



# Welcome to the AHRQ Medicaid and CHIP TA Web-Based Workshop

Tuesday, May 8, 1:00–4:00 p.m. Eastern

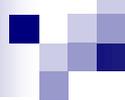
Wednesday, May 9, 1:00–4:00 p.m. Eastern

## **Medicaid Health IT Initiatives Boot Camp: Understanding and Managing Multiple Medicaid Health IT Projects**

**Presented and Facilitated by:**

**Robin Chacon** – *CSG Government Solutions*

**Robert Guenther** – *CSG Government Solutions*



# Before We Begin

- Please note all participants were placed on mute as they joined the Web-based workshop.
- If you wish to be unmuted, choose the “raise hand” option to notify the host.
- If you have a question during the presentation, please send your question to all panelists through the chat. At the end of the presentations and as time allows, there will be a question and answer period.
- We will post the Workshop presentation slides to the project Web site: <http://healthit.ahrq.gov/Medicaid-SCHIP>



# Agenda – Day 1

- 1 – 1:15, Welcome, Group Introductions
- 1:15 – 1:30, Overview
  - Health Insurance Exchanges
  - Eligibility & Enrollment
  - MITA 3.0 and the Seven Conditions & Standards
  - MMIS Modernization
  - ICD-10 and Operating Rules Standards
  - EHR Incentive Program
- 1:30 – 1:50, Topic 1: Health Insurance Exchange
  - Presentation on the program and its key components, including key drivers and timeline.
- 1:50 – 2:10, Topic 2: Eligibility and Enrollment
  - Presentation on the program and its key components, including key drivers and timeline.

# Agenda- Day 1 (continued)

- 2:10 – 2:30, Topic 3: MITA 3.0 and the Seven Standards & Conditions
  - Presentation on the program and its key components, including key drivers and timeline.
- 2:30 – 2:40, BREAK
- 2:40 – 3:00, Topic 4: MMIS Modernization
  - Presentation on the program and its key components, including key drivers and timeline.
- 3:00 – 3:20, Topic 5: ICD-10 and Operating Rules Standards
  - Presentation on the program and its key components, including key drivers and timeline.
- 3:20 – 3:40, Topic 6: EHR Incentive Program
  - Presentation on the program and its key components, including drivers and timeline.
- 3:40 to 4:00, Review Homework Assignment
  - Articulate areas of overlap, investigate options for leveraging resources. Mitigate!

# Evaluation

- Immediately following the second day of the Workshop, an evaluation form will appear on your screen.
- We would very much like to get your feedback. Your input is extremely important to us and will help to improve future sessions to ensure we provide the best possible assistance to your agency.
- If you do not have time to complete the evaluation immediately following the Webinar or would rather receive the form via e-mail, please contact Diana Smith at [dianasmith@rti.org](mailto:dianasmith@rti.org)
- As always, thank you!

# Topic 1: Health Insurance Exchange Basics

Presented by:

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# Insurance Exchanges and Health Reform

## ***What is a Health Insurance (Benefits) Exchange (HIX/HBE)?***

- A marketplace for consumers to purchase commercial health insurance coverage. Types of plans offered include individual policies and small group policies.

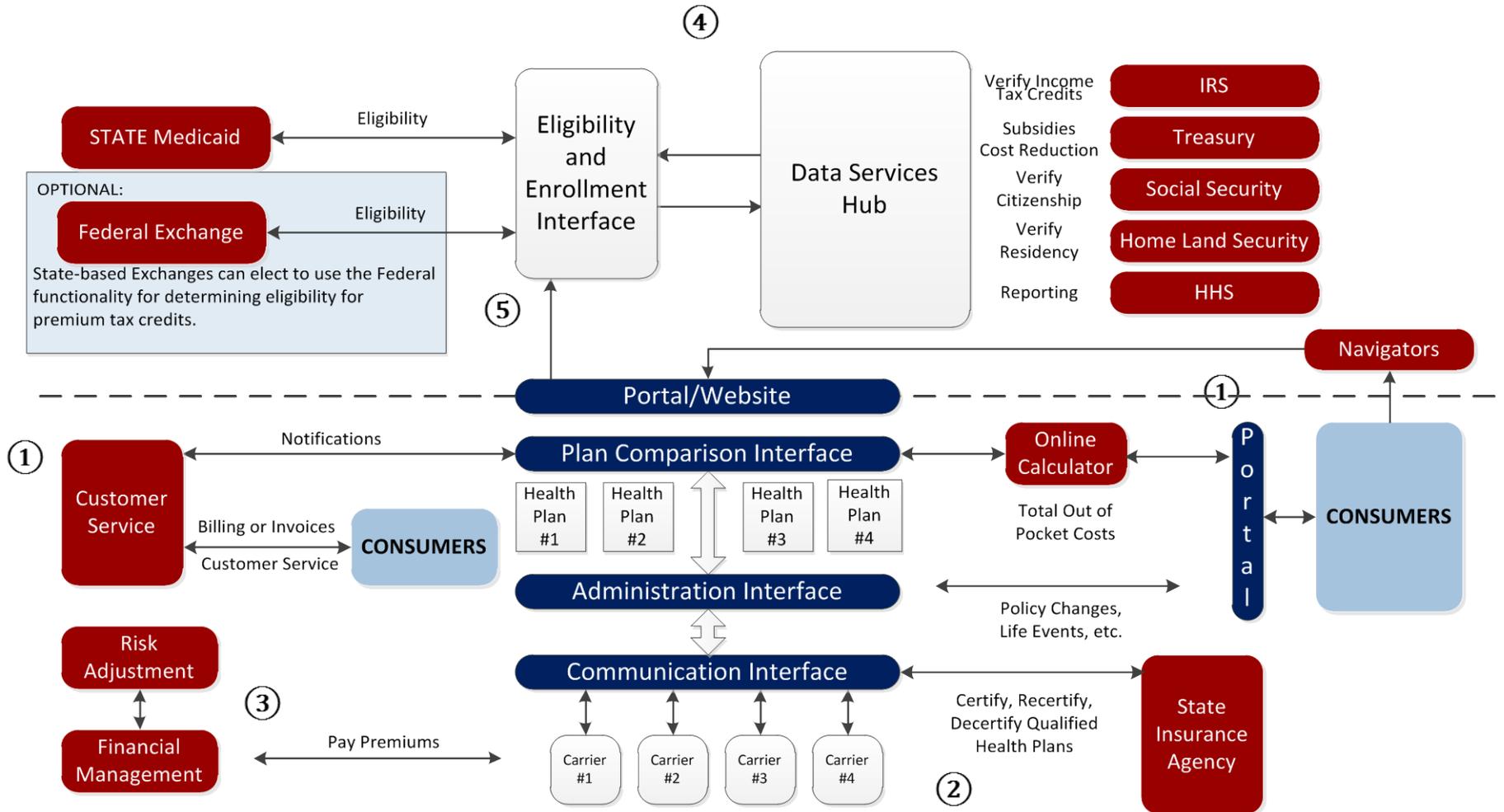
## ***What are the features of an HIX/HBE under Health Reform?***

- Establishes a single access point to affordable health coverage programs:
  - Medicaid
  - Child Health Insurance Program (CHIP)
  - Publicly-subsidized commercial health insurance
- Supports both individual and small group insurance markets
- Provides premium tax credits for eligible individuals to purchase health coverage
- Offers eligible small employers with lower-wage workers a 2-year tax credit to subsidize premium costs

# Insurance Exchange Models

- ***State-based Exchange Model*** – All core functions of the Exchange are operated by the state.
- ***Consortium or Regional Exchange Model*** – More than one state partner together to establish an Exchange that serves the population of participating states.
- ***Federally-facilitated Exchange Model*** – All core functions of the Exchange are operated by the United States Department of Health and Human Services (HHS) on behalf of a state.
- ***Federal Partnership Exchange Model*** – States can elect to participate in the Federally Facilitated Exchange model but retain and operate certain functions of the Exchange. Two primary examples of Federal Partnership models are Plan Management and Consumer Assistance.

