

Electronic Health Record Incentive Programs for Medicaid Providers: How Are States Preparing?

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The Center for Health Care Strategies (CHCS) interviewed Medicaid leaders in six states to better understand how Medicaid agencies are positioning themselves to capitalize on opportunities presented by the American Recovery and Reinvestment Act of 2009. Specifically, CHCS wanted to learn whether states are planning to operate a Medicaid electronic health record (EHR) provider incentive program and, if so, to understand their initial strategies.

On February 17, 2009, President Obama signed the American Recovery and Reinvestment Act (ARRA) of 2009, a \$787 billion economic stimulus bill. ARRA contains many health-related components, including additional and temporary federal funds for Medicaid programs. These dollars are designed to maintain funding for Medicaid coverage and to invest in much-needed health care infrastructure.

ARRA's largest infrastructure investment is in health information technology (HIT), with approximately \$44 billion earmarked for provider incentives to support adoption, implementation, and use of EHRs.¹ Almost half of this will go to eligible Medicaid providers who adopt EHRs and use them in a meaningful way to improve the quality of care. Medicaid agencies will also receive 90/10 federal-state match funding for developing and administering the incentive program for Medicaid providers who adopt and "meaningfully use" EHRs. Participation by states and providers is voluntary.

To better understand how Medicaid agencies are positioning themselves to capitalize on this opportunity, CHCS

interviewed Medicaid directors and/or designated HIT experts in six states. Specifically, CHCS wanted to learn whether states are planning to operate a Medicaid EHR provider incentive program and, if so, to understand their initial strategies and concerns.

This brief summarizes insights from those interviews, which were conducted telephonically in December 2009 and January 2010. During this time period, states were just beginning to understand the potential implications of the Centers for Medicare and Medicaid Services' (CMS) proposed rules for an EHR incentive program, released on December 30, 2009.

Information from these interviews — conducted with Medicaid leaders in Kansas, Michigan, Missouri, Oklahoma, Pennsylvania, and Virginia — can be valuable both for Medicaid stakeholders and for health care entities that will be direct or indirect partners in making HIT or EHR expansion programs a success. Through ARRA, CMS and the Office of the National Coordinator for HIT (ONC) have created several significant funding opportunities to expand HIT/ health

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information exchange (HIE) capacity to improve quality throughout the health care delivery system. Many health care entities, including regional multi-payer alliances, regional extension centers (RECs), quality improvement organizations (QIOs), to-be-determined Beacon communities, health plans, provider organizations, medical societies, and other organizations, will be working with many of the same providers and practices, and must coordinate closely to be successful.

Key Findings

Initial Strategies for Design and Implementation of Medicaid Provider Incentive Programs

All of the states interviewed are planning to operate a Medicaid EHR provider incentive program. Even though both state and provider participation are voluntary, the states all recognized and eagerly anticipated the unprecedented opportunity presented by ARRA to improve the quality of care for Medicaid beneficiaries. States understood how these funds could provide Medicaid, its plans, and provider networks with the technology for improvement. For instance, funds would enable them to create quality reporting tools that provide timely feedback about care gaps, missed opportunities, and disparities in care. States could foresee a future in which Medicaid resources could be shifted from chart reviews and audits to quality improvement (QI) projects.

At the time of the interviews, all states had submitted an HIT planning Advance Planning Document (APD)² to CMS, and half had received CMS approval to use federal funds for planning efforts. One Medicaid program began to develop its provider incentive program “right out of the starting gate” when the legislation was first passed in February 2009. Upon the

August 2009 release of the HIT Policy Council’s recommendations for defining meaningful use,³ this state looked for ways to align its Medicaid QI initiatives with the directions in which ONC and CMS appeared to be going. For example, the state began incorporating HIT functionality and clinical measurement into a provider-level, pay-for-performance program. It also began to work with select practices to conduct a “dry run” of core pediatric measures to explore whether they could achieve meaningful use and, if not, what the barriers were to doing so.

Other states “had [their] hands full with [budgets and other aspects of] health care reform” or were waiting for CMS to approve their HIT planning APDs and/or to release the proposed rules before they began working in earnest on program design. These states may be further behind in planning efforts, but are currently dedicating staff for planning and design.

Medicaid Funding for Provider Incentive Programs

All states are encountering challenges in finding state funds for the 10% match for the design and administration of a provider incentive program. Almost all described limited state funds as a significant obstacle to participation — in some cases, an unrealistic requirement given severe budget deficits. As one state said, “The very fact that this is being done through a stimulus package [(ARRA)] means we’re trying to do this in a recession.”

