What is Meaningful Use?

• Meaningful Use is using certified EHR technology to improve quality, safety, efficiency, and reduce health disparities
  o Engage patients and families in their health care
  o Improve care coordination
  o Improve population and public health
  o All the while maintaining privacy and security

• Meaningful Use mandated in law to receive incentives
Conceptual Approach to Meaningful Use

Data capture and sharing

Advanced clinical processes

Improved outcomes
Medicaid EHR Incentive Program Update

• 43 States have launched Medicaid EHR Incentive Programs
  o Remaining States and most Territories will launch this year
• Through January 2012, 34 States have paid $1.4 billion in Medicaid EHR incentive payments
• Most incentive payments from States are for adopting, implementing, or upgrading to certified EHRs
• Beginning in 2012, States will collect attestations and disburse incentives for Meaningful Use
• Medicaid vs. Medicare EHR Incentive Program
Proposed Stage 2 Rule for EHR Incentive Programs

• Published March 7 on the Federal Register
  o 60-day comment period from March 7 to May 6 (comments can be made at www.regulations.gov)
• Stage 2 Final Rule published – Summer 2012
• Proposed Stage 2 Final Rule start dates:
  o October 1, 2013 for eligible hospitals
  o January 1, 2014 for eligible professionals
Medicaid-Specific Changes

• Proposed an expanded definition of a Medicaid encounter:
  ○ To include any encounter with an individual receiving medical assistance under 1905(b), including Medicaid expansion populations
  ○ To permit inclusion of patients on panels seen within 24 months instead of just 12
  ○ To permit patient volume to be calculated from the most recent 12 months, instead of on the CY
  ○ To include zero-pay Medicaid claims
Medicaid-Specific Changes Continued

• Proposed the inclusion of additional children’s hospitals that do not have a CMS Certification Number (CCN)
• Proposed to extend States’ flexibility with the definition of Meaningful Use to Stage 2
Meaningful Use and HIE

- Several meaningful use measures are enabled through health information exchange (care summaries, public health reporting, etc)
- This has positive implications for CDC for the 3 public health objectives
- Many States are planning to use HIEs as the catcher’s mitt for the clinical quality measures as reported electronically from EHRs starting around 2013 (and for other clinical quality measures, e.g. CHIPRA).
The Nationwide Health Information (NwHIN) Exchange

- CMS signed the Data Use and Reciprocal Support Agreement (DURSA) in July 2011
- CMS successfully on-boarded in December, and is currently exchanging data
  - As of right now, data exchange is unilateral
- CMS is actively engaging with the other Federal Partners
  - Privacy & security issues
  - Funding
  - Technical considerations
End Stage Renal Disease (ESRD)

- CMS has partnered with the National Renal Administrators Association to allow small and medium dialysis facilities to submit EHR data to the CROWNWeb system
- Uses CONNECT and the NwHIN Exchange
- CMS is an exchange partner with the Washington State HIE to receive data from 14 facilities
- Production began February 2012
Electronic Submission of Medical Documentation (esMD)

- This project enables providers to submit patient records to CMS or its Medicare Audit Contractors in an electronic format for auditing/program integrity purposes.
- Phase 1 (CMS receiving data) began September 2011
  - Phase 2 (CMS sending data) planned for October 2012
- Providers send data through health information handlers (HIHs), which are certified by CMS
  - Examples: HIEs, clearinghouses, vendors
- Uses CONNECT, but not the NwHIN Exchange
CMS Strategic Plans

• The Center for Strategic Planning has seven contracts for a wide range of strategic plans
  o Examples: Information Exchange, CQM Infrastructure, and Shared Services
• Final deliverables by spring/summer 2012
• Looking at the next 3-5 years
• Looking at internal as well as external processes
• Interviews throughout CMS, covering all components and major program areas
CMS Strategy Plans, cont.

- These are enterprise-level strategy plans, covering all major programs within CMS
- The unifying focus for all of the strategic plans is improving the provider experience
- While the contracts are separate, contractors are aligning the deliverables with each other
- Some major themes:
  - Use of intermediaries
  - Data elements vs. CQM
  - Single (or at least fewer) point of entry
Health Information Exchange and Medicaid

• Under HITECH, CMS can provide administrative funding to States for enabling meaningful use and health information exchanges
  o Enables MU measures (public health reporting, transmission of care summaries, etc.)
  o Potential use for CQM submission (not just HITECH but also CHIPRA, etc)

• Several States are being approved for HIE funding, and CMS is working with others in the queue.
HIE and Medicaid Continued