# Exchange Core Components



# Exchange Core Components

## ① *Consumer Assistance*

- Key functions include:
  - Education and outreach
  - Consumer appeals
  - Navigator Program management
  - Call center operations
  - Website management
  - Written correspondence with consumers to support eligibility and enrollment.
- Federal Partnership Option for Consumer Assistance allows states participating in the Federally-facilitated Exchange to retain control of direct consumer interactions:

***HINT:*** States can establish a Navigator Grant, but it needs to be funded as part of self-sustaining financial model

State	Federal
Education and Outreach	Website Management
Navigator Program	Call Center Operations
Consumer Appeals	Written Correspondence

# Exchange Core Components

## ② *Plan Management*

- Key functions include:

- Determine the plan selection approach
- Certify, recertify, decertify QHPs
- Collection and analysis of plan rate and benefit package information
- Issuer monitoring and oversight
- Ongoing issuer account management
- Issuer outreach and training.

- Federal Partnership Option for Plan Management allows states participating in the FFE to retain control of Plan Management functions:

- Plan selection and oversight
- Data collection and quality analysis
- Issuer management

**POINTS TO PONDER:**

Will the state be an “Active Purchaser” or allow any willing plan to be offered through the Exchange?

Will the state pursue the establishment of a re-insurance program to manage risk?

**POINTS TO PONDER:**

How many carriers in the current market?  
What is the relationship between the Department of Insurance and the carriers?

# Exchange Core Components

## ③ *Financial Management*

- State-based Exchange Model
  - Financial Sustainability – State-based Exchanges must establish a revenue model to support exchange operations costs.
  - Reinsurance, Risk Adjustment, and Risk Corridors – Programs designed to spread the risk across the markets to minimize impacts of adverse selection and stabilize premiums. (see next slide)
  - Program Integrity – Audit functions to detect fraud, waste and abuse.
- Federally Facilitated Exchange Model
  - Financial Sustainability – The FFE will assess user fees to support the costs of the Exchange operations. HHS will provide further guidance on the details of this in the near future.
  - Risk Adjustment and Program Integrity functions will be managed by the FFE.

### **POINTS TO PONDER:**

How will the state generate revenue to support costs of the Exchange?  
What is the anticipated population that will be served by the Exchange?

**HINT:** Exchanges can elect to use the federal model for Risk Adjustment. Initial notice will be published by October 1, 2012.

# Exchange Core Components

## ③ *Financial Management*

### *Understanding Risk-spreading*

<b>Program:</b>	Reinsurance	Risk Adjustment	Risk Corridors
<b>What:</b>	Provides funding to plans that cover highest cost individuals	Transfers funds from lowest risk plans to highest risk plans	Limit issuer loss (and gains)
<b>Who Participates:</b>	All issuers and TPAs contribute funding; non-grandfathered individual market plans (inside and outside the Exchange) are eligible for payments	Non-grandfathered individual and small group market plans, inside and outside the Exchange	Qualified Health Plans (QHPs)
<b>When:</b>	Throughout year 2014-2016	After end of benefit year; 2014 and subsequent years	After reinsurance and risk adjustment; 2014-2016

Source: "Financial Management 101" Presentation, CCIIO, September 2011

# Exchange Core Components

## ④ *Eligibility Determination*

- Eligibility determination functions include

- Accept applications
- Conduct verifications of applicant information
- Determine eligibility for enrollment in a QHP
- Connect Medicaid and CHIP-eligible applicants to Medicaid & CHIP
- Conduct redeterminations.

**HINT:** A prescreen or short list of questions to determine MAGI eligibility will help direct the consumer to the right program early in the application process.

- Considerations for participation in the Federally Facilitated Exchange:

- HHS guidance issued November 29, 2011, provides states greater flexibility with retaining control of eligibility when participating in the FFE.
- The FFE is responsible for annual redeterminations.
- Close coordination with HHS will be required to ensure “no wrong door” consumer experience.
- Identity Management (“known to the system” identification) is a critical function that will require integrated solution.

**HINT:** Even if a state chooses to operate a State-based Exchange; it can elect to use the federal functionality for determining APTC eligibility.

# Exchange Core Components

## ⑤ **Enrollment**

- Once MAGI eligibility determination is made – if a consumer is eligible for Medicaid or CHIP programs, consumer will need to be enrolled in the program.
  - State-based Exchange model – The state can determine if this enrollment will be done as part of the Exchange or with a transfer to the Medicaid/CHIP program. *(HINT: a key consideration is the impact on cost allocation)*
  - Federally Facilitated Exchange model – Once a consumer is deemed eligible for Medicaid or CHIP, the state will need to enroll the individual in the program.
- Enrollment functions of the Exchange include:
  - Enrollment of consumers into QHPs; and
  - Management of transactions with QHPs and transmission of information necessary to initiate advance payments of the premium tax credit and cost-sharing reductions.

# Exchange Core Components

## ***Governance and Administration***

- Three different options for states to choose from:
  - State Agency
  - Quasi State Agency
  - Non-profit Organization
- Governance Board must meet the following criteria<sup>1</sup>:
  - Is operated under a formal, publicly adopted by-laws or charter
  - Holds regular public board meetings
  - Represents consumer interests through ensuring board composition:
    - Does not have a majority of voting members that have a conflict of interest, such as employees of commercial carriers, agents, or brokers
    - **Includes at least one voting member who is a consumer representative**
    - Includes individuals with relevant experience and knowledge in areas such as healthcare , health benefits administration, healthcare delivery system administration, public health, and policy issues.

<sup>1</sup> DHHS, 45 CFR 155.110 *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers* , Final Rule, Issued: March 12, 2012.

# Exchange Core Components

## ***Governance and Administration Considerations***

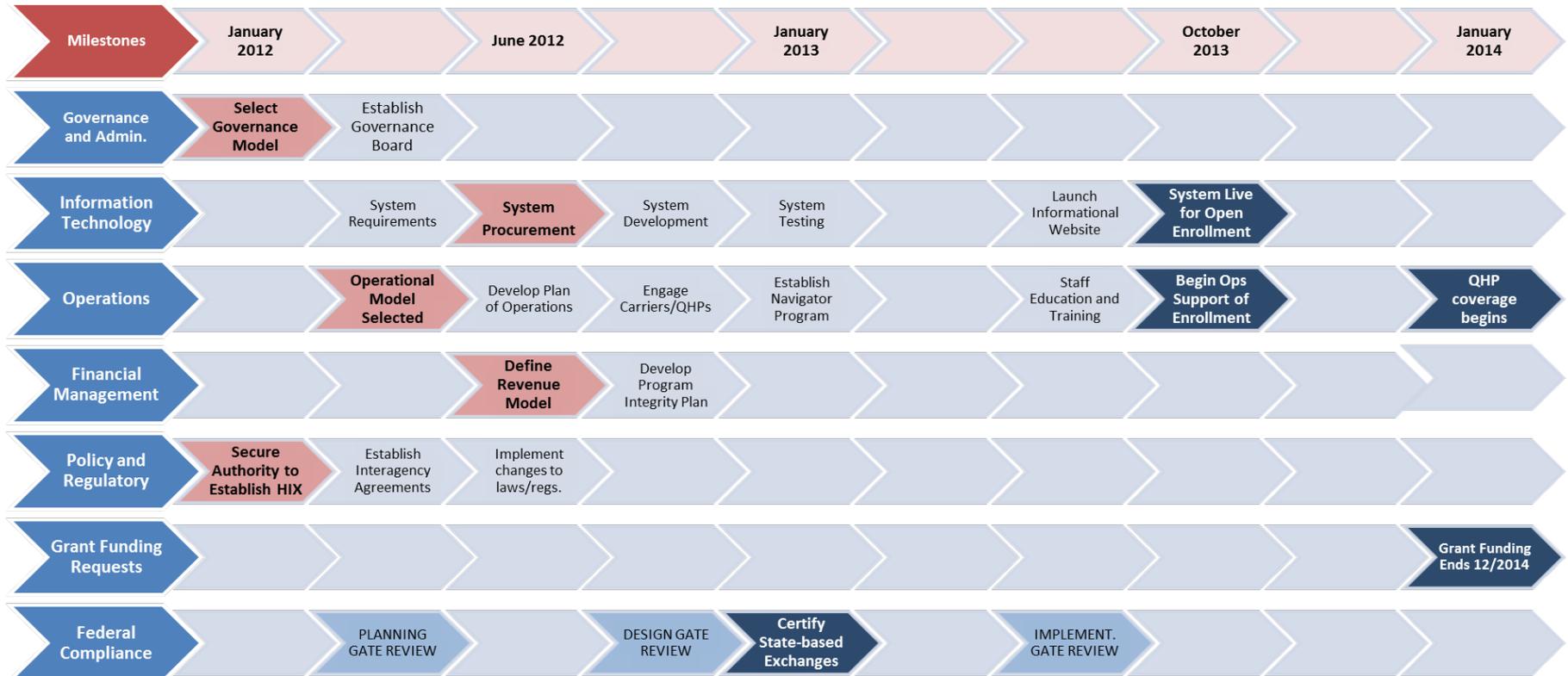
- State-based Exchange Model – Select a governance and administration option that meets the state’s vision for
  - Control/Authority: Executive, Board, or Advisory
  - Flexibility: The ability to adapt to changing policy and regulations
  - Accountability: Level of transparency
  - Interagency Coordination: Level of coordination required and/or supported by model
- Federally Facilitated Exchange Model – The Final Rule is silent on the requirements for governance of states participating in the federal exchange, so states have greater flexibility.
  - States will need the authority to enter into an agreement with HHS.
  - Even Federal Exchange participation will require state interaction. If a Federal Partnership model is selected, the State will need to select a model for overseeing the state-based functions.