Despite these reservations, all of the states interviewed were exploring funding options. As one state noted, “We’re cutting drastically everywhere, but we *will* find the funding for an incentive program!” Some states were seeking legislative funding for new state positions and/or contracts with external entities (e.g., universities, QIOs, consulting firms,

etc.) to design, administer, and oversee the provider incentive program. One state was considering asking local foundations for funding.

States were pleased that CMS proposed to provide alternative and optional early payments to Medicaid practices for adopting, implementing, or upgrading certified EHRs. One state said it planned to “rely heavily on year-one [alternative and optional early incentive] payments to get Medicaid practices up and running.” However, states voiced concern that this approach could offer “refunds but not up-front capital” to practices. Many under-resourced Medicaid practices would simply not have the up-front dollars for EHRs. In response, state officials were exploring ways to offer practices loans that could be repaid with year-one payments from CMS.

Ability to Identify Eligible Medicaid Providers

States unanimously voiced concern about their capacity to identify eligible, non-hospital based (and non-FQHC-based) providers with 30% Medicaid encounters (or pediatricians with 20%), as stated in the proposed rules. States can identify the number of Medicaid patients per provider, but need access to all-payer data to calculate Medicaid as a percentage of all encounters, including commercial, Medicare, and others. Without access to all-payer data, states are concerned that the proposed approach would require practices to self-identify — a burden for providers.

Despite this concern, states are exploring various methods to estimate the number of eligible Medicaid providers. One said that Medicaid staff, RECs, QIOs, and other entities were needed to “hit the street and knock on doors” to identify and talk with practices. Another state said that it would rely on practices to self-identify as high-volume Medicaid

providers, through attestation, with subsequent auditing by the state; and one, planned to survey its provider network to identify eligible practices. Some states were teaming up with Medicaid health plans to identify high-volume Medicaid practices in provider networks. One state was using literature from practice management associations to make assumptions about the number of Medicaid patients that would comprise a high-volume provider’s panel, while another was working with local medical societies to reach out to practices via e-mail.

Regardless of the approach, all states wanted increased flexibility in the final rules from CMS for identifying eligible Medicaid practices. For example, an alternative approach would be to designate a “raw number” threshold of Medicaid patients per provider to identify an eligible primary care practice.

Role of Medicaid Health Plans in Provider Incentive Programs

At the time of the interviews, the involvement of Medicaid health plans varied among states. Health plans were “at the table” with increased engagement anticipated as planning progressed. Some states were already thinking more strategically about ways to leverage plan resources.

For example, one state noted that plans could play a significant role in the design and implementation of provider incentive programs, helping to identify high-volume practices, engage provider networks, connect practices to regional HIEs, and provide training, education, and technical assistance to their networks. Noting that practices typically contract with multiple plans, the state said that these activities would be enhanced significantly from the practice perspective if plans adopted a unified “plan-agnostic” approach. While states recognized the likely overlap in the

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In one state, a particularly innovative plan is “positioning itself to play a different role and to redesign its business model, recognizing that the way it manages care needs to change.” EHR expansion would provide this plan with unprecedented access to clinical quality information, helping it better manage provider quality and member health. This plan was positioning itself to become a “focal point” to which providers could look for technical assistance, training, and connectivity, and in doing so, drive its network toward HIT adoption.

Medicaid Collaboration with Regional Extension Centers

Interviews revealed varying levels of collaboration between Medicaid and established or potential RECs. Some states did not yet have ONC approval for RECs. States with ONC-approved RECs were discussing the division of labor among Medicaid, plans, and RECs. All states recognized their critical role in ensuring that the distinct needs of Medicaid providers, particularly small practices with a high volume of Medicaid patients, are addressed.

States were aware of the overlap in the skill sets of Medicaid agencies, plans, and RECs, and were discussing potential ways to “divide and conquer.” In one scenario, the local RECs would provide EHR training, assess provider needs, develop a business plan for each practice, and help the practice identify EHR options to meet their needs. The state and its plans would supplement REC technical assistance and support Medicaid providers with the highest resource needs, practices with more than 10 providers, and non-physician eligible providers (e.g., dentists,

nurse practitioners, certified nurse-midwives, and physician assistants).

