

Information Technology and the Aging Network: Opportunities to Enhance Information Technology Capacity

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Purpose

The purpose of this report is to examine opportunities for the Aging Network to expand partnerships with health care organizations and other entities through focusing on the value of investing in information technology (IT). These opportunities include connecting to Health Information Exchanges (HIEs) using currently available funding through the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH). It follows a 2016 report issued by the National Association of Area Agencies on Aging (n4a), which examined the state of IT in Area Agencies on Aging (AAAs) across the country. That report, “Information Technology in Area Agencies on Aging,” identified issues and barriers AAAs face in addressing IT needs: implementation costs, interoperability with health care organizations, data sharing challenges, and identifying flexibly designed systems that are capable of addressing evolving IT needs.

Here, we focus on a federal funding opportunity and the experiences of three AAAs that are actively seeking to build out IT in the context of contracts with an expanding number of health care organizations and payers. As the U.S. health care system shifts to accommodate population management and value-based models of care, the need to link multiple data streams across community-based organizations, medical providers, and individuals is increasingly salient and pressing.

Accordingly, the report discusses how and why AAAs may wish to bolster their IT capacity, and provides recommendations for next steps.

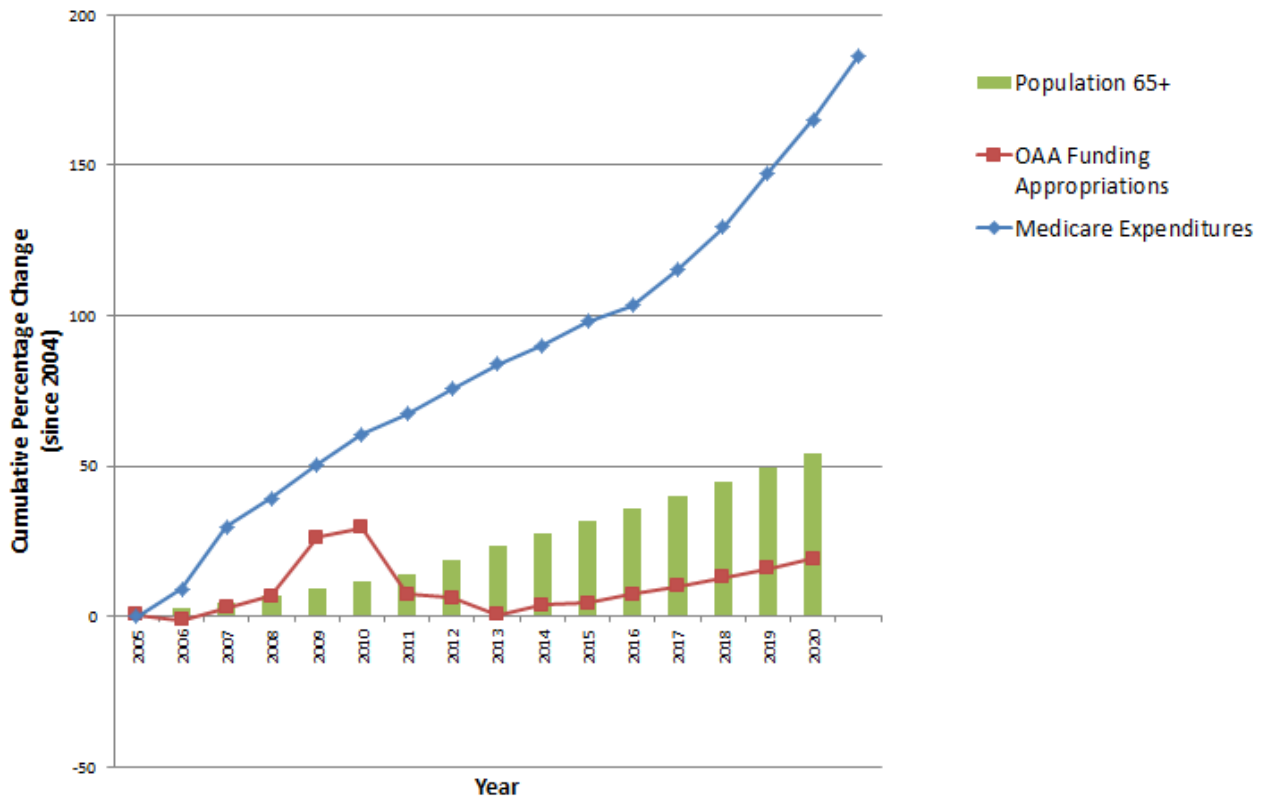
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1.0 INTRODUCTION AND BACKGROUND

Almost as soon as Medicare, Medicaid, and the Older Americans Act (OAA) were enacted in July 1965, stark disparities began to emerge in federal and state spending on health care and social services. By 2015, Medicare and Medicaid annual expenditures had catapulted to \$1.2 trillion, while OAA funding increased very slowly, to reach \$1.88 billion.

Figure 1: Growth of the Aging Population Compared with Changes in OAA Funding and Medicare Spending¹



In a parallel trend, the emphasis in research and policy on medical care during this period dwarfed attention paid to the social determinants of health and the role that these factors play in influencing outcomes for older adults. Over time, the health and social services sectors developed quite separately. As a result, today many health care organizations remain unfamiliar with the range of cost-effective, community-anchored supports that are available through AAAs and community-

¹ Figure 1 is based on data presented in N Engl J Med 373;5 (*nejm.org*), Ravi B. Parikh, M.D., M.P.P., Anne Montgomery, M.S., and Joanne Lynn, M.D., The Older Americans Act at 50—Community-Based Care in a Value-Driven Era, July 30, 2015, pp. 399-401. Copyright © 2015 Massachusetts Medical Society. Reprinted with permission. Data source for OAA Funding Appropriations is from: Congressional Research Service; Medicare Expenditures: the Centers for Medicare and Medicaid Services; Population: U.S. Census Bureau. Values have not been adjusted for inflation. Projection for OAA appropriations assumes linear growth at the same rate of FY2015 to FY2016, based on the president’s FY 2016 budget.

based organizations (CBOs) for individuals who need some assistance at home, instead assuming that AAAs only provide free services to poor seniors.

Now, as the reality of the baby boomer-driven age wave takes hold and value-based care models expand in Medicare and Medicaid, attention is shifting to the outsize role that cost-effective supportive services play in managing the needs of high-cost, complex patients. For chronically ill and disabled populations living at home, a primary challenge in accomplishing effective care coordination is that some service needs are ongoing, as compared to episodic; they also vary substantially from individual to individual depending on a range of environmental and social factors (i.e., social determinants of health). The success of any given intervention, therefore, depends on how well it is coordinated with others. Adding to this complexity is the fact that different services are usually delivered by providers working in different settings, who are reimbursed through various programs and contracts. Despite much discussion in recent years about the need for better care coordination for particular high-cost populations—e.g., dually eligible beneficiaries and others who frequently seek care through the emergency room—systems of centrally organized services for individuals with complex needs are not yet well developed across the health care and social services sectors. As the age wave accelerates, more tightly integrated models of care will be essential to handle the quickly rising need for supportive services.²

Because it is deeply embedded in communities across the country across tens of thousands of organizations, the Aging Network is in a prime position to co-lead this shift. The number of individuals receiving services through the Aging Network—including more than 600 Area Agencies on Aging (AAAs), 256 Title VI Native American aging programs, 56 State Units on Aging, and roughly 20,000 community-based organizations—is growing. The system served 11 million adults in fiscal year 2014 with OAA funding. Many more were served through Medicaid and a widening array of contracts with health care organizations, individuals, foundations, organizations serving younger people with disabilities, and more. For example, 63% of AAAs report they are working with state Medicaid agencies or other types of integrated care plans.³ Prospects for continued growth are strong: Over the next 15 years, the number of elders who will need supports to remain in their own homes as they age into self-care disability and frailty will rise markedly—particularly in states such as Florida, West Virginia, Maine, and many Midwestern states, where the average age of the population is already well above 40.