### **POINTS TO**

### **PONDER:**

For a State participating in the FFE, how will the State oversee integration with the Federal Exchange?

# Key Activities and Milestones



LEGEND:



# Exchange Planning Considerations

*Whether a state decides to operate a State-based Exchange or participate in the Federally-facilitated Exchange, the following should be considered as part of the planning effort:*

System Considerations	State	Federal
Track population by category of service (FMAP)	X	X
Modify hierarchy of eligibility rules	X	X
Impact Assessment of existing state systems	X	X
System Performance/ Capacity	X	X
Data Security	X	X
Existing State Operations Impact	State	Federal
Medicaid/CHIP enrollment and disenrollment	X	X
Non-MAGI exceptions, TANF and SNAP eligibility determinations and enrollments	X	X
File maintenance (i.e. address change)	X	X
Maintenance of the Master Client Index	X	X
Call center support	X	X

# Topic 2: Eligibility and Enrollment

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# Eligibility and Health Reform

## *The Eligibility Final Rule was issued March 23, 2012. What has changed?*

- Simplified eligibility to four categories:
  - Children < 19 years of age
  - Pregnant women
  - 65 and older
  - Adults (19 – 64 years old)
- Expands Medicaid to cover residents up to 133%\* FPL
- Modernizes eligibility verification rules to rely primarily on electronic data sources
- Codifies the streamlining of income-based rules (Modified Adjusted Gross Income, or MAGI) and systems for processing Medicaid and CHIP applications and renewals for most individuals.

**HINT:** \*You may also hear this referred to as 138% - the calculation in the ACA is 138% with a 5% disallowance which is effectively 133%.

# Eligibility and Health Reform

## ***Eligibility Determination - What is MAGI?***

- Filling in the gaps of existing Medicaid coverage
  - Mandated Medicaid/CHIP coverage for up to 133% of FPL
  - Provides advance premium tax credits (subsidies) for up to 400% FPL
- 6 Exceptions (non-MAGI determinations)
  - 1 – **Individuals whose eligibility for Medicaid does not require a determination of income by a State Medicaid agency** (Medicaid Breast & Cervical Cancer, Foster Care, Adoption Assistance, SSI)
  - 2 – Individuals who are age 65 or older
  - 3 – Individuals whose eligibility is being determined on the basis of being blind or disabled, or on the basis of being treated as being blind or disabled.
  - 4 – Individuals whose eligibility is being determined on the basis of the need for long-term care services, including nursing facility services; home- and community-based services under 1915 or 1115.
  - 5 – Individuals being evaluated for eligibility for Medicare cost sharing assistance
  - 6 – Medically Needy (Spend Down only)

***HINT:*** Regardless of the approach to implementing a Health Insurance Exchange, states will need to continue to determine eligibility for the non-MAGI population.

# Eligibility and Health Reform

## *Eligibility Determination – What is MAGI?*

- Asset tests are eliminated
- MAGI Rules determine eligibility for:
  - Medicaid/CHIP Eligible population
  - Premium Subsidy population
- Modified Adjusted Gross Income
  - Adjusted Gross Income = Total Income – IRA Deductions – Student Loan/Tuition/Fees
  - MAGI = Adjusted Gross Income + Foreign Tax Credits + Non-Exempt Interest (+ certain Social Security Income to align with Medicaid)

***HINT:*** For the expanded Medicaid population (101% – 133% of FPL), under the ACA, claims will receive 100% FMAP for the first three years, with a graduated reduction in FMAP in later years..

# Eligibility – Subsidy (APTC) Basics

## *Who is eligible for subsidy of health insurance coverage (advance premium tax credits)?*

- Eligibility for premium tax credits are based on a sliding scale—based on income from 133% – 400% FPL
- Legal aliens who are not eligible for Medicaid can receive premium subsidies, reduced cost sharing, and purchase insurance through the Exchange
- Individuals and families with access to “affordable” employer-sponsored insurance are not eligible for premium subsidies

***HINT:*** Affordability is defined under the ACA as 2% – 9.5% maximum out-of-pocket expense as a % of income.

# Eligibility System Modernization

## *So, how can States support all of this change?*

- In June 2011, HHS expanded the definition of MMIS to include Eligibility Determination systems (42 CFR §433 Subpart C)
  - Provides states 90% Federal Financial Participation (FFP) to fund Eligibility System technology projects.
  - Funding is available for expenses incurred through December 2015.
  - In order to access funding, new technology must support the Seven Standards and Conditions defined by CMS (published in April 2011).
- Cost Allocation IS **CRITICAL!**
  - In a letter from HHS Secy. Sebelius in August 2011, cost allocation to other public assistance programs can be waived (OMB Circular A-87).
  - Cost allocation is required between the Exchange, Medicaid, and CHIP to the extent that the Eligibility Determination system supports these programs.
  - CMS and CCIIO are coordinating closely through the Gate Review and grant management process.
- CMS has developed an expedited review checklist to support a streamlined approval process for eligibility system funding requests.

# Eligibility System Considerations

*How a State approaches the implementation of these eligibility changes is dependent upon the current technology environment within the State.*

## ***Should you modify or replace the current system?***

- How old is the current technology?
- Is the current eligibility system flexible enough to support rule changes?
- How will the modification or replacement project meet the Seven Standards and Conditions?
- Does the current environment support an integrated application process?
- What resources are required? Are available?

## ***What is the timeline to implement changes?***

- Where are you now?
- What is the approach to implementing the Insurance Exchange Eligibility changes?

