



NEW CMS Medicaid IT Guidance Supporting States Towards Interoperability



***ONC Annual Meeting
November 29, 2018***

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Medicaid HIE/Interoperability Funding Sources

	HITECH Act	MITA System Funding (Medicaid Information Technical Architecture)
Duration	Ends in 2021	Ongoing
Funding for design, development & implementation	Yes, 90% match	Yes, 90% match
Operational Support	No	Yes, 75% match
On-boarding support	Yes	No
Policy basis for funding	Meaningful Use objectives & measures	Business processes

New State Medicaid Directors Letters

- April 18, 2018: “Mechanized Claims Processing and Information Retrieval Systems – Reuse” (SMD 18-005)
 - <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18005.pdf>
- June 11, 2018: “Leveraging Medicaid Technology to Address the Opioid Crisis” (SMD 18-006)
 - <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf>
- July 17, 2018: “21st Century Cures Act Section 5006 Compliance – Provider Directories” (SMD 18-007)
 - <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18007.pdf>
- November 13, 2018: “Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance” (SMD 18-011)
 - <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>

Mechanized Claims Processing and Information Retrieval Systems: SMDL #18-005

- April 18, 2018 “Reuse” letter covers:
- Rationale for Reuse
 - Meeting the Requirement for Reuse
 - Support for Reuse
 - Design Alternatives
 - CMS Goals for Reuse
 - Reuse for HITECH!

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SMD # 18-005

RE: CMS-2392-F Mechanized
Claims Processing and
Information Retrieval Systems –
Reuse

April 18, 2018

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is issuing this fourth in a series of letters to provide sub-regulatory guidance to supplement CMS-2392-F, “Mechanized Claims Processing and Information Retrieval Systems (90/10),” which became effective January 1, 2016.¹ This letter reaffirms the requirement for reuse in 42 CFR Part 433, Subpart C - Mechanized Claims Processing and Information Retrieval Systems.

In reviewing the responses to our Request for Comments in our Notice of Proposed Rulemaking (CMS-2392-P), published on April 16, 2015 (80 FR 20455), we determined there is a need to develop supporting policy and sub-regulatory guidance. In developing sub-regulatory guidance, CMS is engaging our partners and stakeholders in recognition of their valuable experience and unique perspectives on this final rule.

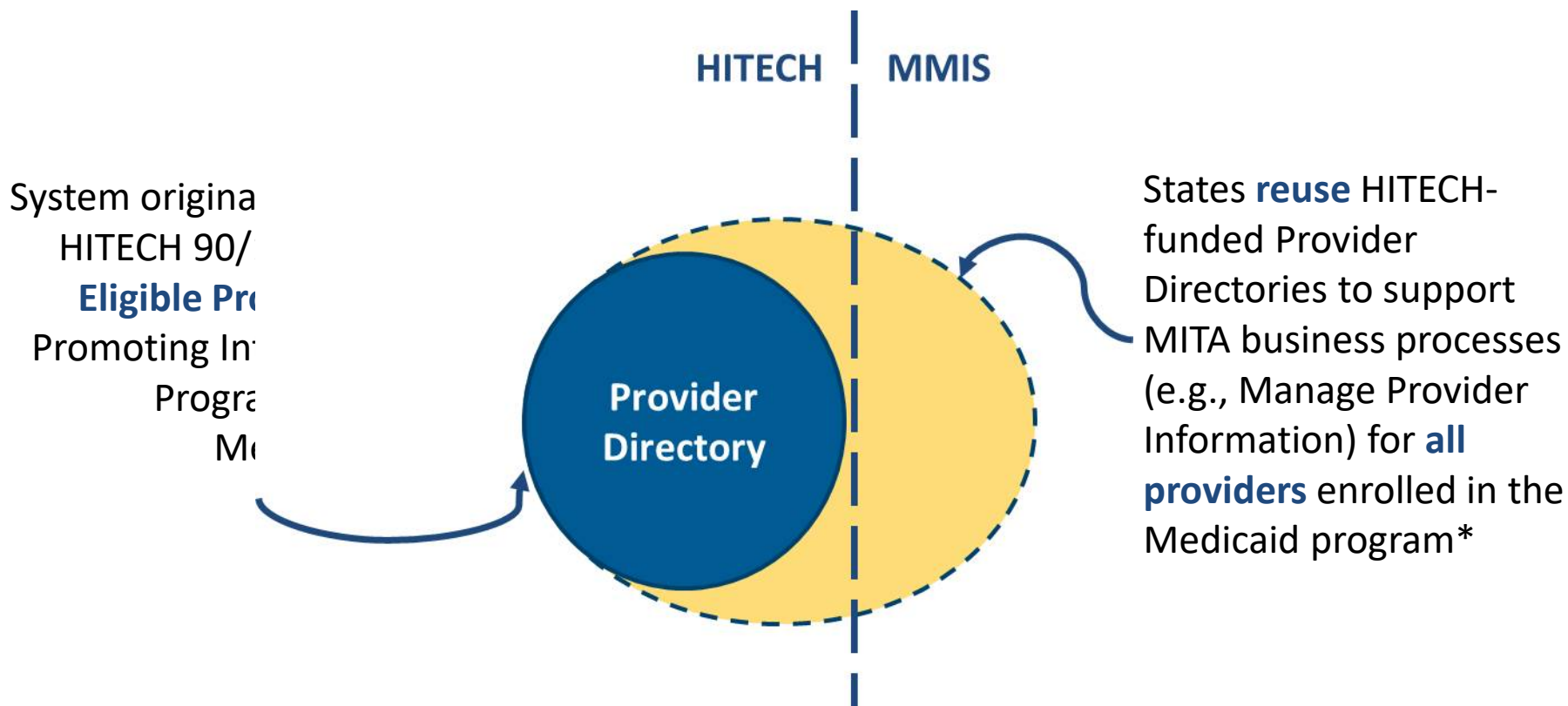
Each of the letters in this series addresses discrete subject areas impacted by the final rule.² This letter elaborates the guidance for reuse, a key aspect of the Advanced Planning Document (APD), as required under 42 CFR § 433.112(b)(13), and an essential characteristic of economical and risk-reduced development, implementation, maintenance, and operations of business processes and systems. Over the long run, reuse is expected to lower implementation and operational costs compared to custom or one-off solutions. This letter consolidates and reinforces guidance and information previously provided to the states.