In response, more and more AAAs are working to rapidly transform historic informal affiliations into organized service delivery systems. These systems, or networks, can be positioned to serve broad geographic areas—including entire states and possibly larger regions—that go far beyond the OAA's designated Planning and Service Areas (PSAs). During the last several years, AAAs have begun to diversify their services beyond traditional OAA funding by contracting with organizations ranging from wellness programs to disability organizations, to hospitals, nursing homes, and other long-term care providers, to geriatricians and managed care plans serving Medicare beneficiaries, Medicaid beneficiaries, and dually eligible beneficiaries.

² Lynn J (2016). *MediCaring Communities: Getting What We Want and Need in Frail Old Age at an Affordable Cost*. Washington, DC: Altarum Institute.

³ National Association of Area Agencies on Aging (2017). *Area Agencies on Aging: Local Leaders in Aging and Community Living*. <http://www.n4a.org/Files/LocalLeadersAAA2017.pdf>

2.0 A FEDERAL HITECH INITIATIVE

Until recently, a major barrier to providing more seamless and effective coordination has been relatively limited adoption of advanced IT systems that can help administrators analyze and help coordinate multiple service providers and populations with varying and interdependent needs. Recognizing this, the federal government began incentivizing IT development and adoption in the health care sector following enactment of the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act, which was approved as part of the American Recovery and Reinvestment Act. Designed to promote the refinement, adoption, and meaningful use of health information technology (HIT), HITECH's funds were aimed at encouraging widespread use and adoption of HIT for certain "eligible" providers. Specifically, Medicare and Medicaid financial payments were linked to "meaningful use" (MU) standards for certified electronic health record systems (EHRs). MU standards have developed over time, with the first stage of MU requiring providers to demonstrate the capacity to capture and share some basic clinical data, and the second stage focusing on more advanced clinical processes. The third stage aims to set standards for EHR reporting systems in the context of improved health care outcomes.

But until February 2016, HITECH's "eligible providers" excluded Aging Network providers, as well as institutional long-term care providers and others. For Medicare, HITECH-eligible providers included doctors of medicine or osteopathy; doctors of dental surgery or dental medicine; doctors of podiatric medicine; optometrists; and chiropractors. In Medicaid, an eligible provider was defined as a physician, a dentist, a nurse-midwife, a nurse practitioner, and a physician assistant practicing in a Federally Qualified Health Center (FQHC) or a Rural Health Clinic that is led by a physician assistant.

When officials at the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) determined that HITECH's stated goal of helping Medicaid providers could be interpreted more broadly, CMS issued a memo in February 2016. Addressed to State Medicaid Directors, the memo states that federal funding at a 90% matching rate is available through 2021 for state expenditures on activities to promote health information exchange and encourage the adoption of certified EHR technology by "certain Medicaid providers." The memo continues: "Subject to CMS prior approval, States may thus be able to claim 90 percent HITECH match for expenditures related to connecting Eligible Providers to other Medicaid providers, including behavioral health providers, substance abuse providers, pharmacies, laboratories, correctional health providers, emergency medical service providers, public health providers, and other Medicaid providers, including community-based Medicaid providers." It further declares that "CMS explicitly encourages and welcomes multistate collaboratives partnering on shared solutions for...interoperability," and will "aggressively support such collaboratives as potentially cost-saving opportunities to increase adoption of interoperability standards and help Eligible Providers demonstrate Meaningful Use."

In summary, the CMS memo is an important policy shift, which recognizes that for purposes of meeting MU stage II and III standards, a broader array of provider types must be included in publicly-funded HIT development activities. It is a welcome development that the Aging Network can now partner with states to explore IT development possibilities, with HITECH matching funding available for building or acquiring new IT, for creating portals into existing systems such as state and regional HIEs, and for technical assistance.

What Are Health Information Exchanges (HIEs)?

Some of the earliest and broadest HIEs were established at the state level through HITECH funding. Today, multiple types of HIEs exist, both in the public and private sectors. HIEs have developed as conduits in order to enable exchange of certain health information elements from EHRs in conformance with a consistent set of discrete and structured data, since EHRs exist to enable information exchange between multiple electronic systems that were not primarily designed to be interoperable. As such, HIEs are designed to improve upon and extend the many “one-off” solutions to interoperability obstacles that have been brokered between EHR vendors and provider practices over the years. To compensate for the lack of well-defined data standards and data exchange protocols in earlier years, vendors and providers alike developed many creative approaches to enable the exchange of needed information about patients who require comprehensive care and are receiving services from multiple providers. Now that stronger standards and transport methods are available, information flows can increase in volume and engage more providers, all at lower unit cost than ever before.

HIE development goals include creating detailed specifications for record formats that can be used to produce EHR patient summary documents that align with ONC’s “Standards & Interoperability Framework” that governs data content and transport. Increasingly, EHR vendors are including standardized, structured data technologies in their products to make it easier for providers to share and access patient health information, in accordance with MU certification standards and payments, which are tied to provider payments for acquiring and deploying EHRs. Because data exchange must be comprehensive, timely, and specific to an individual to be valuable to providers, increasingly, HIEs are developing knowledge about common challenges faced in health care.

Benefits of HIEs in care coordination of individuals with complex needs include: moving data across platforms and among service providers in real time to enable providers to more easily track what is happening with an individual patient/client; data aggregation and analysis using information from individual patients to analyze need and supply of services across populations; performance outcome management for payers; analysis of cost-effective interventions for high-risk patients; and support of EHR use and achieving MU goals for providers and health systems.

Until the February 2016 memo was issued, long-term care providers, including AAAs that were providing services for and administering Medicaid Home and Community Based Services (HCBS) waiver programs, were effectively excluded from federal funding opportunities for IT. This made it harder for the Aging Network to develop its own IT infrastructure, and to influence the shaping of shared IT systems in a way that both includes and demonstrates the value of Aging Network services. It also hampered the ability of AAAs and CBOs to make clear-cut business cases to health care organizations that its suite of health-related services—which a gradually growing body of evidence show can reduce high-cost, low-value care in vulnerable populations—are a worthwhile investment for improving quality and reducing spending on complex patients. Without access to public IT funds, AAAs have relied on funds from local foundations and charities, and some have worked to accumulate reserves from expanding lines of business, to finance IT implementation and

operating costs. The three AAAs that served as the key informant interviews for this paper illustrate this well.

3.0 KEY INFORMANT INTERVIEW #1: FT WAYNE, IN

Aging & In-Home Services of Northeast Indiana, Inc. (AIHS) is the primary resource for older adults, persons with disabilities, and their caregivers, and a funder of services including support for the Councils on Aging in their nine-county service area in Indiana: Allen, Adams, DeKalb, Huntington, LaGrange, Noble, Steuben, Wells, and Whitley. The key informant interview was held on February 20, 2017 with AIHS staff in Ft. Wayne, Indiana.

Similar to other ambitious AAAs around the country, the range of services that AIHS provides under non-OAA contracts, grants, and programs are steadily expanding, fueled by a growing recognition among payers and medical practitioners that older adults require a well-managed, diverse array of supportive services to remain stable following treatment provided in hospitals and other medical settings. Increasingly, AAAs are also serving young populations; 45% of AIHS clients, for example, are under the age of 60.

In recognition of the need for greater flexibility in contracting, AIHS helped lead efforts during the last several years to launch two Limited Liability Corporations (LLCs): Preferred Community Health Partners, which serves the local Ft. Wayne area, and the Indiana Aging Alliance, which was formed to negotiate contracts with managed care organizations (MCOs) on behalf of Indiana's 16 AAAs. At the same time, it became evident to AIHS that a sophisticated IT system was needed to manage multiple contracts featuring varying rules and requirements with diverse community organizations and a range of health care partners, including hospitals, insurance companies, Medicaid, Medicare, and other state and federal programs.

3.1 Information Technology Overview

The IT system that AIHS elected to license is a cloud-based vendor platform, Preferred Population Health Logistics (PHL). (Note: PHL is one of a number of cloud-based case management systems on the market.) Designed for use by AAAs and other CBOs, PHL integrates communications between the health care and social services sectors and focuses on management of complex populations. It meets health care industry standards required in MCO contracts; connects to HIEs; has the capacity to bill directly and to integrate with financial systems maintained by payers; and features an integrated population health management capability.