# Topic 3: MITA 3.0 & the 7 Conditions and Standards

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# Recent Initiatives and Directives

- The Seven Standards and Conditions issued by CMS
- President's Council of Advisors on Science and Technology (PCAST)
- American Recovery and Reinvestment Act (ARRA) of 2009
- Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009
- Health Insurance Portability & Accountability Act (HIPAA) of 1996
- Patient Protection and Affordable Care Act of 2010
- Federal and national initiatives, such as the Consolidated Health Informatics (CHI), Federal Enterprise Architecture (FEA), Federal Health Administration (FHA), and Office of the National Coordinator for Health Information Technology (ONC), which establish frameworks for the architecture of the future.
- Guidance for Exchange and Medicaid Information Technology (IT) Systems, version 2.0

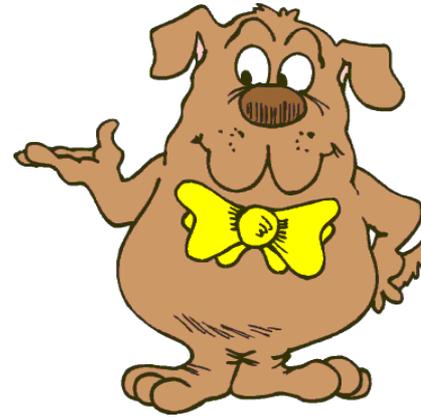
# What is MITA

**Medicaid IT Architecture**



- MITA Is...a *Framework* that guides States and their vendors in the implementation of Medicaid Information Systems
- MITA Is Not...an “implementable” MMIS solution

# MITA Facts



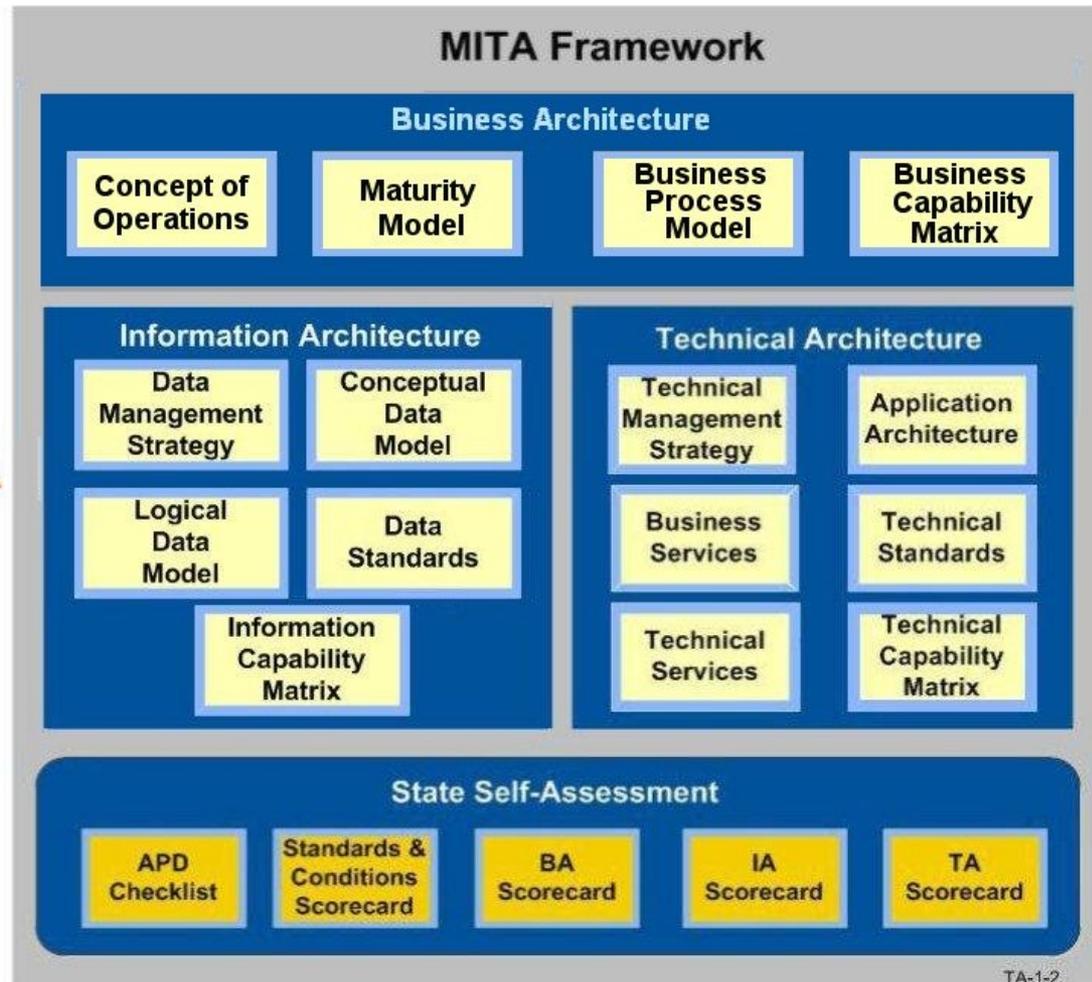
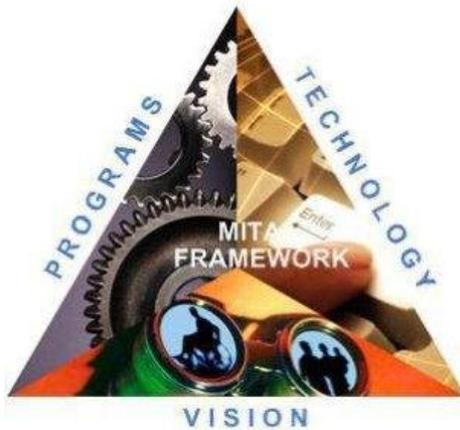
- The MITA framework

- Facilitates a more modern and agile approach to the traditional (legacy) systems development lifecycle.
- Provides a common Framework for the Medicaid Enterprise to plan, architect, engineer, and implement new and changing business requirements.
- Helps to modernize Medicaid IT systems as processes becomes more stable and uniform.
- Lowers the risk of poor implementation.
- Support improved state administration of the Medicaid program.
- Is now codified and required in Federal Regulation.

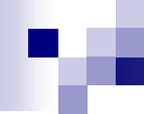
# MITA Timeline

- 2001: Medicaid HIPAA Compliant Concept Model (MHCCM)
- 2006: Framework version 2.0
- 2009: Framework Update version 2.01
- 2012: Framework version 3.0

# MITA 3.0



TA-1-2



# Business Architecture Key Changes

- Concept of Operations modified to document
  - Vision of the future: transformation impact on stakeholders, information exchanges, operations, and health care outcomes
- Maturity Model modified to accommodate
  - Enhanced Funding requirements
  - More clarity for maturity levels
- Business Process Model
  - Ten (10) business areas
  - Eighty (80) business processes
- Business Capability Matrix: performance measures defined - Levels 3, 4, and 5 expanded
- State Self-Assessment (SS-A) now a standalone section

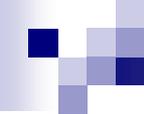
# Business Area Reorganization

<b>Version 2.0</b>	<b>Version 3.0</b>
<ul style="list-style-type: none"><li>• Business Relationship Management</li></ul>	<ul style="list-style-type: none"><li>• Business Relationship Management</li></ul>
<ul style="list-style-type: none"><li>• Care Management</li></ul>	<ul style="list-style-type: none"><li>• Care Management</li></ul>
<ul style="list-style-type: none"><li>• Contractor Management</li></ul>	<ul style="list-style-type: none"><li>• Contractor Management</li></ul>
<ul style="list-style-type: none"><li>• N/A</li></ul>	<ul style="list-style-type: none"><li>• Eligibility and Enrollment Management</li></ul>
<ul style="list-style-type: none"><li>• N/A</li></ul>	<ul style="list-style-type: none"><li>• Financial Management</li></ul>
<ul style="list-style-type: none"><li>• Program Management</li></ul>	<ul style="list-style-type: none"><li>• Health Plan Management</li></ul>
<ul style="list-style-type: none"><li>• Member Management</li></ul>	<ul style="list-style-type: none"><li>• Member Management</li></ul>
<ul style="list-style-type: none"><li>• Operations Management</li></ul>	<ul style="list-style-type: none"><li>• Operations Management</li></ul>
<ul style="list-style-type: none"><li>• Program Integrity Management</li></ul>	<ul style="list-style-type: none"><li>• Performance Management</li></ul>
<ul style="list-style-type: none"><li>• Provider Management</li></ul>	<ul style="list-style-type: none"><li>• Provider Management</li></ul>



# Information Architecture Key Changes

- The Introduction includes a table called “Summary of Components,” which explains the components of the Information Architecture.
- The Conceptual Data Model (CDM) identifies subject areas and groupings of data important to the business and defines their general relationships.
- The Logical Data Model (LDM) contains details (entities, attributes, and relationships) derived from the CDM.
- MITA standards are structured data standards, or vocabulary data standards. Part II, Chapter 5, identifies the applicable standard for each data element.



