



CMS Draft Guiding Principles for the Use of the 90/10 HITECH Administrative Funds & Implementation Issues

CMS Multi-State Collaborative HIT Conference
February 9, 2010

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Purpose of this Session

- Ground Rules for 90% HITECH Admin
- CMS Guiding Principles
- What Does CMS Consider Critical for the SMHP to Focus On?

HITECH 90% Admin FFP:

Three Conditions

1. Administer incentive payments including tracking of meaningful use (MU) by Medicaid providers
2. Conduct adequate oversight including routine tracking of MU attestations and reporting mechanisms
3. Pursue initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information

Getting Started

- What internal systems can you utilize?
 - Ex. MMIS system to issue the incentive payments
- What new IT infrastructure will you need?
 - Ex. Data repository for clinical quality measures
- What existing infrastructure/resources can you use?
 - Ex. State HIE; Program Integrity Audits



Hard & Fast Rules for Admin Do Apply for “Reasonableness”

- CMS intends to follow **OMB Circular A-87** which defines reasonableness

Hard & Fast Administrative Claiming Rules Cont'd

- Funding for the non-Federal share of Medicaid HIT administrative payments should be consistent with existing statutes and regulations regarding Medicaid financing.



CMS Guiding Principles for the 90/10

- Per (t)(9)(C), CMS will consider approval for 90/10 FFP for States' proposed initiatives that will meet the following criteria:
 - I. Serve as a direct accelerant to the success of the State's Medicaid EHR Incentive Program and facilitate the dispersion and use of certified EHRs.

Guiding Principles Cont'd

2. Will, in most cases, be normalized and integrated into the Medicaid business enterprise (an example of an exception is point-in-time technical assistance), such as technical bridges between Medicaid and statewide health information exchanges

Guiding Principles Cont'd

3. Are designed to be well-defined projects with specific goals, that would enhance the capability of the Medicaid program to exchange health information necessary to allow providers to be meaningful users of certified EHRs



Guiding Principles Cont'd

4. Cannot otherwise be funded by the CMS MMIS matching funds

Guiding Principles Cont'd

5. Are a complement to ONC funding for HIE (that is inclusive of Medicaid)- following the fair share principle across all payers

Guiding Principles Cont'd

6. Are working in concert, and to a satisfactory performance level, with the ONC HIE activities in the State, as the HIE work under those cooperative agreements is viewed by CMS as an integral piece of a successful Medicaid EHR Incentive Program

Guiding Principles Cont'd

7. Are not duplicating technical assistance efforts conducted by the ONC-funded Regional Extension Centers to the same specific providers.

Guiding Principles Cont'd

8. Are procured following the principles of free and open competition for all contracts unless waived by CMS

Guiding Principles Cont'd

9. Are developmental and/or time-limited in nature, and not part of on-going operational activities (an example of what would not meet this standard would be paying for providers' HIE transaction fees)

Guiding Principles Cont'd

10. Are cost-allocated where part of a multi-payer enterprise, using a methodology that identifies Medicaid's pro-rated share where the denominator is either the total patient volume or total patient cost, adjusted by an estimation of Medicaid provider participation in the State EHR Incentive Program over the next five years

Guiding Principles: Cost-Allocation

Cont'd

- Cost allocation should involve the timely and assured financial participation of all parties so that Medicaid funds are not the sole contributor at the onset
- CMS views the Medicaid share as appropriate only for a governmental or non-profit utility, not privately-held and for-profit
- CMS is open to considering other cost allocation methodologies, subject to prior review and approval



Guiding Principles Cont'd

- II. Are not intended to be permanent initiatives, however will in most cases, lead to a permanent and sustainable outcome



Guiding Principles Cont'd

12. Are described and integrated into the State Medicaid HIT Plan

What about On-Going Provider Costs for HIE Participation?

- Providers expenses derived from participation in health information exchange would be better addressed not through the HITECH 90/10 administrative matching funds but instead through how States reimburse their providers.
- CMS will entertain State Plan Amendments that speak to payment policies meant to incentive providers to report data, e.g. the medical home per-member/per-month model.



The Oklahoma Example

- Oklahoma was approved, under demo authority, to broaden the impact of its enhanced PCMH program by the addition of Health Area Networks with core components of care management/care coordination, **electronic health records**, improved access to specialty care, telemedicine, and expanded quality improvement strategies.
- Networks will receive a Per Member Per Month (PMPM) payment that will be paid in addition to the monthly care coordination fee paid to the PCP.

The Alabama Example

- Submitting a SPA to increase the dispensing fees for pharmacists who participate in e-prescribing
- PMPM model for providers participating in the medical home program

HITECH MEDICAID EHR INCENTIVE PROGRAM:



IMPLEMENTATION ISSUES

Key Areas To Consider- *How Will You Know?*

- Who has the minimum Patient Volume ?
- Who is a Qualified/Licensed/Non-Sanctioned Medicaid Provider ?
- Who are Eligible Professionals or Eligible Hospitals?
- Who are Non-hospital based EPs?
- Which EPs Practices Predominately at an FQHC/RHC?

More How Do You Know Questions:

- Who has Adopted, Implemented or Upgraded to certified EHR technology?
- Who is using Certified EHR technology?
- That there are no dual payments with other States or Medicare?
- That the EPs' Assigned Payments went to the permissible Recipients?



Are you thinking about....?

- Data sources for all of those criteria?
- What's your “front door” (e.g. website, help desk, etc) for Medicaid providers to your State's EHR Incentive Program?
- How will you collect meaningful use data in 2012? Including clinical quality measures?

Core Operational Issues

- How will you know who should get an incentive payment?
 - How will you know if they've already been paid?
- How will you pay them?
- How will you audit them?
- What barriers to Meaningful Use exist that Medicaid could help alleviate?



Key Oversight Issues

- What should States need to audit pre-payment 100% of the time?
- What should States audit using a sampling strategy, either pre- or post-payment?
- What are some proxy data measures that would trigger a more extensive audit?
- How can States use a light footprint (low provider burden) but with a solid PI methodology?

What about your ONC HIE Work?

- Is Medicaid at the table?
- What are the shared activities?
 - Outreach/Provider communications?
 - Needs assessments?
 - HIT infrastructure?
 - Consent/Privacy issues?
 - Governance

Pending CMS Guidance & TA

- Updated SMHP template
- Sample Audit Strategy
- Additional Guidance on the use of the 90/10 funds
- Targeted technical assistance to States