The software features drop-down menus to minimize documentation time and standardize and reduce the length of time needed to do varying assessments that are required under different payer programs. Assessments are designed to be comprehensive: covering needs, barriers to care, and the goals and objectives of elders and family caregivers. PHL tracks individuals longitudinally, maintaining both active and inactive client records over time. PHL has been fully aligned with all National Committee for Quality Assurance (NCQA) Long Term Services and Supports (LTSS) Accreditation standards to assure quality.

With respect to procedures for protecting patient privacy, AIHS has negotiated a substantial number of Business Associate Agreements (BAAs) with health care organizations to comport with standards required under the Health Insurance Portability and Accountability Act (HIPAA), which are stored in PHL. PHL's connection to Indiana's HIE (Indiana Health Information Network or IHIE) and/or to individual health system electronic medical records allows AIHS to access hospital admission-discharge-transfer (ADT) alerts. This means that AIHS knows within 24 hours which hospitals their clients are in for purposes of making contact with staff, and to obtain information about discharge plans and follow-up visits with individual clinicians.

PHL can be configured to export assessment and care plan summary information to EHRs maintained by primary care practitioners, and can receive and upload information from health care providers and certain other programs that an elder is currently enrolled in (or has been in the past), which can be used to help auto-populate an individual's record. The population management feature can pull and aggregate data in various ways. For example, queries can be run on the number of individuals who sought care in the emergency room one to five times during the past month, and information can be compiled on a per-provider or per-payer basis.

3.2 Calculating Return on Investment (ROI): How This Can Help AAAs

For any given contract (or potential contract) the software used by AIHS employs an "agent-based" approach that calculates projected costs at the individual level in order to estimate potential costs and savings for all parties. Information from health care providers (e.g., outpatient data, minimum and maximum cost, most frequent usage, and hospitalization and emergency room usage) are factored in, along with claims data on specific populations by diagnosis. Also factored in is the cost of care in different settings.

On the social services side, caseloads and labor costs for administrative staff, social workers, and other field staff are calculated. Different interventions that are being used by a particular payer or health care organization (e.g., low-touch telephone only vs. in-home case management services) can be modeled. The costs of different interventions for a population of enrollees can then be compared, and ROI results can be presented over different time periods. According to Connie Benton Wolfe, president & CEO of AIHS, having the ability to present and calculate ROI for providers, programs, and payers is a key factor in expanding the reach and impact of the Aging Network. "That's how we get a seat at the table with potential partners and payers," she observed.

AIHS financed its initial acquisition of a PHL license with accumulated savings from "a small margin in some of our integrated care work combined with other local dollars," Benton Wolfe explained. And while acknowledging that "a lot of AAAs have never had to pay for data management in any way," she argued that if an AAA does not control their data systems it "limits you substantially in terms of your business line." For example, Benton Wolfe noted that Indiana's current Medicaid Waiver HCBS case management program provides \$100 per month per patient. AIHS recently modeled projected savings that could accrue to Medicaid if waiver clients were moved into a more comprehensive case management intervention modeled on Medicare's Community-Based Care Transitions Program (CCTP). Initial ROI calculations show possible savings to Medicaid of \$63 million on 15,000 lives per year. In this way, she concluded, IT investment can be viewed as "more than just a tool to get new business. It's actually a way to expand business that you currently have."

4.0 KEY INFORMANT INTERVIEW #2: ST JOSEPH, MI

A second key informant interview was conducted on February 22, 2017 with the Region IV AAA located in St. Joseph, MI. Region IV covers a three-county area in southwest Michigan made up of Berrien, Cass, and Van Buren counties, including Lake Michigan coastal areas in two of the three counties. The AAA is co-located with the Disability Network of Southwest Michigan and a Program of All-Inclusive Care, PACE of Southwest Michigan. The description that follows is based on interviews with AAA Executive Director Lynn Kellogg and Christine Vanlandingham, fund and product development officer.

4.1 Information Technology Overview

The Michigan Region IV AAA and its IT systems are organized programmatically:

1. Operation of the MI Choice Medicaid HCBS waiver program, a capitated, full-risk, pre-paid ambulatory health plan;
2. Contracts with two insurers in Michigan’s demonstration program on integrated care for dually eligible Medicare/Medicaid beneficiaries, called MI Health Link;
3. A demonstration project composed of Lakeland Health, a nonprofit community-owned health system; two local Federally Qualified Health Centers (FQHCs); and the St. Joseph AAA. Currently in its third and final year, the demonstration is building an “interagency care team” that connects medical and social service providers. It is also working to streamline IT solutions that can more seamlessly coordinate and demonstrate the value of AAA and CBO services.

Still, Kellogg noted that the use of multiple IT systems, duplicate data entry, and lack of interoperability remain challenges. The Medicaid HCBS waiver program has two different IT systems, requiring support coordinators to double-enter data in the MI Choice Information System; one is a system that has been used in Michigan waiver programs for many years, and a second is a system that is gradually replacing it—a HIPAA-compliant, cloud-based application that provides comprehensive waiver management software including pre-admission screening, assessment, person-centered plans of care, service plans, quality reports, billing, and claims processing. Double entry into the two systems is necessary until the multi-year change-over is completed. To enhance MI Choice’s connectivity with Lakeland Health, read-only capability within Lakeland Health’s EHR system, EPIC, has been established for Lakeland patients receiving MI Choice services through Region IV AAA. Additional connectivity is in the planning stages.

As a contractor for two insurers in Michigan’s demonstration project for dually eligible beneficiaries, AAA staff must navigate two additional systems. Both Aetna and Meridian Health Plan participate in the demonstration, and are contracting with the St. Joseph’s AAA for certain care management and nursing facility transition services. In the next phase of the demonstration, the AAA will begin creating care plans. These will be narrative documents that will be shared with the relevant payer—an effective protocol for communication, but not an interoperable IT system.

Development work on the interagency care team project involves connectivity with both Lakeland Health and two FQHCs. This project requires the St. Joseph AAA to use another IT system called “Resource Connection,” a cloud-based tool, which allows AAA, Lakeland, and FQHC staff to communicate common goals and progress on shared patients. This workaround allows information

and service records for individuals served by Information and Communication Technology (ICT) to be accessed by AAA, Lakeland, and FQHC staff, and to share narrative documents. However, AAA care managers are not able to add to the patient's longitudinal plan of care. As a result, Resource Connection functions as a communication tool, but not as an interoperable health care and social services IT system.

In addition, traditional OAA-funded services have separate requirements for submitting data on services that comply with state requirements and feed into National Aging Program Information System (NAPIS) reporting that is maintained by the Administration for Community Living (ACL). Thus, various IT systems are used by the Region IV AAA and its CBO subcontractors.

4.2 Challenges of Multiple Systems

By training and vocation, Region IV staff are well-equipped to organize and provide community-based and social services to older adults and people with disabilities in their service area. They are less equipped to deal with multiple non-coordinated IT systems, and find it difficult to work with multiple systems. "The biggest challenge staff identified is that... [the systems] don't speak to each other," Kellogg explained. "They have to enter into MICIS [MI Choice Information System], and then it has to be hand entered into [another Medicaid system known as] COMPASS. The language that's required in MICIS is different than COMPASS; it needs to be written in a different format. So there's dual entry just within one [HCBS] program, one funding source. That's a challenge."

For their call center, Region IV uses a "Harmony" software product, staffing it with 5 people who field about 600 calls per month. This system works well for initial contacts, allowing the AAA to quickly track needs and requests for services and to identify service gaps. Despite the fact that this is yet another system for agency staff to learn and maintain, the community-wide planning functions make it a useful part of their suite of IT solutions. "A perfect state would be having one system internally that is able to exchange data," Kellogg said. "Right now, it's not even copy-and-paste, because the language needs to be different [for different record-keeping systems]. We really are Switzerland. We brought [health care and social services] parties closer together by being able to share information and willingness to explore action." Vanlandingham added that the varying IT systems are overly reliant on workarounds, increasing the risk that these arrangements could be overwhelmed by volume at some point, and more and more impractical and inefficient to operate as the AAA begins to provide more and more services.

