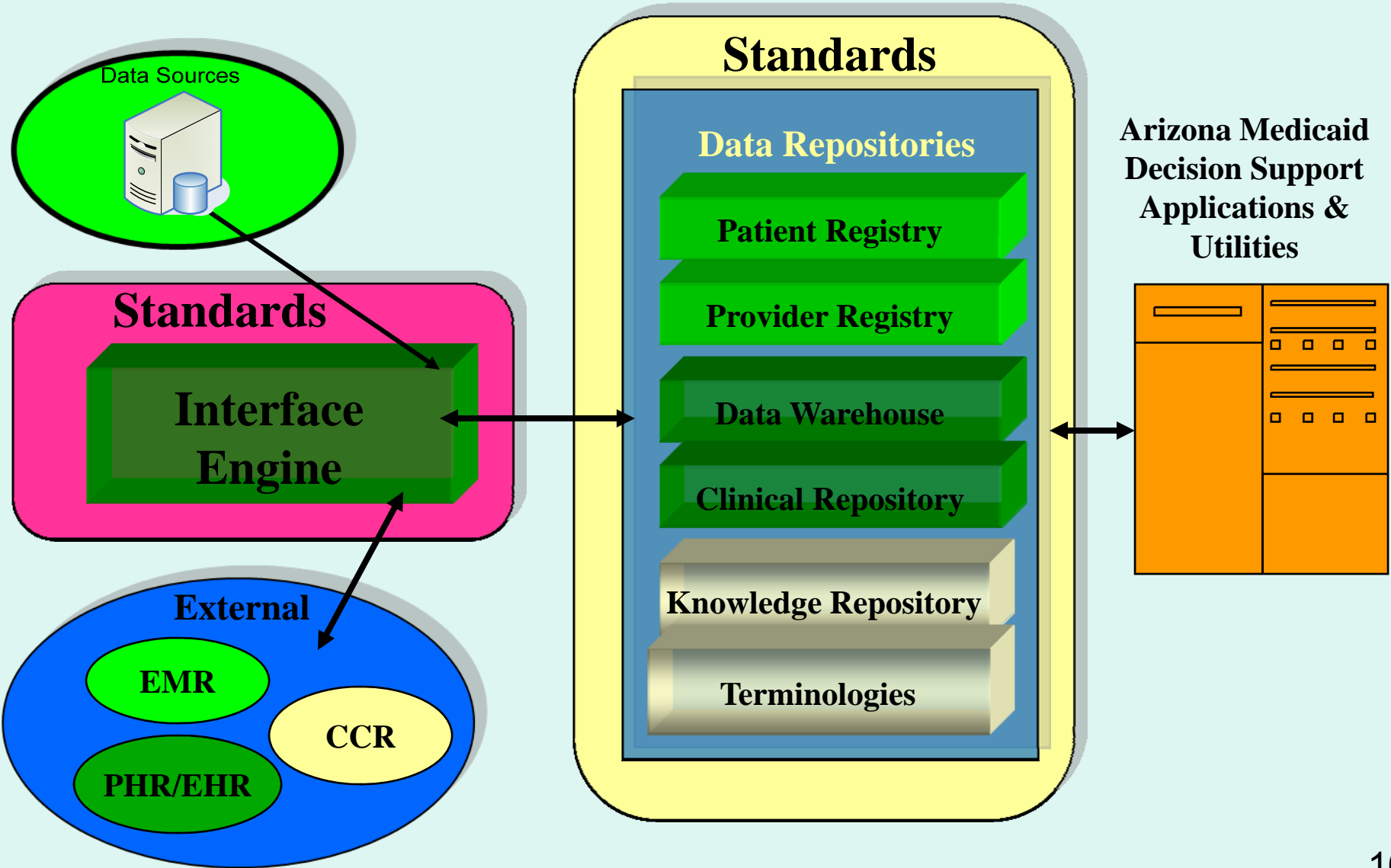
**Arizona Health System Transformation  
HIT Infrastructure**

**Web Based Self Help & E-learning Applications**

**E-Prescribing Adoption Initiative**

**Clinical and Enterprise Decision Support**

# The Arizona Medicaid Electronic Health Record Data Repository Relationships and Decision Support Infrastructure





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# Richard Baron, MD

Practicing Internist, Greenhouse Internists, PC

- Practices general internal medicine at a five-doctor group serving an economically and racially diverse community in Philadelphia.
- Greenhouse a pioneer in the comprehensive adoption of electronic health records in the small practice environment.
- Previously, chief medical officer of Health Partners, a not-for-profit Medicaid HMO.
- Architect of CHCS' Best Clinical and Administrative Practices program, funded by RWJF, which reached plans serving over half the U.S. Medicaid managed care population.
- Member of the NCQA Standards Committee since January 2005, and chair of the American Board of Internal Medicine since July 2008.
- M.D. from Yale, A.B. in English from Harvard.