Initial Reflections on the Proposed Definition of Meaningful Use

Because interviews with Medicaid agencies occurred around the time the proposed rules were released, states were just starting to digest the information and consider the implications for Medicaid. Initial reactions and concerns included the following:

- Identifying eligible Medicaid providers by percentage of Medicaid encounters is a challenge for states, as they do not currently have access to all-payer data. States would like flexibility in identifying and defining eligible Medicaid providers.
- States have concerns about the large number of and “unrealistically high attainment bar” set for HIT functionality measures. States were interested in increased flexibility for Medicaid practices to demonstrate HIT functionality.
- Primary care providers would be heavily burdened by the proposed rule’s extensive reporting requirements — 29 clinical measures (far more than those required of specialists). States were interested in reducing this number to lessen the burden.
- In states with multiple bordering states, the Medicaid agencies were interested in “thinking through how the provider incentive program would realistically work” across states. States recognized that program administration would be complicated further for providers in border areas and those who practice in multiple locations.
- Some states were concerned that nursing homes — a significant provider and cost for Medicaid programs — were not eligible for the EHR incentive

program. EHRs would be a critical tool for meeting the need to better coordinate and manage care for the Medicaid beneficiaries they serve.

What's Keeping Medicaid Agencies Up at Night?

Lastly, CHCS asked Medicaid leaders to identify their overriding concerns regarding the opportunities presented by ARRA. Not surprisingly, all questioned whether they would have the resources needed to operate a provider incentive program. One state's representative noted its need for funding to develop an entire unit within Medicaid to support a provider incentive program.

Another state representative said that its greatest fear was "missing this enormous opportunity" due to the potentially competing opportunities of health care reform and Medicaid coverage expansions. He noted, "As transformative as HIE will be, given the scale of potential change coming from insurance coverage, reform would trump HIE."

All states worried whether eligible Medicaid practices would choose or be able to participate in the provider incentive program, particularly after states had made investments in developing the programs. One state official said, "If Medicaid practices don't come to the party, aren't we just reinforcing a two-tiered health care system?"

States without an anointed REC were concerned about not having this critical resource available to help practices choose, implement, and operate a certified EHR. Practices that serve a large number of Medicaid patients, particularly small practices, face unique and daunting challenges around care delivery and quality improvement. These practices tend to be woefully under-resourced and disenfranchised from a larger provider network. They do not have the

infrastructure, staff, or financial resources to implement and use an EHR to improve care delivery and quality. As such, intensive, tailored, and sustained technical assistance to these practices will be critical to success.

Another state leader recognized that its Medicaid agency would need to "develop a new skill set — how to think like a health plan and manage our Medicaid population." State Medicaid agencies typically collect and analyze eligibility, enrollment, and claims information; however, with increased access to a new, rich source of clinical information, Medicaid programs will have an expanded responsibility to manage the health of low-income and diverse populations. As one state expert said, "Medicaid simply doesn't do this [clinical-level work] right now. Medicaid will be doing new things in three to five years that we just don't do now."

A few states shared their confusion about the numerous federal funding opportunities available, including RECs, the Beacon communities, and the provider incentive programs. They were concerned about confusing providers and duplicating resources instead of maximizing the available federal funding opportunities.

Lastly, one state official was candid in expressing concerns about managing the sharp increase in pitches from HIT vendors. These lobbying efforts could undermine the incremental gains that states and RECs would otherwise make in getting unbiased information to providers. The contractors "will get the legislature all ginned up and Medicaid will be caught in the cross hairs."

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Conclusion

Despite the budgetary crisis facing the states interviewed, state officials were unwavering in their commitment to take advantage of the historic opportunity facing Medicaid. As the interviewees read through and digest the potential implications the proposed rules will have for Medicaid programs, all six will submit their recommendations to CMS and

prepare themselves to move forward in a strategic manner to capitalize on the resources being made available.

CHCS plans to re-interview these states and others over the next three to six months to understand how the landscape evolves in the first quarter of 2010, and to chronicle how the states adapt to these ongoing changes.

Resources from the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS is working directly with states, health plans, and Medicaid providers to reduce disparities in care by strengthening the primary care infrastructure, particularly within small practices serving a large proportion of low-income and diverse patients. To learn about CHCS' initiatives or to download publications from our online resource library, visit www.chcs.org.

Endnotes

¹ American Recovery and Reinvestment Act of 2009, Division B, Title IV, Medicare and Medicaid Health Information Technology; Miscellaneous Medicare Provisions, Subtitle A — Medicare Incentives, and Subtitle B — Medicaid Incentives.

² <http://www.cms.hhs.gov/smdl/downloads/SMD090109.pdf>.

³ http://healthit.hhs.gov/portal/server.pt?open=512&objID=1269&&PageID=16501&mode=2&in_hi_userid=11113&cached=true.