Region IV has received funding to improve IT from several foundations, including the Healthy Berrien Consortium, United Way of Southwest Michigan, the Michigan Health Endowment Fund, and the Frederick S. Upton Foundation. The overall goal is to identify IT solutions for sharing information between the AAA, FQHCs, and Lakeland Health System hospitals focusing on high-risk patients. Overall, Kellogg and Vanlandingham agree that while AAAs are expert in organizing and delivering community-based services and community LTSS, they will need more streamlined and comprehensive solutions over time to increase the volume of services they can deliver, and to operate as full partners with health care systems.

Michigan's HIE, Michigan Health Information Network Shared Services (MiHIN), is being used by some AAAs in the Detroit area. At some point in the future, Region IV may want to link to MiHIN, Kellogg said, but to date, because the area health systems all use EPIC (a large HIT vendor of EHRs) that connect to the MiHIN, Kellogg has not seen a need for the Region IV AAA to subscribe

separately. Instead, “we have grant funding available to help us implement our development as an EPIC site,” she explained. “It is our mechanism here to connect with health care providers. We have to have the billable codes and payment structures set up...[to] bring in enough revenue for us to be able to sustain the ongoing cost associated with having EPIC.” At present, she concluded, developing solid links between services that the AAA provides, and linking these with insurers and health systems through various contracts is key to staying relevant and moving farther into a role as a community services broker with local health systems.

5.0 KEY INFORMANT INTERVIEW #3: Atlanta, GA

The AAA for the 10-county region in Georgia that includes Atlanta is part of the Atlanta Regional Commission (ARC), an intergovernmental coordination agency. As one of 12 AAAs in Georgia, the ARC organizes and delivers OAA-funded services and Medicaid HCBS waiver services. Its coverage area includes urban, suburban, and rural counties, is ethnically and socioeconomically diverse, and has an overall population of 4.4 million people.⁴ Kathryn Lawler, AAA director⁵ until early 2017, and Jennifer Beamer, analytics and technology coordinator, were interviewed on February 22, 2017. The narrative below is derived from that discussion.

Like many AAAs, ARC is in an era of growth and expansion. In 2013, 85% of their funding was from traditional grant-based aging and disability program funds; by 2016, the agency’s budget had grown by \$4 million. “We’re now running the entire human services transportation system for the fourth largest county in Georgia, so it’s a big system,” Lawler explained. “That’s where we saw a lot of growth. There has [also] been some increase in opportunities with Medicaid programs. We’ve seen some enrollment” increases, and “we’ve gotten new funding for nursing home transitions as well.” Each of these operates on a different IT platform, however, making exchange of information with external entities a major challenge. Therefore, as in the Region IV AAA in southwestern Michigan, ARC staff must enter data into multiple systems.

In 2014, ARC implemented an LTSS data management system for its regional programs. The Social Assistance Management System (SAMS) is a Mediware/Harmony product that is compatible with federal reporting for OAA services, but is not easily adaptable for purposes of gathering and analyzing information on services that are funded through other programs. For example, it is not customizable or flexible enough to enable ARC to significantly expand its business, and is not working well for newer lines of business. As a result, ARC has been exploring an interface. “What we originally thought about,” Lawler said, “is one software system that could do everything, and we have moved away from that, understanding that a regional system might actually require a lot of [integration between] different systems.”

ARC provides services under two Medicaid HCBS waiver programs: the Community Care Services Program (CCSP), which focuses on nursing home diversion, and SOURCE, an enhanced case management program that links with primary care physicians. The two programs require ARC staff to work with different IT systems in order to communicate with the Medicaid Managed Information

⁴ <http://www.atlantaregional.com/info-center/arc-region/population-housing-data>

⁵ Lawler stepped down on December 30, 2016, but assists ARC in a consulting role until the new director’s (Becky Kurtz) start date on April 3, 2017

System (MMIS), a state run data system which comports with federal mechanized claims processing and data retrieval functions.⁶ ARC is currently using SAMS for the SOURCE waiver, and a different state system, known as Aging Information Management System (AIMS), which was developed for the CCSP waiver. At the same time, Georgia is moving the CCSP into yet a different IT application, known as “Framework.”

In another challenge, the IT systems that ARC is currently using are not comprehensive. For example, waiting lists can be maintained, but there is no ability to conduct root-cause analysis on service shortages. Fortunately, the ARC’s call-in system, “InContact,” allows AAA staff to follow up with callers on whether they received the services to which they were referred, and whether they were effective in meeting their needs. This workaround is creative, but not as complete as they would like for area wide service and delivery planning. InContact allows for collection of data such as the number of callers asking for a certain service and the number of referrals made to various services, but not a comprehensive set of data that is useful for developing future plans or even accurately assessing the totality of current need in the region.

All told, the ARC staff use four different data systems: InContact for their call center; Elder Services Program (ESP) which supports resource management and services for information and referral work; Framework for one Medicaid HCBS waiver, and SAMS for client management in all other programs. The staff time and effort required to master and use these different programs is significant, and the limitations of the varying systems, which do not communicate with each other, create problems in service and resource planning.

However, ARC is exploring more interoperability via the state’s HIE, the Georgia Health Information Network, which operates similarly to a data warehouse model. In a data warehouse model, patient information is sent by providers to a secure data repository operated by the state; other providers can then access these data to look up lab results, medications, or other services an individual has received. While this is furthering progress, it is challenging for ARC to make major strides in building broader health and social services markets, because there are legal barriers to doing so. Specifically, under state law, regional commissions are prohibited from forming separate non-profits or LLCs. To address this issue, Georgia AAAs are now analyzing how it may be possible to amend the law in a way that would enable them to create an entity to manage statewide contracts, expand work with health care organizations, and grow their service capacity.

Georgia is involved in another federal initiative that is in relatively early stages of development, the electronic Long-Term Services and Supports (eLTSS) initiative, which is developing standard data sets for use in community-based LTSS. AAAs can participate in development of the eLTSS initiative as standards are piloted and tested. As a state, Georgia is one of the Testing Experience and Functional Tools (TEFT) pilot sites for the eLTSS project, and as part of that, AAAs in the state were asked to participate in planning and testing discussions on which data elements would be important to include in standardized HIT data collection. Testing of the TEFT tools in Georgia and eight other states is scheduled to be completed by December 31, 2017. The standards created and tested in this effort will be used to underpin more centralized and person-centered IT that will be built into vendor software products in the future for use in the community-based LTSS delivery system, of which AAAs are an integral part. Therefore, while the eLTSS initiative is still in a development phase, as it advances, it bears watching.

⁶<https://www.medicaid.gov/medicaid/data-and-systems/mmis/index.html>

In summary, Georgia's experience highlights challenges with an incremental approach to service delivery and IT system changes. Looking forward, more flexible standards-based IT systems are needed to not only connect with various EHRs and the state's HIE, but also as a critical component of infrastructure needed for expansion. Adding lines of business such as subcontracting with managed care plans and integrated health systems will require that the IT systems used by ARC for OAA and Medicaid work also connect in an interoperable manner with new external partners.

6.0 DISCUSSION

IT system requirements depend on the specific needs of payers. At the state level, many legacy state Medicaid IT systems are old and relatively low in functionality, with limited options for advanced care coordination. While AAAs may be able to participate in state-level or regional planning bodies focused on IT development, on a practical level it is unlikely that a single AAA will be able to strongly influence the direction of major state systems, at least in the short term. The current dependence of many AAAs on these Medicaid IT systems, in conjunction with limited funds to develop local alternatives, make it unlikely that most AAAs will be able to innovate to their maximum capacity unless and until they develop a business model to address IT.

