

Testimony of Dianne Hasselman
Director of Quality and Equality, Center for Health Care Strategies
before the

**Health Information Technology Policy Committee
Meaningful Use Workgroup
June 4, 2010**

9:00 a.m. – 3:30 p.m. (Eastern)
Washington Marriott @ Metro Center
Washington, DC

Introduction and Background

Thank you for the opportunity to submit a written statement to the HIT Policy Committee on behalf of the Center for Health Care Strategies (CHCS) and share our perspective. We appreciate the Committee's ongoing work in this area and being part of this important national discussion.

CHCS is a national nonprofit health care resource center founded in 1995. Our mission is to improve health care quality and cost-effectiveness within Medicaid. As the nation's largest health care purchaser in terms of covered lives (60 million Americans and growing), Medicaid comprises 50+ "learning laboratories" across the country – laboratories that can leverage tools and resources to reduce disparities in care and transform our health care system. CHCS is primarily funded by philanthropies including the Robert Wood Johnson Foundation, The Commonwealth Fund, the California HealthCare Foundation, and others.

CHCS works with federal policymakers, state Medicaid agencies, health plans serving Medicaid beneficiaries, and, increasingly, providers who primarily serve Medicaid patients.

It is with this perspective – of underserved patient populations, state Medicaid agencies, plans, and under-resourced, high-volume Medicaid primary care practices – that we respond to the Committee's questions regarding solutions for using HIT to close – or at least not widen – the disparities gap in Medicaid.

1. What do you see as the greatest risks posed by the implementation of HIT in relationship to potentially increasing disparities in health processes and outcomes?

If a state Medicaid agency decides not to participate in the voluntary EHR provider incentive program or does not use the opportunity for greater transformation of the delivery system, the existing disparities gap will widen for Medicaid. The EHR provider incentive program is not just about spreading technology; rather it is about leveraging technology to transform the greater Medicaid delivery system. Most Medicaid agencies recognize this and many are positioning themselves for greater transformation, but some are not. This divergence in state strategy could threaten to widen disparities among state Medicaid programs. That said, despite the severe budgetary constraints facing almost

every state legislature, we would like to believe that all Medicaid agencies will choose to participate in the incentive program.

Assuming that most if not all states will participate, the next greatest risk is that small, high-volume Medicaid practices – i.e., solo practitioners and practices with three or fewer clinicians – will be left behind. We know that small, high-volume Medicaid practices serve a large percentage of Medicaid beneficiaries, including large clusters of racially and ethnically diverse patients. For example, Michigan Medicaid data examined in a CHCS study showed that 50 percent of beneficiaries in Detroit receive care in practices with three or fewer providers.¹ In many states and regions, these small practices serve the majority of Medicaid beneficiaries. They are under-resourced, and disenfranchised from larger integrated systems and from quality improvement activities.

These small, high-volume Medicaid practices will be left behind if they are: (a) not successfully engaged to participate in the incentive program; or (b) engaged, but are such a “heavy lift” for the regional extension centers (RECs) that they may be abandoned. This would contribute to even greater disparities in health outcomes and further disenfranchisement of under-resourced providers from an HIT-transformed health care delivery system. Medicaid programs should help with Medicaid practice transformation activities.

Medicaid programs have been striving to actively engage small, high-volume practices in HIT adoption and practice transformation. These efforts have been very challenging for all parties with limited results to date. I have met with solo practitioners in Oklahoma City, Detroit and Philadelphia and while these physicians truly want to improve care for their communities, they are extremely reluctant to adopt HIT. Many of these providers do not know what a registry is, and they have no idea what HEDIS means. Many do not have computers. All are overburdened and struggle to lift their heads up from providing basic services.

That said, the small, high-volume Medicaid practices which do rise to the challenge and implement HIT are empowered by the new patient information they can access at the fingertips. Non-physician staff can proactively identify who their diabetic patients are, what services or tests they have or have not received, and plan accordingly. Medical assistants can assist patients with health education and improved self-care management, address gaps in care and reduce some of the care burdens that would otherwise be left to the physician.

2. What are you, or others with whom you work, doing (or planning to do) to reduce the risk of exacerbating disparities as HIT is implemented across the county?

CHCS is working with several state Medicaid agencies and regional quality improvement alliances to explore viable, effective, and sustainable solutions for engaging and supporting small high-volume Medicaid practices. Through these efforts, which include

¹ Moon J, Weiser R, Highsmith N, Somers S., *The Relationship between Practice Size and Quality of Care in Medicaid*. Center for Health Care Strategies, Inc., July 2009.

the adoption and meaningful use of HIT, we believe disparities in care will be identified, tracked and reduced. Examples are.