# Technical Architecture Key Changes

- TA now includes Cloud Computing concepts, such as “Software as a Service (SaaS)”.
- TCM is available to provide States with a technical self-assessment tool by introducing the groupings of Technical Service Areas (TSA) and subgrouping of Service Classifications.
- TA now contains an extensive listing of the current technology standards to be used in defining the various components of the technical architecture. The listed standards align with the MITA goals and objectives and the modularity and interoperability components of CMS Seven Standards and Conditions.

# 7 Conditions and Standards

- ✓ Modularity Standard
- ✓ MITA Condition
- ✓ Industry Standards Condition
- ✓ Leverage Condition
- ✓ Business Results Condition
- ✓ Reporting Condition
- ✓ Interoperability Condition



# 1. Modularity Standard

- SDLC Methodologies
- Open Interfaces
- Exposed APIs
- Business Rules Engines
- HHS – Designated Repository





## 2. MITA Condition

- Annual State Self-Assessment (SS-A)
- 5-year roadmap for MITA Maturity
- Concept of Operations (COO)
- Business Process Models (BPM)

### 3. Industry Standards Condition

- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Section 508 - Rehabilitation Act
- Section 1104 - Affordable Care Act
- Section 1561 - Affordable Care Act



## 4. Leverage Condition

- Intra-state Project Collaboration
- Using COTS Software
- Identifying Components for Reuse





## 5. Business Results Condition

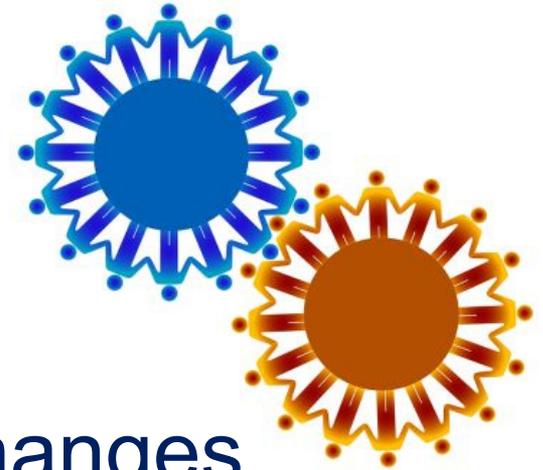
- Systems should support
  - Accurate and timely processing of claims adjudications
  - Effective communications with providers, beneficiaries, and the public.
- Degree of Automation
- Customer Service
- Performance Standards and Testing

## 6. Reporting Condition

- Solutions should produce transaction data, reports, and performance information that contributes to:
  - program evaluation
  - continuous improvement in business operations
  - transparency and accountability
- Systems should be able to produce and to expose electronically the accurate data that are necessary for oversight, administration, evaluation, integrity, and transparency.

# 7. Interoperability Condition

- HIE – Health Information Exchanges
- Federal Hub
- HIX – Health Insurance Exchanges
- Standardized messaging, protocols, and architecture



# Topic 4: MMIS Modernization

Presented by:

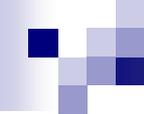
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# Introduction

- Medicaid agencies are facing dynamic changes in policy and struggling to comply with Medicaid Information Technology Architecture (MITA) goals, all in the context of performing their current operational duties. Addressing these multidimensional challenges, agencies are embarking on the daunting task of modernizing their Medicaid Management Information Systems (MMIS).



# Considerations

- Understanding of Organizational Structure
- Identification of Key Stakeholders
- Knowledge of Current MMIS Landscape and Business Operations
- Understanding of Technical Options (e.g., SOA, Cloud Computing)
- Collaboration Opportunities (HIX, E&E, HIE - EHRs)
- Funding



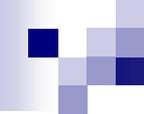
# Transition and Implementation Planning (PAPD)

- Mobilize key stakeholders
- Conduct transition plan kickoff meeting
- Identify projects and approaches
- Identify drivers, funding, and resource priority
- Prioritize projects and approaches
- Develop and publish transition plan



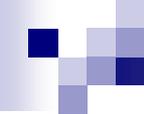
# Obtain Federal Approval and Funding (IAPD)

- Prepare statement of needs
- Analyze viable solutions
- Evaluate costs and benefits
- Develop state project plan
- Estimate budget and cost allocation
- Document and submit IAPD



# Project Launch

- Review and finalize transition plan and IAPD
- Develop project work plan
- Mobilize key stakeholders
- Finalize project plan
- Begin work



# Determine Detailed Functional Requirements

- Prepare baseline use cases
- Schedule JAR sessions and plan agendas
- Conduct JAR sessions
- Document detailed functional requirements
- Trace functional requirements to use cases
- Publish requirements report



# Determine Detailed Technical Requirements

- Identify technical architecture team
- Conduct technical team workshop
- Confirm required interfaces and dependencies
- Develop conceptual technical architecture
- Document technical requirements
- Published technical requirements

# Develop RFP

- Review and validate IAPD
- Draft procurement timeline
- Draft RFP outline
- Draft RFP content
- Develop performance evaluation plan
- Submit RFP to CMS for approval



# Select Implementation vendors

- Conduct pre-bid conference
- Release RFP
- Respond to vendor questions
- Evaluate RFP responses using performance evaluation plan
- Finalize evaluation approvals
- Notify vendors, and publish selections

# Topic 5: ICD-10 & Operating Standards

Presented by:

Bob Guenther, Healthcare and Human Services Client Executive

CSG Government Solutions

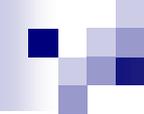
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# ICD-10 Overview



# Introduction

- ICD-10 replaces a 25-year-old code set that has failed to keep up with modern terminology and practice
- ICD-10 provides detailed information on a patient's condition through specific diagnoses
- ICD-10 provides a more specific and modern approach to classifying inpatient hospital procedures

# ICD-10 is no Small Feet....er, Feat!

The transition to ICD-10 will impact every system, process and transaction that contains or uses a patient diagnosis or procedure code. Direct effects to state Medicaid plans include:

- ✓ coverage determinations
- ✓ payment determinations
- ✓ medical review policies
- ✓ plan structures
- ✓ statistical reporting
- ✓ actuarial projections
- ✓ fraud and abuse monitoring
- ✓ quality measurements





# Major Change...

- Not just the usual annual update
- ICD-10 markedly different from ICD-9
- Requires changes to almost all clinical and administrative systems
- Requires changes to business processes
- Changes to reimbursement and coverage
- Will enable significant improvements in care management, public health reporting, research, and quality measurement



# High-Level Comparison CM

<b>ICD-9-CM</b>	<b>ICD-10-CM</b>
No placeholder characters	Includes place holders ('x')
Approximately 14,000 codes	Over 69,000 codes
Limited initial/subsequent visit detail	Initial/subsequent visit, episode of care, and disease stage detail
Limited symptom codes	Restructuring of diagnosis/symptom codes
Antiquated terminology	Modern healthcare terminology
Severity parameters limited	Extensive inclusion of severity parameters
Laterality missing (Left vs. Right)	Laterality present
Limited specificity	Greater specificity

# High-Level Comparison PCS

<b>ICD-9-PCS</b>	<b>ICD-10-PCS</b>
Not structured	Very structured
Volume included in CM	Managed separately from CM
Use of eponyms and named procedures	Avoids eponyms and named procedures
Uses combination codes	Avoids using combination codes
~ 3,800 procedure codes	72,000 procedure codes