Enhanced Funding Requirements

CMS provides, under 42 CFR §433.112(a), 90 percent enhanced federal financial participation (FFP) for Medicaid technology investments funded through an approved APD. One of the 22

Example of Reuse within a State

HITECH systems reused within a state to support MITA Business Processes



*States leverage MMIS DDI and O&M funding to adapt and maintain HITECH system for enterprise-level processes



Leveraging Medicaid Technology to Address the Opioid Crisis

Published June 11, 2018

<https://www.medicaid.gov/federal-policy-guidance/downloads/smd18006.pdf>

Leveraging Medicaid Technology to Address the Opioid Crisis

THE PRESIDENT'S COMMISSION ON COMBATING DRUG ADDICTION AND THE OPIOID CRISIS

(https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf)

- PDMP/EHR integration
- Predictive Analytics for case management
- Substance Use Disorder related CDS tools
- Medication Assisted Therapy (MAT), including via telehealth
- Linkages to other non-controlled RX data & other data (drug court, care teams, etc.)
- E-prescribing of controlled substances (ePCS)
- Public Health Tools
- Telemedicine & telepsychiatry
- Case management & care plans for Neonatal Abstinence Syndrome
- Patient-facing technology including apps
- Shared electronic care plans



21st Century Cures Act Section 5006 Compliance – Provider Directories

Published July 18, 2018

<https://www.medicaid.gov/federal-policy-guidance/downloads/smd18007.pdf>

21st Century Cures Act Section 5006 Compliance – Provider Directories

- Requires states to build a provider directory using MITA funds for their fee-for-service providers including certain data points (availability, cultural competence, etc.)
- Emphasizes to states they should re-use provider directories funded by HITECH
- Emphasizes to states they should align with ONC OTECH workgroup
- Tied together with larger MyHealthEData initiative, BlueButton, etc.

HOT QUOTES!

Provider directories published by State Medicaid agencies can help some Medicaid beneficiaries find out if a provider is accepting new patients, which can help improve access to care. And, with thoughtful implementation, such provider directories could help reduce provider burden and improve interoperability. As Medicaid patients often move between multiple care settings, a more dynamic provider directory that has functionalities beyond a list of providers might also work with a master person index or master client index to coordinate care by exchanging clinical information in a manner which supports the objectives of the MyHealthEData Initiative. Further, linking identity proofing and care coordination technologies to rules engines that allow a Medicaid patient to direct how his or her data is shared further advances the objectives of MyHealthEData.