6.1 Care Coordination

Moreover, private insurance companies and Medicare-reimbursed payers such as Accountable Care Organizations (ACOs) and Medicare Advantage plans present different opportunities and challenges than those posed by state Medicaid programs. In general, payers and providers operating in a value-based reimbursement framework are likely to be open to considering new options for care coordination and management services if a clear financial gain in the form of a ROI can be demonstrated. For example, pay-for-performance models and capitated programs, in which reduction of average cost per client is essential to profit margins, may be willing to invest more in spending on comprehensive case management if there is evidence—and data—that these services can reduce the total cost of care. Other providers may be interested in care coordination to try to avoid financial penalties for undesired outcomes, such as hospital readmissions.

The recent rise of interest in care coordination as a specialized business service to optimize service delivery for older adults living with chronic conditions and functional limitations creates a potential new revenue stream for AAAs that have the capability to organize and deliver these services. High-cost patients who need both medical care and long-term services and supports, such as frail elders, have the most to gain from improved care coordination. A principal challenge is how to create the administrative management piece on a scale that is attractive to large payers and health care systems. In addition, allocation of savings is critical to the sales model for comprehensive case management services that AAAs are increasingly providing.

6.2 Scalability and Start-up Decisions

In the economics of information system management, scale is a centrally important element. While start-up costs to service the first client may seem overwhelming, when amortized over thousands of individuals, these costs become justifiable. Ongoing maintenance and improvement costs are also

more likely to be reasonable when considered as a fraction of a large usage base. Because ROI drives technology spending, it is important that AAAs considering technology investment have access to a robust ROI model that allocates costs for their indirect investment in technology to observable financial benefits seen elsewhere.

For AAAs and many other organizations considering whether to make investments in IT, decisions often turn on a “build versus buy” decision: Is it better to build something new, or buy a solution from a vendor? Does the organization want to run the equipment and a network, or use a cloud-based service that runs on the Internet? Most small organizations gravitate toward cloud-based services, which generally have a lower cost of acquisition, cost less to operate, and reduce the need for local staff with information systems training. Indiana’s AIHS demonstrates how AAAs can adopt a cloud-based architecture that sidesteps the limitations of a state-provided IT system that was developed for the state’s Medicaid program.

6.3 HIE Opportunities

For some AAAs, HIEs may have the potential to become important business partners in the development and expansion of services. Originally conceptualized as conduits for moving health care information between providers, HIEs are now developing other services—storage of health information, portal services that providers can use to view and analyze case management information, and data analysis services for population analysis and predictive analytics. Other services are being offered by some HIEs. For example, negotiating a Business Associates Agreement (BAA) with health care providers in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) can be a complex and lengthy process. In response, some HIEs have simplified BAAs between providers connected to their networks. Information sharing agreements may also form part of an HIE contract, resulting in simplified paperwork for both patients and providers.

Since HIEs were developed to serve geographic regions, they are natural partners for enabling communications across these areas. And because AAAs are not restricted to providing services in PSAs except for those funded by the OAA, they have the flexibility to offer care coordination services across broad geographic areas if they so choose in partnership with health care organizations that want to offer such services to their patients/enrollees. An AAA (or group of AAAs) that connects to multiple HIEs could, therefore, access a large geographic market. Alternatively, an AAA that operates with a “hub and spoke” system, as AIHS does, which connects other AAAs and CBOs (spokes) to a cloud-based management system through its license (hub), could use this kind of IT architecture to establish a care coordination network.

6.4 Connecting Across Silos

Increasingly, having access to IT that communicates across “information silos” will be critical to the business success of the Aging Network. Information silos exist wherever a specialized need for information exists. Payers, for example, seek IT systems that are optimized for their payment processes. Primary care providers have different needs that involve clinical data, and they also must be able to transmit payment requests to payers. Patients and family caregivers have other needs for accurate and timely information that is optimized for patient education and decision-making. AAAs

need IT systems that can communicate on all of these levels. To create a seamless coordinated care system, data must be able to flow freely between silos.

In general, as provider networks become larger, their information systems capabilities are improving. Yet increased competition and reduced profit margins are also driving consolidation in the health care sector. From the vantage point of large health systems, contracting for services for a limited geographic area (such as a PSA) may not provide the scale that is wanted. To overcome this, multiple AAAs could form a regional or statewide strategy group to investigate collaboration opportunities for sharing or coordinating services. Working together in this way may help achieve economies of scale, and creates a period of business opportunity—but that window could close quickly as other care coordination providers seeking to play a dominant role emerge in specific geographic markets. This suggests it would be prudent for AAAs to act rapidly to investigate the issues involved in becoming bigger players in comprehensive care coordination and population health management. The larger the patient base, the greater the likelihood that health partners will be interested in population health management and care optimization for vulnerable populations. Moreover, AAA networks with a broad reach will be more attractive.

6.5 Electronic Social Services Data

With respect to identifying what are the most important pieces of information that need to be exchanged among providers to support an older adult living at home, and that are also of critical importance to the individual and his or her family caregiver, key informants in the three AAAs interviewed felt that social determinants of health are the factors *most* likely to be left out of EHR or other care records—yet are often a determining factor for clinical outcomes. For example, Lynn Kellogg of Michigan’s Region IV AAA pointed out that “for a couple of our clients, the patient was the caregiver for someone else, and we had to solve that set of problems...” Kellogg added: “Without documenting and resolving underlying social issues, medical care will often not happen, or not be followed through. AAAs know this, and have a strong role in educating clinical and hospital professionals about these realities and opportunities to improve health outcomes by addressing social problems.”

With regard to how data that are collected could be used to inform analyses of the value of social services and supports in keeping vulnerable older adults out of high-cost medical settings, AIHS’s Connie Benton Wolfe expressed confidence that data on health care utilization (such as emergency department and skilled nursing facility admissions) that are collected and analyzed through the PHL IT system allow AIHS to clearly demonstrate positive ROIs to many current and potential partners—particularly payers—for investing in “upstream” lower-cost social supports and services that reduce total spending.

AIHS’s Paul Watkins added that he foresees a future in which “ultimately you get the technology out of the way entirely...I see a quick dropdown [menu design and an easy way to] select the values you need, get the information quickly, allow it to collect that information from multiple areas while you’re sitting there by using a tablet or some [other] type of technology...where you can quickly tap something out of the corner of your eye so you can actually get back to being a social worker again and building up that rapport with clients and really just having a candid conversation about their different needs.”

7.0 CONCLUDING OBSERVATIONS AND RECOMMENDATIONS

For AAAs to be competitive in the rapidly evolving market of optimizing care for older adults and people with disabilities requires access to state-of-the-art IT that focuses specifically on care coordination, risk stratification, population management, social determinants of health, and integrated service delivery models spanning multiple care providers. These types of systems are rapidly emerging as a highly competitive class of IT in their own right. In addition to enhanced capabilities now seen in large-scale EHR systems, cloud-based services that eliminate the expense and complexity of “on-premises” systems (i.e., software and technology that are located within the physical confines of an enterprise) are increasingly available.

AAAs are in an excellent position to align with providers across the country to help reduce utilization of high-cost services for “high utilizers” that health care organizations are increasingly held accountable for with regard to performance bonuses and penalties. Yet the ROI for payers is the most compelling, because they have a clear mission to reduce overall spending. High-quality, AAA-provided services that can maintain frail elders and other high utilizers “upstream” by using cost-effective, comprehensive case management services to lower the utilization of ER, inpatient hospitalization, and possibly skilled nursing facility (SNF) care—and thus significantly reduce total spending—will be in demand during the next several decades.

Importantly, AAAs should also consider pursuing funding through the 90/10 match available through HITECH. CMS’s February 2016 letter to State Medicaid Directors effectively urges all organizations involved in delivering Medicaid services to proactively engage with HIEs in order to improve quality and efficiency. More than 50% of AAAs already participate in delivery of HCBS waiver services, and many have developed strong relationships with local health systems through providing care management, post-discharge follow-up care, and connecting beneficiaries to a range of community services they need to live as independently as possible in their own homes. In a subsection of the memo titled “Care Plan Exchange,” the agency states: “States are encouraged to consider care plan exchange for patients with multiple chronic conditions who might be coordinating care between many specialists, hospital(s), long-term care facilities, rehabilitation centers, home health care providers, or other Medicaid community-based providers.”