# Code Specificity Example



ICD-9 code – Striking against or struck accidentally in sports without subsequent fall.  
(E917.0)

# ICD-10: Sports injuries now coded with sport and reason for injury...

- ▶ W21.00 Struck by hit or thrown ball, unspecified type
- ▶ W21.01 Struck by football
- ▶ W21.02 Struck by soccer ball
- ▶ W21.03 Struck by baseball
- ▶ W21.04 Struck by golf ball
- ▶ W21.05 Struck by basketball
- ▶ W21.06 Struck by volleyball
- ▶ W21.07 Struck by softball
- ▶ W21.09 Struck by other hit or thrown ball
- ▶ W21.31 Struck by shoe cleats
- ▶ Stepped on by shoe cleats
- ▶ W21.32 Struck by skate blades
- ▶ Skated over by skate blades
- ▶ W21.39 Struck by other sports foot wear
- ▶ W21.4 Striking against diving board
- ▶ W21.11 Struck by baseball bat
- ▶ W21.12 Struck by tennis racquet
- ▶ W21.13 Struck by golf club
- ▶ W21.19 Struck by other bat, racquet or club
- ▶ W21.210 Struck by ice hockey stick
- ▶ W21.211 Struck by field hockey stick
- ▶ W21.220 Struck by ice hockey puck
- ▶ W21.221 Struck by field hockey puck
- ▶ W21.81 Striking against or struck by football helmet
- ▶ W21.89 Striking against or struck by other sports equipment
- ▶ W21.9 Striking against or struck by unspecified sports equipment

# Range of Applications



- Improved care management of beneficiaries
- Boost efficiencies by identification of specific health conditions, diagnoses, and procedures
- More effective coverage and payment determination
- Better data for fraud and abuse monitoring
- Links to electronic health records (EHRs) and additional information
- Strategic planning for member, provider, and benefit service improvements
- Performance monitoring and increased capacity to report quality measures
- Quality assurance of clinical and administrative processes

# Improved Care Management of Beneficiaries



- Better diagnosis identification provides opportunity to:
  - Identify candidates sooner for special attention
    - Diabetes
    - Asthma
  - Track severity of disease and measure progress
  - Identify disease groupings that may merit special attention
  - Design educational programs, as disease clusters are identified
  - Design new care management programs

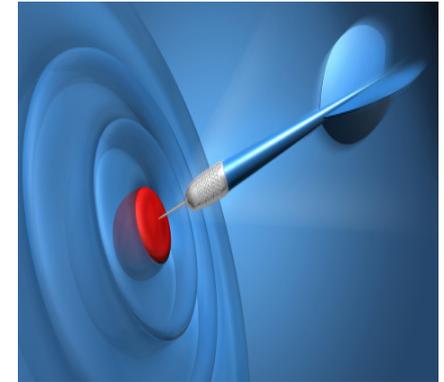
# Boost Efficiencies

- ICD-10 provides more specific information about diagnoses and inpatient hospital procedures
- This should provide an opportunity to determine which types of procedures are the most cost-effective for specific conditions
- It may be a way to start saving Medicaid payments!
- On the administrative side, there should be less need for additional information to make payment decisions



# More Effective Coverage and Payment Determination

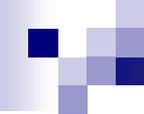
- The more specific information provided in the ICD-10 codes presents an opportunity for coverage and policy revisions
- Policies can now pinpoint more specific conditions and more specific procedures
- Medicaid programs can make better decisions on whether or not to cover procedures based on better diagnosis information on the claim
- Medicaid programs can more accurately pay for procedures based on specific diagnoses and the severity of the diagnosis



# Links to Electronic Health Records and Additional Information

- ICD-10 codes must be supported by documentation contained in EHRs
- Expect that the tools for ICD-10 coding will be included in new EHRs
- Should be able to link codes directly to specific information
- Requests for information will be more specific and accurate





# Quality and Performance Measures

- Many quality measures are either based on or specific to diagnoses
- ICD-10 provides an opportunity to create more targeted and more accurate quality measures by using better diagnosis information
- Provider quality and performance measures can thus be improved, and the data considered more accurate
- Medicaid agencies can use this information to determine if beneficiaries are getting the right care
- Can look at provider patterns of care versus industry benchmarks
- Compare Medicaid population with other populations

# Strategic Planning for Beneficiary, Provider, and Benefit Services Improvement



- Strategic planning is another opportunity for use of the better data that ICD-10 will provide
- Once enough data is collected, trending can begin and support strategic planning for:
  - Relating beneficiary demographic information with conditions
  - Looking at provider caseload trends by condition
  - Determining better benefit packages for the Medicaid population

# No Clear Mapping



- Not always one ICD-9 to many ICD-10s
- Need more specific information to go from ICD-9 to ICD-10
- CMS has published “GEMs,” general equivalence tables – Not a clear map
- Affects Fiscal and Service Neutrality

# Key Activities



- Build organizational awareness and commitment
- Identify key stakeholders
- Evaluate interfaces where codes are exchanged
- Identify all systems that utilize or hold diagnosis codes
- Identify all processes/policies that utilize diagnosis codes
- Identify all contractors that rely on diagnosis codes
- Determine and encourage provider readiness
- Identify issues affected in claims processing
- Prioritize remediation efforts