HOT QUOTES!

verifying a provider's licensure, board certification, sanctions, etc. In recent years, as states have invested more in systems capable of coordinating care across providers, provider directories are, in many cases, also supporting connections between providers by allowing providers to exchange structured data supporting transitions of care, including summaries of care, discharge summaries, problem lists, medication histories, bi-directional connections to public health for reporting and alerting, etc. Provider directories that are part of health information exchanges outside of state government may provide the data to support this section and should be considered by states as they consider their efforts to meet the requirements of Section 5006 of the Cures Act, so long as the provider directory is also published on the public website of the state agency, particularly if such health information exchanges have previously been supported by HITECH funds.

HOT QUOTES!

Provider directories have the ability to support the MyHealthEData Initiative by creating a system by which a patient's health information may follow him or her from provider to provider. Provider directories as described in Section 5006 of the Cures Act and components of the state enterprise such as case management systems, registries, or care coordination platforms, are increasingly likely to support health information exchange and interoperability, often serving as a hub where Medicaid providers coordinate care. States are reminded that 42 CFR § 433.112(b)(16) was amended in the Medicaid Program; Mechanized Claims Processing and Information Retrieval Systems (90/10) final rule (80 FR 75817), to state that “[t]he system supports seamless coordination and integration with the Marketplace, the Federal Data Services Hub, and allows interoperability with health information exchanges, public health agencies, human services programs, and community organizations, providing outreach and enrollment assistance services as applicable.”



Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance - SMD 18-011

Published November 13, 2018

<https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf>

HOT QUOTES!

Improving data-sharing capabilities between schools, hospitals, primary care, criminal justice, and specialized mental health providers is an effective way to improve communications between these types of entities and the healthcare system. States may be able to access enhanced federal Medicaid matching funds for costs to state Medicaid agencies of implementing and operating technology to improve data-sharing capabilities as part of the Medicaid Information Technology Architecture (MITA).^{xxvi} Many of the business processes described in MITA 3.0 regarding Care Management focus specifically on systems supporting the collection of information about an individual's health status and needs. States could use this authority and enhanced match to develop connections between mental health care providers and schools, hospitals, primary care, criminal justice, and faith communities, consistent with the discussion of "Interoperability" contained in the final rule on this topic.^{xxvii} For example, enhanced federal financial participation (FFP) could be available to states for the development by the state of data-sharing capabilities between hospitals and community-based mental health providers such that when a beneficiary with SMI or SED is being discharged from a hospital, that beneficiary's records regarding treatment could more easily be transferred to a community-based treatment provider or, if the beneficiary was being admitted to a hospital for acute care, the community-based mental health provider could be notified more easily.

HOT QUOTES!

Another strategy for helping adults with SMI or children with SED access appropriate levels of care is development of the capability to track which mental health providers are accepting Medicaid beneficiaries at different levels of care throughout the state, including outpatient, intensive outpatient, inpatient, and community-based crisis services. Development by the state of this capability to track available mental health providers, such as through a type of registry reflecting qualified providers that is frequently updated, could be reimbursed under MITA 3.0 at 90% of the development costs and 75% of the operational costs.^{lxii} Furthermore, Medicaid managed care plans (managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and, where applicable, primary care case management plans) must identify as part of provider directories whether a network provider is accepting new patients under 42 C.F.R. § 438.10(h)(1)(vi).

HOT QUOTES!

Use of telehealth technologies to support provision of the Collaborative Care model is another important strategy for facilitating broader availability of integrated mental health care and primary care.^{xli} States may be able to access enhanced match under MITA 3.0^{xlii} for state development of telehealth-enabling technology to be used by Medicaid providers to coordinate care for beneficiaries. Some examples include development of virtual treatment centers or remote counseling options integrated into care coordination technology consistent with the “Managing Care Information” business process under MITA 3.0 which includes activities connecting providers to patients and facilitating access to services.^{xliii} For supporting state costs associated with implementing the Collaborative Care model or other team-based approaches, states could also consider using the existing authority for Care Plan Exchange under MITA 3.0.^{xliv} The treatment services themselves that are provided via tele-health technology could be covered using state plan or other Medicaid authorities.

Questions



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