This recognizes that AAAs are part of expanding integrated delivery networks, in which partnerships with health care organizations will become part of the fabric of almost all communities across the U.S. during the next 15 years. To achieve maximum flexibility in contracting for opportunities with health care organizations and other potential partners, AAAs therefore need to take steps to achieve IT integration as well. One way to start down this road is to reach out to State Medicaid Agencies as quickly as possible to explore the possible advantages of a 90/10 matching fund for establishing robust connections with HIEs. Funds are available through 2021 on a rolling basis if approved by CMS, and could make a solid contribution to assisting the Aging Network with one of their identified challenges: the high start-up costs associated with improved IT systems.

Interviewees also discussed the possibility of establishing national electronic standards for use by LTSS providers. As proposed, policymakers have suggested an electronic social and supportive services record could be populated and used by various social services providers in AAAs across the country, and could also be used by individual beneficiaries and family caregivers. Key informants expressed interest in exploring the concept.

Concerning considerations for developing a generalized design for an electronic social and supportive services record that could be populated and used by various social services providers in AAAs across the country, and which could also be used by individual beneficiaries and family caregivers, key informants expressed interest in exploring the concept. AIHS's Benton Wolfe commented: "I would describe it as a flexible standardization....I think we're going to go through a period of discovery, so you need everybody to be able to play in their sandboxes to start out with and then consolidate an initial round of information. I think [if] you can have a series of consolidated standardization processes, you're going to learn a lot from different geographic areas, different regions of the country, and I can see regional standardization being used to point us in the direction for national standardization. I think the data will show us what that means." Connie Benton Wolfe further reflected: "I think we can start looking at some key components and saying, 'Do we need to do a 2-hour holistic assessment every time, or can we dwindle it down to a 15 or 20-minute intervention that's going to point us in the same direction?' ...I think it's to be determined, but you ...can't just be flailing around with every professor's research project, every type of grant, every type of innovation that's out there, and try to meet all of those needs. You'll get lost."

In closing, Benton Wolfe reflected that "if you can find ways to work together, there are ways to survive and thrive in this environment. Probably our strength going forward in terms of building our business case is to figure out those things we do really well, measure our outcomes, sell our business case, and be able to sell it across boundaries...I consider this to be a business environment for us in terms of opportunity that is more outstanding than any I've seen in my very long career."

8.0 Acknowledgements:

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9.0 APPENDIX I

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850



SMD# 16-003

**RE: Availability of HITECH Administrative
Matching Funds to Help Professionals and
Hospitals Eligible for Medicaid EHR Incentive
Payments Connect to Other Medicaid Providers**

February 29, 2016

Dear State Medicaid Director:

This letter updates guidance issued by the Centers for Medicare & Medicaid Services (CMS) about the availability of federal funding at the 90 percent matching rate for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers. CMS previously issued guidance on this topic in State Medicaid Director (SMD) Letter #10-016 (August 17, 2010)¹, SMD Letter #11-004 (May 18, 2011)², and a 2013 guidance document, “CMS Answers to Frequently Asked Questions (9/10/2013)” (2013 guidance).

This updated guidance expands the scope of State expenditures eligible for the 90 percent matching rate, and supports the goals of, “Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Version 1.0,”³ published by the Department of Health and Human Services, Office of the National Coordinator (ONC) for Health Information Technology, on October 6, 2015. In this letter, we are expanding our interpretation of the scope of State expenditures eligible for the 90 percent HITECH match, given the greater importance of coordination of care across providers and transitions of care in Meaningful Use modified Stage 2 and Stage 3. This letter supersedes the 2013 guidance but many of the principles of that guidance, as indicated in this letter, remain valid. We intend to issue updated, detailed guidance that integrates those principles with the interpretive changes set forth in this letter.

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, added sections 1903(a)(3)(F) and 1903(t) to the Social Security Act. These provisions make available to States 100 percent Federal matching funding for incentive payments to eligible Medicaid providers to encourage the adoption and use of certified EHR technology through 2021, and 90 percent Federal matching funding (the 90 percent HITECH match) for State administrative expenses related to the program, including State administrative expenses related to pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information, subject to CMS approval. CMS has implemented these

¹ Available at <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10016.pdf>

² Available at <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD11004.pdf>

³ Available at <https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf>

provisions in regulations at 42 CFR Part 495. When attesting to Meaningful Use modified Stage 2 or Stage 3, professionals and hospitals that are eligible for Medicaid EHR Incentive Payments (collectively referred to in this document as Eligible Providers) must demonstrate the ability to electronically coordinate with other providers across care settings under the CMS regulations at 42 CFR Part 495. In order to meet these Meaningful Use objectives, Eligible Providers will often need to electronically coordinate care with other Medicaid providers that are not eligible for Medicaid EHR incentive payments.

SMD Letters #10-016 and #11-004 explained that state costs related to HIE promotion may be matched at the 90 percent HITECH matching rate only if they can be directly correlated to the Medicaid EHR Incentive Program. In the 2013 guidance, we therefore explained that States' costs of facilitating connections for providers to an HIE may be matched at the 90 percent HITECH matching rate only if the providers are Eligible Providers. We now explain that State costs of facilitating connections between Eligible Providers and other Medicaid providers (for example, through an HIE or other interoperable systems), or costs of other activities that promote other Medicaid providers' use of EHR and HIE, can also be matched at the 90 percent HITECH matching rate, but only if State expenditures on these activities help Eligible Providers meet the Meaningful Use objectives. Subject to CMS prior approval, States may thus be able to claim 90 percent HITECH match for expenditures related to connecting Eligible Providers to other Medicaid providers, including behavioral health providers, substance abuse treatment providers, long-term care providers (including nursing facilities), home health providers, pharmacies, laboratories, correctional health providers, emergency medical service providers, public health providers, and other Medicaid providers, including community-based Medicaid providers.

For example, an Eligible Provider might be a physician needing to meet the modified Stage 2 or Stage 3 Meaningful Use objective for health information exchange (*see* 42 CFR 495.22(e)(5)(i) or 495.24(d)(7)(i)(A)) when transitioning patients to another Medicaid provider such as a nursing facility, or a home health care provider. Or an eligible hospital might need to meet the objective for Medication Reconciliation and compare records with other providers to confirm that the information it has on patients' medication is accurate when it admits patients into its care (*see* 42 CFR 495.22(e)(7)(i) or 495.24(d)(7)(ii)(B)(3)(i)). Subject to CMS approval, States can claim 90 percent HITECH match in the costs of developing connectivity between Eligible Providers (whether eligible professionals or eligible hospitals) and other Medicaid providers if this will help the Eligible Providers demonstrate Meaningful Use.

CMS explicitly encourages and welcomes multistate collaboratives partnering on shared solutions for HIE and interoperability, including for the activities discussed in this letter (facilitation of EHR Meaningful Use and related communications through the HIE system). CMS will aggressively support such collaboratives as potentially cost-saving opportunities to increase adoption of interoperability standards and help Eligible Providers demonstrate Meaningful Use. Such collaboratives should promote Medicaid Information Technology Architecture (MITA) principles on scalability, reusability, modularity, and interoperability. We note that ONC is a willing partner in helping States develop open source and open architecture tools for HIE that are consistent with MITA principles.

Cost controls, cost allocations, and other payers

States must ensure that any 90 percent HITECH match claimed under the guidance in this letter supports Eligible Providers' demonstration of Meaningful Use modified Stage 2 and Stage 3, and must therefore report on the extent to which the activities they are funding help Eligible Providers demonstrate Meaningful Use. CMS will require States to describe in advance which specific Meaningful Use measures they intend to support in the Implementation Advance Planning Document (IAPD) as well as to confirm such measures are indeed supported post-implementation. Under no circumstances may States claim 90 percent HITECH match in the costs of actually providing EHR technology to providers or supplementing the functionality of provider EHR systems. This funding is available, subject to CMS approval, as of the date of this letter, and will not be available retroactively.