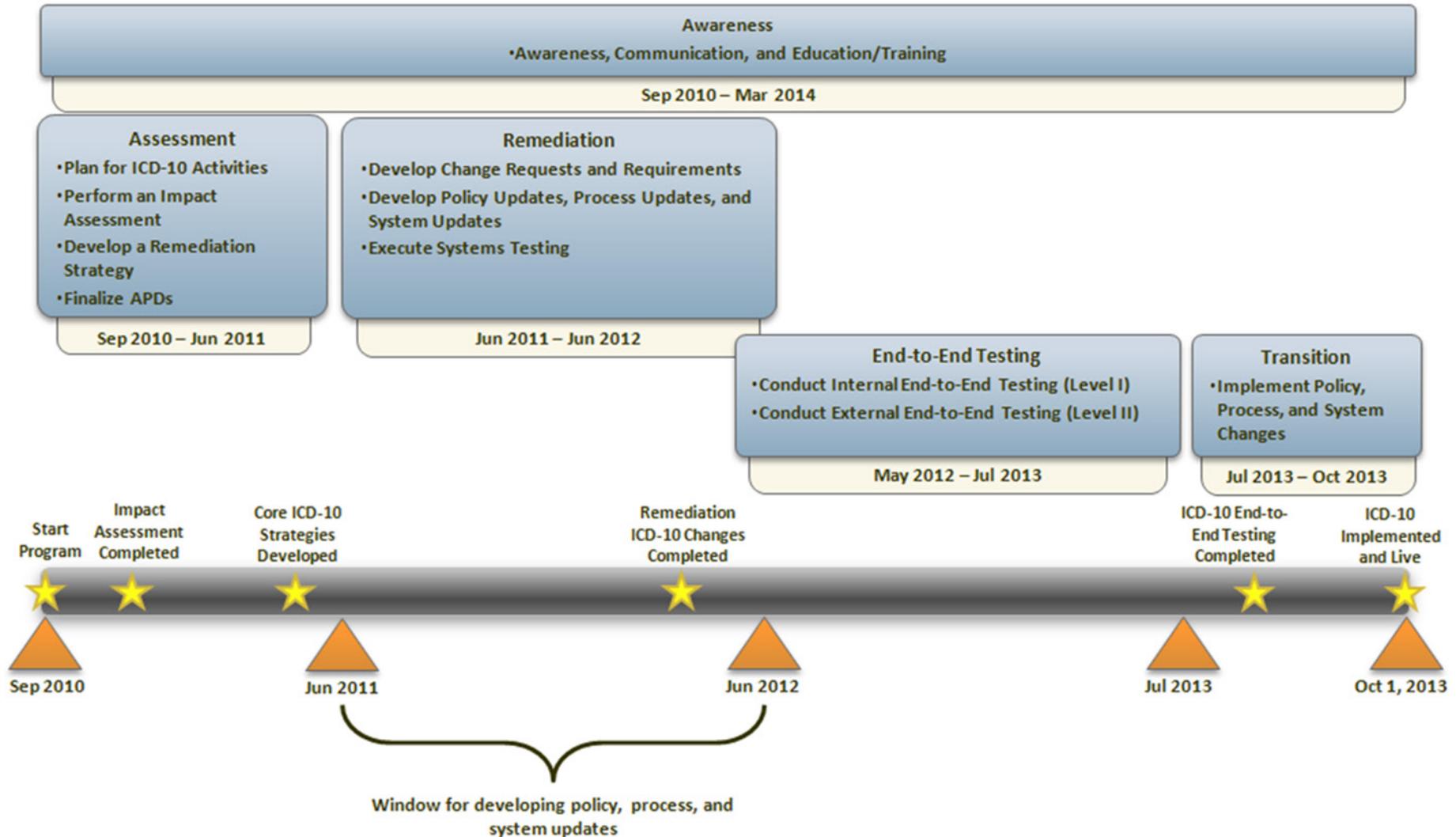
# Regulatory Timing



- ICD-10-CM and ICD-10-PCS must be used on all transactions for services performed on and after October 1, 2013\* (date of discharge for inpatient)
- Service-date based, not transaction-date based
- Must continue to handle ICD-9 codes for services prior to October 1, 2013
- Same implementation date for all entities
- No “transition period”

\* NPRM for ICD-10 compliance deadline extension to October 1, 2014 is currently in a 30 day comment period ending on May 17, 2012. It appears likely that the deadline will be extended.

# CMS Compliance Timeline





# Operating Rules Overview

# Introduction

- Section 1104 of the ACA adopts Operating Rules as defined to be “the necessary business rules and guidelines for the electronic exchange of information that are not defined by a standard or its implementation specifications.”
- These rules are meant to realize administrative simplification of HIPAA standard transactions and will only be developed for Electronic Data Interchange (EDI) of healthcare transactions for which HIPAA standards have been adopted.

# Operating Rules for EDI

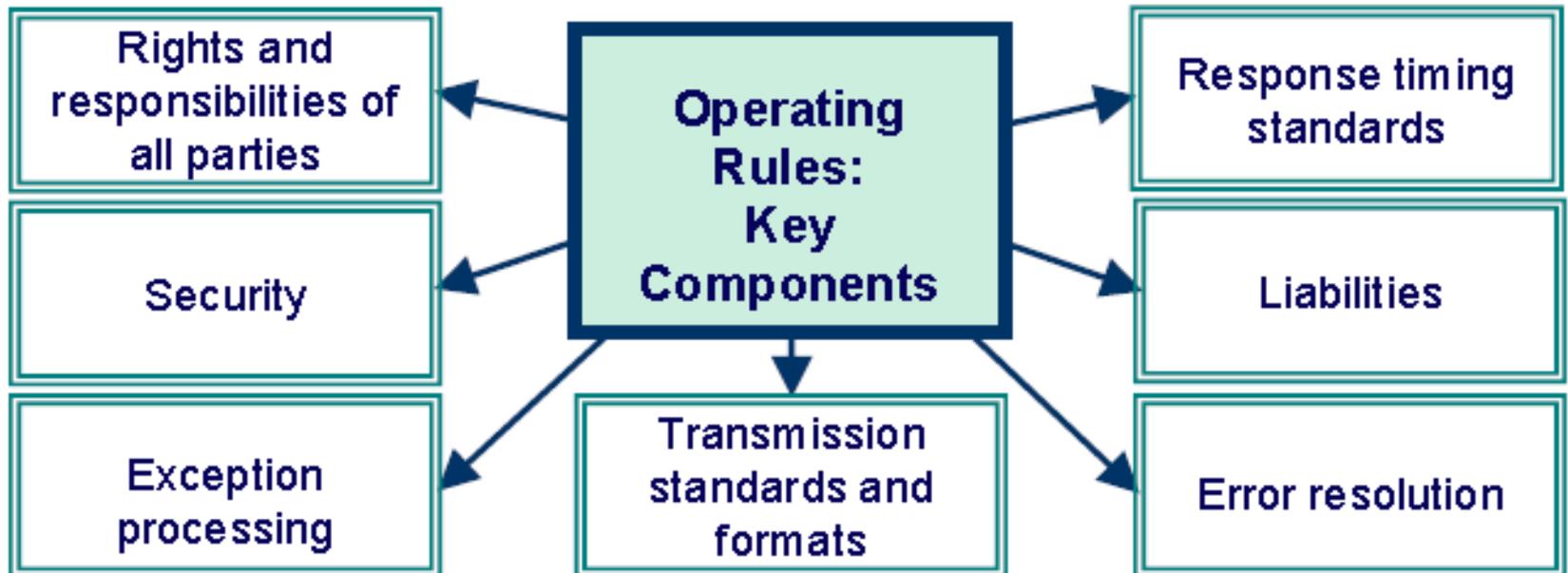
- Three sets of operating rules developed for use with (EDI) transaction standards are:
  - Eligibility and Claim Status
  - Claims payment advice and electronic funds transfer (EFT/ERA)
  - Health claims/encounter information (claims attachments), enrollment/disenrollment in a health plan, health plan premium payments, referral certification and authorization
- Timeline for certifying\* compliance:
  - Eligibility and Claim Status – December 31, 2013
  - EFT/ERA – December 31, 2013
  - Claim Attachments, enrollment/disenrollment in a health plan, health plan premium payments, referral certification and authorization – December 31, 2015

\* Note: there is no timeline for the development of the official certification process, other than “by late 2013.”

# Operating Rules Example

- The 270/271 transaction—each state created its own “Companion Guide,” which contained that state’s version of eligibility “operating rules.” There was little real interoperability among the states even though HIPAA is a “standard.”
- Operating rules create a national “Companion Guide” of how to exchange eligibility data across state and federal agencies.