• The parameters for Medicaid funding for States’ HIE activities are outlined in a State Medicaid Directors Letter from May 2011
  o Highlights include cost allocation among other payers and providers per OMB A87

• Example projects include provider directories, master patient indexes, interfaces with public health, privacy & security applications, and discounts for HIE participation fees for providers eligible for EHR incentive payments
HIE Sustainability

- Sustainability is the key challenge
- May 2011 State Medicaid Director letter
  - Developmental costs, not O+M costs
  - Fair share and cost allocation with other entities
    - Examples: private payer funding, subscription fees, grants
- Several models are evident, consistent with the ONC-funded operational plans:
  - “Network of networks”
  - Statewide, enterprise HIE
An Integrated Approach

- CMS is proactively working with States to spread HIE benefits across multiple systems
  - MMIS
  - Enrollment & Eligibility
  - HIX
- Including these other systems is efficient and will maximize funding from CMS
- CMS is also working with ONC to ensure that the HITECH funding and ONC grants are aligned
  - Many State plans include NwHIN and Direct
Update on ONC’s State HIE Program: Existing Environment

Little exchange occurring

- Almost three quarters of the time (73 percent) PCPs do not get discharge info within two days. Almost always sent by paper or fax (2009, Commonwealth)
- Only 19 percent of hospitals report they are sharing clinical information electronically with providers outside system (2010, AHA)

Cost of exchange high, time to develop is long

- Interfaces cost $5K to $20K due to lack of standardization, implementation variability, mapping costs
- Community deployment of query-based exchange often takes years to develop

Poised to grow rapidly, spurred by new payment approaches

- New payment models are the business case for exchange
- More than 70 percent of hospitals plan to invest in HIE services (2011, CapSite)
- Number of active “private” HIE entities tripled from 52 in 2009 to 161 in 2010 (2011, KLAS)

Many approaches and models

- In addition to RHIOs, many other approaches emerging, including local models advanced by newly emerging ACOs, exchange options offered by EHR vendors, and services provided by national exchange networks
- Seeing a full portfolio of exchange options, meeting different needs
Evolving Conception of the Role of State HIE Program

Prior Assumption

- One state-run HIE network serving majority of exchange needs of the state
- Focus on developing query-based exchange

Current

- There will be multiple exchange networks and models in a state
- Key role of the state HIE program is to catalyze exchange in state by reducing costs of exchange, filling gaps and assuring common baseline of trust and interoperability, building on the market and focusing on stage one meaningful use
Focus and Approach

Focus - Give providers viable options to meet MU exchange requirements

- E-prescribing
- Care summary exchange
- Lab results exchange
- Public health reporting
- Patient engagement

Approach

- Make rapid progress
- Build on existing assets and private sector investments
- Every state different, cannot take a cookie cutter approach
- Leverage full portfolio of national standards
We are here today...

Receipt of Discharge Information by Primary Care Physicians

<table>
<thead>
<tr>
<th>Time Frame (n=1,442)</th>
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<tbody>
<tr>
<td>Less than 48 Hours</td>
<td>27%</td>
</tr>
<tr>
<td>2 to 4 Days</td>
<td>29%</td>
</tr>
<tr>
<td>5 to 14 Days</td>
<td>26%</td>
</tr>
<tr>
<td>15 to 30 Days</td>
<td>6%</td>
</tr>
<tr>
<td>More than 30 Days</td>
<td>1%</td>
</tr>
<tr>
<td>Rarely/Never Receive Adequate Support</td>
<td>5%</td>
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<tr>
<td>Not Sure/Decline to Answer</td>
<td>4%</td>
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</table>

<table>
<thead>
<tr>
<th>Delivery Method (n=1,290)*</th>
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<tbody>
<tr>
<td>Fax</td>
<td>62%</td>
</tr>
<tr>
<td>Mail</td>
<td>30%</td>
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<tr>
<td>Email</td>
<td>8%</td>
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<tr>
<td>Remote Access</td>
<td>15%</td>
</tr>
<tr>
<td>Other</td>
<td>11%</td>
</tr>
<tr>
<td>Not Sure/ Decline to Answer</td>
<td>1%</td>
</tr>
</tbody>
</table>

19 percent of hospitals are exchanging clinical care records with ambulatory providers outside system (2010)

Will we soon see this curve for care summary exchange or lab exchange?