Additionally, States should claim the 90 percent HITECH match for HIE-related costs relating to Medicaid providers that are not eligible for Medicaid EHR incentive payments only if those HIE-related costs help Eligible Providers demonstrate Meaningful Use. For example, it would not be appropriate for States to claim the 90 percent HITECH match for costs related to an HIE system that did not connect to or include Eligible Providers and therefore would not help Eligible Providers demonstrate Meaningful Use.

States should continue to adhere to the guidance in SMD Letter #11-004 detailing how Medicaid funding should be part of an overall financial plan that leverages multiple public and private funding sources to develop HIEs. Similarly, States are reminded that per SMD Letter #11-004, the 90 percent HITECH match cannot be used for ongoing operations and maintenance costs. This updated guidance makes no changes to the general cost allocation principles and fair share principles States should follow in proposing funding models to CMS for HIEs or interoperable systems, although under this updated guidance, the Medicaid portion of such cost allocations may increase to include costs associated with connecting Eligible Providers to other Medicaid providers. CMS has approved several different cost allocation methodologies for States and those various methodologies will be affected differently by this guidance. CMS will provide technical assistance on the impact of this guidance on specific States. Similarly, States should continue to complete and update the "Health Information Technology Implementation Advance Planning Document (HIT IAPD) Template⁴," developed by CMS and the Office of Management and Budget, in which States detail cost allocation models and other financial considerations. States should meet with CMS to review cost allocation models that carefully consider the extent to which the HIE or other interoperable system benefits Eligible Providers, other Medicaid providers, non-Medicaid providers, and other payers.

Medicaid Information Technology Architecture (MITA) emphasizes the importance of interoperability and industry standards. States should take an aggressive approach to HIE and interoperability governance for purposes of supporting interoperability while focusing on security and standards to keep interface costs to a minimum. The CMS final rule published on December 4, 2015, "Mechanized Claims Processing & Information Retrieval Systems (90/10)"

⁴ <https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/medicaidhitapdtemplate.pdf>

requires in 42 CFR 433.112 a new focus on industry standards in MITA that support more efficient, standards-based information exchange as described in 45 CFR Part 170. Specifically, 45 CFR Part 170 defines the Common Clinical Data Set, transport standards, functional standards, content exchange standards and implementation specifications for exchanging electronic health information, and vocabulary standards for representing electronic health information. In implementing these standards, we encourage States to develop partnerships with non-profit collaboratives and other industry participants such as DirectTrust that further support Direct Secure Messaging through trust frameworks that reduce the costs and technical complexities of electronic health information exchange for providers.

The interoperable systems described in this letter are part of the MITA and interfaces to these systems should appropriately follow a Service-Oriented Architecture (SOA) as well as adhere to industry standards. States should aggressively pursue HIE and interoperability solutions for Medicaid providers that either obviate the need for costly interfaces, or utilize open architecture solutions that make such interfaces easily acquired. For example, consistent with the software ownership rights held by the state under 45 CFR § 95.617, States might require that HIE interfaces designed, developed, or installed with Federal financial participation be made available at reduced or no cost to other Medicaid providers connecting to the same HIE. Furthermore, States could require that such interfaces (or the code for such interfaces) be made publicly available. Additionally, CMS and ONC support States in sharing open source tools and interfaces with other States to further drive down the costs of HIEs, interfaces, and other interoperable systems.

States are also reminded that careful alignment and coordination with other funding sources should be thoroughly discussed with CMS and addressed in an Implementation Advance Planning Document Update (IAPD-U), specifically Appendix D. States continue to be encouraged to consult with CMS in advance of formal State Medicaid HIT Plan (SMHP) and IAPD submissions to obtain technical assistance regarding the funding options and boundaries outlined in this and the previous SMD Letters, and additional technical assistance will be provided when we release an update to the 2013 guidance that reflects the new criteria for the 90 percent HITECH match described here. States should reach out to their CMS regional office's Medicaid HIT staff lead as the initial point of contact.

Below are some examples of the types of state costs for which 90 percent HITECH match might be available, subject to CMS approval.

Federal Financial Participation (FFP) for On-boarding Medicaid providers to HIEs or interoperable systems

On-boarding is the technical and administrative process by which a provider joins an HIE or interoperable system and secure communications are established and all appropriate Business Associate Agreements, contracts and consents are put in place. State activities related to on-boarding might include the HIE's activities involved in connecting a provider to the HIE so that the provider is able to successfully exchange data and use the HIE's services. The 90 percent HITECH match is available to cover a state's reasonable costs (e.g., interfaces and testing) to on-board providers to an HIE. Subject to the parameters and cost controls described above, States

may claim 90 percent HITECH match for state costs of supporting the initial on-boarding of Medicaid providers onto an HIE, or onto any interoperable system that connects Eligible Providers to other Medicaid providers. Costs can be claimed both if they are incurred by the state to support the initial on-boarding of Eligible Providers and if they are incurred by the state to support the on-boarding of other Medicaid providers, provided that connecting the other Medicaid providers helps Eligible Providers demonstrate, and meet requirements for, Meaningful Use. States should coordinate with CMS on defining benchmarks and targets for on-boarding providers. States are reminded that, consistent with the principles described in both SMD Letter #10-016 and SMD Letter #11-004, the 90 percent HITECH match is for implementation only, and States should work with CMS on establishing an endpoint to onboarding and always ensure costs are allocated as appropriate across other payers. Also, the scope of the onboarding should be clearly defined and reviewed with CMS prior to IAPD submission to ensure that any costs claimed help Eligible Providers meet Meaningful Use and to ensure that HIE-related costs benefiting providers that are not eligible for Medicaid EHR incentive payments are claimed only if these costs help Eligible Providers demonstrate Meaningful Use. States should generally refer to SMD Letters #10-016 and #11-004 for other information about allowable onboarding costs.

Pharmacies: Similarly, subject to the parameters and cost controls described above, States may claim the 90 percent HITECH match for the costs of supporting the initial on-boarding of pharmacies to HIEs or other interoperable systems, if on-boarding the pharmacies helps Eligible Providers meet Meaningful Use objectives, such as the objectives around sending electronic prescriptions or the objectives around conducting medication reconciliations, both described in 42 CFR 495.22 and 495.24.

Clinical Laboratories: Subject to the parameters and cost controls described above, States may also claim 90 percent HITECH match for the costs of supporting the initial on-boarding of clinical laboratories to HIEs or interoperable systems, if on-boarding these laboratories helps Eligible Providers meet Meaningful Use objectives, such as the objectives for Electronic Reportable Lab Results or laboratory orders in Computerized Provider Order Entry (CPOE) described in 42 CFR 495.22 and 495.24.

Public Health Providers: Similarly, subject to the parameters and cost controls described above, States may also claim 90 percent HITECH match for the costs of on-boarding Medicaid public health providers to interoperable systems and HIEs connected to Eligible Providers so that Eligible Providers are able to meet Meaningful Use measures focused on public health reporting and the exchange of public health data, including activities such as validation and testing for reporting of public health measures described in 42 CFR 495.22 and 495.24.

FFP for interoperability and HIE architecture

As with expenses for on-boarding, States may claim 90 percent HITECH match for their costs of connecting Eligible Providers to other Medicaid providers via HIEs or other interoperable systems, if doing so helps Eligible Providers demonstrate Meaningful Use and the cost controls described above are met.

Specifically, 90 percent HITECH match would be available for States' costs related to the design, development, and implementation of infrastructure for several HIE components and interoperable systems that most directly support Eligible Providers in coordinating care with other Medicaid providers in order to demonstrate Meaningful Use. As described in SMD Letter #11-004, the 90 percent HITECH match cannot be used for ongoing operations and maintenance costs after this technology is established and functional. These components and systems include:

Provider Directories: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of provider directories that allow for the exchange of secure messages and structured data to coordinate care or calculate clinical quality measures between Eligible Providers and other Medicaid providers, so long as these costs help Eligible Providers meet Meaningful Use and the cost controls described above are met. The 90 percent HITECH match would not be appropriate for costs of developing a separate subdirectory for a class of providers that are not eligible for Medicaid EHR incentive payments and that are unlikely ever to exchange records with an Eligible Provider. CMS emphasizes the importance of dynamic provider directories with, as appropriate, bidirectional communications to public health agencies and public health registries. CMS particularly supports approaches to provider directories that provide solutions for Eligible Providers to connect to other Medicaid providers with lower EHR adoption rates, if doing so helps the Eligible Providers demonstrate Meaningful Use. Secure, web-based provider directories, for example, might help Eligible Providers coordinate care more effectively with long term care providers, behavioral health providers, substance abuse providers, etc. CMS expects that States will consider provider directories as a Medicaid enterprise asset that can also support Medicaid Management Information System (MMIS) functionality, with the reminder that, per SMD Letter #10-016, States should not claim 90 percent HITECH match for costs that could otherwise be matched with MMIS matching funds.