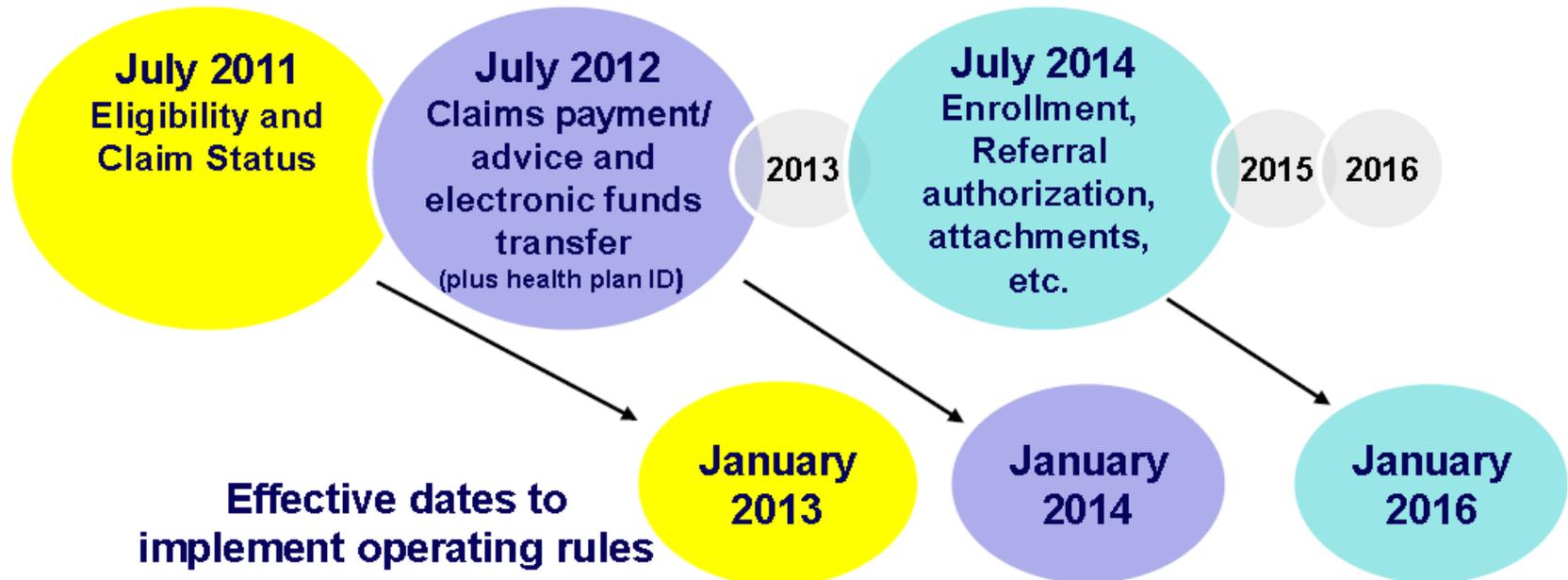
# Key Components



# Operating Rules Implementation Timeline

Operating rule writing and mandated implementation timeframe per ACA legislation

## Adoption deadlines to finalize operating rules



# Topic 6: Electronic Health Record (EHR) Incentive Program

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# HITECH and the EHR Incentive Program

## *What is the purpose of the HITECH Legislation?*

- As part of the American Reinvestment and Recovery Act (ARRA), the HITECH legislation was designed to improve health outcomes, facilitate access to care, and reduce healthcare costs by:
  - Providing financial support to providers and Medicaid agencies
  - Investing in technology frameworks to facilitate the sharing/exchange of health records and data for “meaningful use”

## *What is the EHR Incentive Program?*

- Provides incentive payments to qualified providers to **adopt, implement or upgrade** technology to manage patient health records.
  - Medicare Fee-For-Service (FFS) Incentive Program – Eligible Professionals (EPs), Eligible Hospitals (EHs), and Critical Access Hospitals (CAHs)
  - Medicare Advantage (MA) EHR – MA EPs, and MA-affiliated eligible hospitals
  - **Medicaid EHR Incentive Program\*** – EPs and EHs  
*(Medicaid EHR Incentive Program is VOLUNTARY)*
- Providers must provide evidence that data exchange achieves “meaningful use” in Years 2 – 6.

**HINT:** Even if an EP provider is eligible under multiple incentive programs, he/she can only receive funding under one EHR program.

# HITECH and the EHR Incentive Program

## *What is “Meaningful Use” (MU)?*

- CMS states in the final rule that the definition of MU will evolve as technology develops and is adopted over time and anticipates this to occur in three stages:
  - **Stage 1** – Consists of a set of “core” objectives and measures and a set of “menu” objectives and measures. Providers must report satisfactorily on all of the core objectives and five of the menu objectives.
  - **Stage 2** – Notice of proposed rule making was published February 23, 2012. The NPRM includes new clinical and quality measures, new reporting mechanisms; minor changes to the Medicare and Medicaid programs.
  - **Stage 3** – Not yet defined; anticipated by end of CY2013.
- In implementing the EHR incentive program, during 2011, states were allowed to have EPs and EOs attest to “meaningful use” and audit providers to ensure compliance.
- Beginning in 2012, states will begin collecting quality data from providers to validate meaningful use.
- Stage 2 rulemaking will be finalized Summer 2012; effective October 2013 for EOs and January 2014 for EPs.

# Medicaid EHR Incentive Program Basics

Provider Eligibility based on Patient Volume<sup>2</sup>

Entity	Minimum Medicaid patient volume threshold	Or the Medicaid EP practices predominantly in an FQHC or RHC—30% needy individual patient volume threshold
Physicians	30%	
- Pediatricians	20%	
Dentists	30%	
Certified Nurse Midwives	30%	
PAs when practicing at an FQHC/RHC that is so led by a PA	30%	
Nurse Practitioners	30%	
Children's Hospitals	No Requirement	
Acute Care Hospitals	10%	

<sup>2</sup> Source: HITECH EHR Incentive Program Agency External Training, CMS, February 2010

# Medicaid EHR Incentive Program Basics

*What is the structure of the Medicaid incentive payments for EPs?<sup>2</sup>*

	First Calendar Year in Which EPs Receive an Incentive Pymt.					
Calendar Year	CY2011	CY2012	CY2013	CY2014	CY2015	CY2016
2011	\$21,250					
2012	\$ 8,500	\$21,250				
2013	\$ 8,500	\$ 8,500	\$21,250			
2014	\$ 8,500	\$ 8,500	\$ 8,500	\$21,250		
2015	\$ 8,500	\$ 8,500	\$ 8,500	\$ 8,500	\$21,250	
2016	\$ 8,500	\$ 8,500	\$ 8,500	\$ 8,500	\$ 8,500	\$21,250
2017		\$ 8,500	\$ 8,500	\$ 8,500	\$ 8,500	\$ 8,500
2018			\$ 8,500	\$ 8,500	\$ 8,500	\$ 8,500
2019				\$ 8,500	\$ 8,500	\$ 8,500
2020					\$ 8,500	\$ 8,500
2021						\$ 8,500
<b>Total</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>	<b>\$63,750</b>

<sup>2</sup> Source: HITECH EHR Incentive Program Agency External Training, CMS, February 2010

# Medicaid EHR Incentive Program Basics

## ***What is the structure of the Medicaid incentive payments for EHs?***

- Payments are issued by Federal Fiscal Year.
- Provider-specific aggregate dollar limits, based on a formula that first calculates a base amount of \$2 million plus a per discharge amount (based on Medicare/Medicaid share).
- Hospitals meeting Medicare MU requirements may be deemed eligible for Medicaid payments
- Medicare hospitals cannot receive payments after 2016. For Medicaid, hospitals cannot initiate payments after 2016 but can receive payments if they initiated the program before 2016.

***HINT: Does it really matter? EHR or EMR – what's the difference?*** In the healthcare industry, you will hear “electronic health record” (EHR) and “electronic medical record” (EMR) used interchangeably. What is important to know for the Medicaid Incentive Program is that providers need to use certified EHR technology to qualify for incentive payments. CMS has a list of vendors /products that are certified.

# Medicaid EHR Incentive Program Basics

## *Medicaid EHR Program Requirements:*

- Conduct adequate financial oversight
- Verify that providers are eligible and engaging in activities that may be reimbursed through the program
- Report actual expenditures for the program through the Medicaid Budget and Expenditure System
- Set up an automated system to:
  - Verify provider eligibility;
  - Ensure accurate payments to providers; and
  - Identify overpayments and duplicate payments.
- Ensure that incentive payments are made directly to an eligible provider or appropriate State- or provider-designated third party without any reductions or rebates
- Audit providers, collect overpayments, and report any suspected fraud or abuse to HHS
- Set up a provider appeals process to resolve incentive payment disputes

# Medicaid EHR Incentive Program Basics

## ***What financial support is available to States to establish an EHR Incentive Program and how can funding be accessed?***

- 90% federal financial participation (FFP) is available to assist states in establishing a Medicaid EHR Incentive Program.
- States must receive approval of the following documents to utilize the enhanced match:
  - State Medicaid Health Information Technology Plan (SMHP);
  - Health Information Technology Planning Advance Planning Document (PAPD); and
  - Health Information Technology Implementation Advance Planning Document (IAPD)
- States need to update the SMHP annually and the IAPD(U) as funding needs change.

# EHR Incentive Program Considerations

## *What is next for EHR?*

- For a status of where states are, see the handout “CMS Status of Medicaid EHR Incentive Programs.”
- How quickly are providers adopting EHR in your state?
- What communication and stakeholder outreach has been effective in notifying providers about the funding that is available?
- Are EHR providers participating in State Health Information Exchanges?
- How does EHR intersect with other HIT Initiatives states are facing?
- What lessons learned can be shared with other states? What lessons learned can be applied across other technology projects?