# Supporting Practices in EHR Adoption: A Physician's Perspective

Richard J. Baron, MD, FACP  
Senior Health Consultant to CHCS  
President, Greenhouse Internists, PC

CHCS HITECH Webinar  
April 23, 2009

# Charts are for documentation, right?

- In a paper world, charts function as
  - Archival records perhaps reviewed later
  - Evidence to support billing
  - Key evidence in malpractice suits
  - Repository of “all the information” on a patient
- Connection between charting and payment
  - Longer the note, higher the fee
  - “Work we have to do, but don’t get paid to do”
    - Literally – and derisively – “paperwork”

# What do doctors do with EHRs?

- Use the word-processing features
  - 51% of financial return on EHR comes from more aggressive coding
  - Current products major “attraction”: create long, detailed notes effortlessly
    - “Higher value” notes (???)
- **4%** of adoptions are “comprehensive”
- This is clearly not what you want, and not likely to be “*meaningful use*”

# My “framework” for supports docs will need

- Technological support
  - Keep a system *working*
- Training support
  - Learn how to *use the system* as designed
- Work flow re-design support
  - Change the way work is done with the system
- Most important: change in (self) expectations
  - Change in job description, change in payment

# Technological support

- The printer in room 3
  - If it doesn't work, docs won't print scripts
- **NO DOWNTIME**
  - Patient needs are ongoing, no room for crashes
- Network management, hardware issues, software bugs, virus protection, etc.
  - Small businesses will need strategies to cope with all this, and it's not what vendors sell

# Training support

- Must reach *everyone* in office
  - Some will need training on using a mouse
  - **Most** – especially doctors – will need typing
- How to use the system and its features
- “Super users”
  - In-office folks to troubleshoot problems

# Work flow re-design

- “Go live”- but everything’s *still* on paper
  - Day 30- *almost* everything’s still on paper
- Everyone’s job changes
  - Prescription refill, filing, appointments, labs
- Evolutionary process
  - Initial work flow: focus on data conversion
  - Later work flows: start to use “new capacities”
  - Structured vs. unstructured data
  - *Ongoing* new delegations- even 5 years out!

# Change in (self) expectations

- “Value” thought to equal “payment”
  - Huge lack of fit in primary care
- Shift to non-visit based care
- Using EHR functionality for population mgmt
- “New” cognitive models (e.g., Wagner, IHI, IPIP)
- If you don’t change payment, you contribute to the inertia maintaining the old system

# How we are “happier doctors” with an EHR

- Meet patients’ needs more effectively
  - Data in a context (“what was my weight last time?”)
  - “Can you fax that prescription?”
- Activate a team
  - Can delegate activities safely and reliably
  - Staff can take initiative
- Can do proactive, non-visit based care
- E-mail, interactive web have been great

# Some “structural” issues for states

- Who will be your “HIT extension” provider?
  - Can guarantee you will need one!
  - Can you create “learning communities”?
- How to flow funds for HIT?
  - Good to have it “pulled out” from regular flow
  - Use as opportunity to get away from FFS
- Linkage with other HIT needs/initiatives?
  - Public health? E-Rx? QI/performance reporting?
- Role of managed care intermediaries?

# Some technology/training resources you can use

- QIOs- got ready with “8<sup>th</sup> scope of work”
  - DOQIT-U:  
<http://www.masspro.org/HIT/DOQU/index.php>
- AHRQ has a big investment here:
  - <http://www.norc.org/projects/ahrq+national+resource+center+for+health+information+technology.htm>

# Work flow, job re-design resources

- Institute for Healthcare Improvement (IHI.org)
- IPIP (ABMS: Improving Performance in Practice)
  - <http://www.ncafp.com/home/programs/ipip>
- ABMS Maintenance of Certification (MOC) programs
- Patient Centered Primary Care Collaborative
  - <http://www.pcpcc.net/> (employer coalition)



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