Secure Electronic Messaging: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of secure messaging solutions that connect Eligible Providers to other Medicaid providers and allow for the exchange of secure messages and structured data, so long as these costs help Eligible Providers meet Meaningful Use and the cost controls described above are met. States are encouraged to utilize Direct Secure Messaging as a transport standard that is secure and scalable. States should refer to the “Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 3 and Modifications to Meaningful Use in 2015 Through 2017” rule for guidance on meeting the Certified Electronic Health Record Technology (CEHRT) requirements for purposes of Meaningful Use⁵. States may also refer to ONC’s 2016 Interoperability Standards Advisory (ISA), a publication that provides the identification, assessment, and determination of the “best available” interoperability standards and implementation specifications for industry use to fulfill specific clinical health IT interoperability needs⁶. States should also be prescriptive in governance requirements to ensure maximal interoperability in the most secure and efficient manner possible. ONC is a willing partner with CMS in helping States deploy Direct Secure Messaging systems and developing

⁵ <https://www.federalregister.gov/articles/2015/10/16/2015-25595/medicare-and-medicaid-programs-electronic-health-record-incentive-program-stage-3-and-modifications>

⁶ <https://www.healthit.gov/sites/default/files/2016-interoperability-standards-advisory-final-508.pdf>

related governance requirements to ensure that Eligible Providers can connect to other Medicaid providers.

Query Exchange: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of query-based health information exchange, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. States may support coordination of care between Eligible Providers and other Medicaid providers by linking them into a query-based HIE that allows for secure, standards-based information exchange with thorough identity management protocols. A Query Exchange might access a state's Clinical Data Warehouse and similarly be integrated with analytic and reporting functions. These activities may support aggregate queries from providers to support population health activities performed by public health or other entities involved in population health improvement, provided that doing so helps Eligible Providers meet Meaningful Use. Given the unique data and exchange governance challenges of Query Exchange, States are encouraged to reach out to ONC to help formulate governance guidance and best practices.

Care Plan Exchange: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of interoperable systems and HIEs that facilitate the exchange of electronic care plans between Eligible Providers and other Medicaid providers, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. Medicaid providers coordinating care across multiple care settings may exchange care plans containing treatment plans and goals, as well as problem lists, medication history and other clinical and non-clinical content added and updated as appropriate by members of a patient's care team, including Medicaid social service providers. States are encouraged to consider care plan exchange for patients with multiple chronic conditions who might be coordinating care between many specialists, hospital(s), long term care facilities, rehabilitation centers, home health care providers, or other Medicaid community-based providers. Similarly, children in the foster care system might benefit from care plans shared across Medicaid providers (including Eligible Providers) to facilitate coordination of the children's care. As discussed above, costs related to exchanging care plans between Medicaid providers and other programs, such as foster care programs, may need to be allocated between benefitting programs.

Encounter Alerting: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of communications within an HIE or interoperable system connecting Eligible Providers and other Medicaid providers about the admission, discharge or transfer of Medicaid patients, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. These communications among Medicaid providers may contain structured data regarding treatment plans, medication history, drug allergies, or other secure content that aids in the coordination of patient care, including coordination of social services as appropriate.

Public Health Systems: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of public health systems and connections to public health systems, so long as the cost controls described above are met, and so long as these costs help Eligible Providers meet Meaningful Use measures focused on public health reporting and the exchange of public health data described in 42 CFR 495.22 and 495.24. It is worth

emphasizing that state costs eligible for the 90 percent HITECH match might include costs related to developing registry and system architecture for Prescription Drug Monitoring Programs (PDMPs), as per FAQ #13413⁷ PDMPs can be considered a specialized registry to which Eligible Providers may submit data in order to meet Meaningful Use objectives. States should, however, keep in mind that MMIS matching funds might in some circumstances be a more appropriate source of federal funding for costs related to developing a PDMP. Again, States should not claim 90 percent HITECH match for costs that could otherwise be matched with MMIS matching funds.

Health Information Services Provider (HISP) Services: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of HISP Services that coordinate the technical and administrative work of connecting Eligible Providers to other Medicaid providers, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. HISP Services may coordinate encryption standards across providers, as well as coordinate contracts, Business Associate Agreements or other consents deemed appropriate for the HIEs or interoperable systems. States should be careful to distinguish between on-boarding services and HISP Services, as the scope of HISP activities overlaps with the scope of on-boarding activities, and the state should confirm that activities are only supported with federal funding once. States should clearly define the scope of HISP activities and on-boarding activities as appropriate.

This is not an exhaustive list of the types of state costs for design, development, and implementation of HIE components and interoperable systems for which 90 percent HITECH match might be claimed. Design, development, and implementation costs associated with other HIE components and interoperable systems might be supported by the 90 percent HITECH match as long as these costs help Eligible Providers achieve Meaningful Use and meet the cost controls described above, and will be considered by CMS accordingly.

Under this updated guidance, States remain able, subject to CMS approval, to claim 90 percent HITECH match for design, development, and implementation costs related to personal health records (PHRs), as utilizing a PHR through an HIE will often be the best way for many Eligible Providers to meet the Meaningful Use modified stage 2 Patient Electronic Access objective (*see* 42 CFR 495.22(e)(8)) and/or the Meaningful Use stage 3 Coordination of Care Through Patient Engagement objective (*see* 42 CFR 495.24(d)(6)). The parameters for HITECH administrative funding discussed in SMD Letters #10-016 and #11-004 continue to be relevant to PHR funding requests from States.

Conclusion

With more States utilizing or exploring the possibilities of vehicles for delivery system reform that benefit from coordination of care, such as health homes, primary care case management, managed care, home and community-based service programs, and performance-based incentive payment structures, there is an expectation that the Medicaid Enterprise infrastructure will be designed to support these efforts. These efforts therefore support the MITA principles of

⁷ <https://questions.cms.gov/faq.php?faqId=13413>

reusability, interoperability, and care management in providing a foundation for further delivery system reform.

As States enter the fifth year of the Medicaid EHR Incentive Program, CMS and ONC expect them to leverage available federal funding for tools and guidance to help Eligible Providers demonstrate Meaningful Use, which might include strengthening data exchange between Eligible Providers and other Medicaid providers. States may have questions about the Health Insurance Portability and Accountability Act (HIPAA) considerations applicable to creating more diverse HIEs and interoperable systems, so we have included links to guidance from the U.S. Department of Health and Human Services Office for Civil Rights and the Office of the National Coordinator for Health Information Technology describing uses and disclosures that are permitted under HIPAA⁸. Note that the discussion in the linked guidance only concerns the uses and disclosures that are permitted under HIPAA, and does not address when state costs related to the discussed activities would be eligible for the 90 percent HITECH match. This next phase of infrastructure development and connectivity will best position all Eligible Providers to successfully demonstrate Meaningful Use of Certified EHR Technology while solidifying a broader network of health information exchange among Medicaid providers, writ large.

Sincerely,

/s/

Vikki Wachino
Director

Enclosure

cc:

National Association of Medicaid Directors
National Academy for State Health Policy
National Governors Association
American Public Human Services Association
Association of State Territorial Health Officials
Council of State Governments
National Conference of State Legislatures

⁸ https://www.healthit.gov/sites/default/files/exchange_health_care_ops.pdf and https://www.healthit.gov/sites/default/files/exchange_treatment.pdf