- **Identify and target small, high-volume, high-opportunity practices.** State Medicaid programs and plans have the ability to identify high volume Medicaid practices, or practices on the margin of eligibility, the percentage of diverse patients in those practices and the practice’s performance measures. With this information, Medicaid and RECs can strategically target limited resources to these practices, maximizing the “bang for their buck.”
- **Provide sufficient quality improvement supports at the point of care to augment REC support.** Some Medicaid agencies are deploying quality improvement resources at the point of care. Programs in North Carolina, Oklahoma, Pennsylvania and Michigan deploy quality improvement coaches, pay for and populate HIT tools, share aggregated practice-level performance information with physicians, and provide financial incentives up front to practices. They recognize that reducing disparities requires many interventions, not just an EHR. Providing sufficient supports will be particularly critical as providers move into Stage 2 and quality improvement at the point of care.
- **Leverage HIT for larger delivery system transformation.** Medicaid programs need to think about ways to link HIT with medical/health home adoption and payment reform efforts, e.g., paying primary care practices to be medical homes or leveraging the upcoming increase in Medicaid primary care rates. States like Pennsylvania and Oklahoma are already positioning their programs.
- **Link small, high-volume Medicaid practices together.** Medicaid programs recognize the potential value of peer networks – virtual or otherwise – of small, high-volume Medicaid practices. As such, they are convening collaboratives where small practices can share their experiences through various stages of transformation, such as HIT adoption and use, and/or contracting with physician networks to focus on quality improvement or care management.
- **Create alignment with public and private payers and purchasers.** Under the Robert Wood Johnson Foundation’s *Aligning Forces for Quality* initiative, for instance, regional alliances in Ohio, Washington, Maine and Minnesota are working with their Medicaid agencies to identify and survey high-volume Medicaid practices, and link specific practice characteristics to clinical outcomes. Understanding the barriers these practices face will help guide practice-based quality improvement and transformation efforts, including HIT. A number of these regional alliances are RECs or Beacon communities.

3. What research is being done, or needs to be done, in this area to inform the HIT Policy Committee in trying to establish guidelines that will move providers to implement methods of using HIT to reduce disparities?

CHCS is currently funding and evaluating two initiatives on reducing disparities in Medicaid, that include HIT. We will release findings later this year.

More needs to be learned about:

- The size and types of practices serving the majority of Medicaid beneficiaries in specific states and regions, including who they are, and their resource needs;
- How real practice transformation, like meaningful use of HIT, is sparked and sustained within small, high-volume Medicaid practices;
- How to “make the business case” to a small high-volume Medicaid practice that an EHR will produce a positive return on investment;
- How to engage Medicaid patients in the medical home, and ways that HIT can enhance this engagement; and
- The ways that Medicaid and the RECs can successfully work together to support practices in improving quality and reducing inequities.

4. With patient and family engagement in care at the forefront of our thinking about improving our Nation’s health, what particular strategies would you recommend to us as potential meaningful use requirements in 2013 and 2015 for the vulnerable populations we have asked you to address?

Given the high prevalence of behavioral health conditions in Medicaid – half of Medicaid beneficiaries with disabilities also have a psychiatric illness diagnosis, and 27 percent of the nation’s total mental health care costs are financed by Medicaid - the Committee should explore physical and behavioral health care coordination measures in future MU requirements. Medicaid patients and their families struggle to address the long-standing silos that exist between physical and behavioral health care providers.

Similarly, extending technology and meaningful use to incorporate other providers – nursing homes, other long-term care providers and community care teams that are so critical to the Medicaid population – would also be an important future strategy.

The committee may also want to explore how Arizona’s Medicaid program is engaging its consumers via HIT. Last year, Arizona was implementing web-based e-learning tools tailored to the needs of Medicaid patients and available in the provider office.

5. How can the meaningful use of HIT specifically reduce a health disparity?

HIT will help public and private payers, purchasers and providers shine light on disparities and target limited resources to providers that could yield the biggest quality improvement bang for the buck, e.g., medication management to reduce adverse reactions and contraindications, use of decision supports and alerts to help providers promote preventive screenings and identify patient at risk for severe, but preventable, acute health care episodes.

6. What specific HIT applications have been used to address health literacy (panel 1), culture (panel 2), or access (panel 3)?

In our initiatives, the small, Medicaid practices are using a variety of registry applications to address disparities. These applications include *Reach My Doctor*², Cielo³, Wellcentives⁴, and CareMeasures, a product that the Iowa Foundation for Medical Care developed for Oklahoma’s Medicaid program.

It’s interesting to note that some small practices feel compelled to adopt local “home grown” products, as opposed to commercial applications, to bring business to their community. These home grown products often create another layer of complexity as they are often not readily interoperable.

7. Please share any relevant evidence on your topic.

Thank you again for the invitation to participate in this important process and share our perspective. The CHCS website, which is at <http://www.chcs.org>, has many resources that may be valuable to you, including issue briefs, toolkits and other materials on reducing disparities in care for Medicaid beneficiaries.

² For more information, visit <http://www.rmdnetworks.com/>

³ For more information, visit <http://www.cielomedical.com/>

⁴ For more information, visit <http://www.wellcentive.com/index.html>