Number of e-Prescribers in US by Method of Prescribing

- Stand-alone e-Rx System
- EHR
- Total

Dec-06 to Jun-11
Texas White Space
# State HIE program opportunities to fill gaps, lower cost of exchange and assure trust

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Description</th>
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<tbody>
<tr>
<td>White Space</td>
<td>Large areas of state don’t have viable exchange options for providers</td>
</tr>
<tr>
<td>Duplication</td>
<td>Every exchange creates own eMPIO, identity solution &amp; directories</td>
</tr>
<tr>
<td>Information Silos</td>
<td>Unconnected exchange networks don’t support info following patient across entire delivery system</td>
</tr>
<tr>
<td>Disparities</td>
<td>Low capacity data suppliers do not have resources or technical capacity to participate in exchange</td>
</tr>
<tr>
<td>Emerging Networks</td>
<td>Emerging networks need resources and technical support</td>
</tr>
<tr>
<td>Public Health Capacity</td>
<td>States’ numerous reporting needs are resolved in one-off ways or aren’t electronic</td>
</tr>
<tr>
<td>No Shared Trust/Interop</td>
<td>Lack of common technical and trust requirements makes negotiations and agreements difficult and slows public support and exchange progress</td>
</tr>
</tbody>
</table>

## Strategies

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Strategies to Address</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>White Space</td>
<td><strong>Directed Exchange</strong> - Jumpstart low-cost directed exchange services to support meaningful use requirements</td>
<td>51</td>
</tr>
<tr>
<td>Duplication</td>
<td><strong>Shared Services</strong> - Offer open, shared services like provider directories and identity services that can be reused</td>
<td>54</td>
</tr>
<tr>
<td>Information Silos</td>
<td><strong>Connect the nodes</strong> - Infrastructure, standards, policies and services to connect existing exchange networks</td>
<td>25</td>
</tr>
<tr>
<td>Disparities</td>
<td><strong>REC for HIE</strong> - Grants and technical support for CAHs, independent labs, rural pharmacies to participate in exchange</td>
<td>20</td>
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<tr>
<td>Emerging Networks</td>
<td><strong>Support local networks</strong> – Connectivity grants and trust/standards requirements for emerging exchange entities</td>
<td>5</td>
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<tr>
<td>Public Health Capacity</td>
<td><strong>Serve reporting needs of state</strong> - Support public health and quality reporting to state agencies</td>
<td>28</td>
</tr>
<tr>
<td>No Shared Trust/Interop Requirements</td>
<td><strong>Accreditation and validation</strong> of exchange entities against consensus technical and policy requirements</td>
<td>17</td>
</tr>
</tbody>
</table>
Rapid facilitation of directed exchange capabilities to support Stage 1 meaningful use

Bolstering of sub-state exchanges through financial and technical support, tied to performance goals

Thin-layer state-level network to connect existing sub-state exchanges

Statewide HIE activities providing a wide spectrum of HIE services directly to end-users and to sub-state exchanges where they exist

Preconditions:
- Little to no exchange activity
- Many providers and data trading partners that have limited HIT capabilities
- If HIE activity exists, no cross entity exchange

Preconditions:
- Sub-state nodes exist, but capacity needs to be built to meet Stage 1 MU
- Nodes are not connected
- No existing statewide exchange entity

Preconditions:
- Operational sub-state nodes
- Nodes are not connected
- No existing statewide exchange entity
- Diverse local HIE approaches

Preconditions:
- Operational state-level entity
- Strong stakeholder buy-in
- State government authority/financial support
- Existing staff capacity
Delaware

*Directed exchange* - Jumpstart low-cost directed exchange services to support meaningful use requirements

- Provider outreach focused on how service can help providers coordinate care and meet meaningful use requirements:
  - Sharing a care summary when patient referred
  - Immunization reporting
  - LTPAC transitions
- Offered a time-limited free sign-up period to create a sense of urgency among eligible providers and hospitals
- A month after launch, more than 500 providers signed up for service
Wisconsin
*Shared services* - Offer open, shared services like provider directories and identity services that can be reused

- One of the key factors for a large scale adoption of a provider directory is for it to be flexible and provide accurate and up-to-date information.
- Every provider added to the provider directory is checked against 13 discrete elements leading to an accuracy rate of 98% with elimination of duplicates.
- The provider directory is easily configured and integrated into other existing systems such as the WHIO (Wisconsin Health Information Organization), WCHQ (Wisconsin Collaborative for Healthcare Quality), and the WCMEW (Wisconsin Council on Medical Education and Workforce).
- Currently the provider directory only has capabilities that allow end-users to search for physicians and clinics, but future plans will allow for the HISP to synchronize Direct certificates and addresses to fields within the provider directory.
Indiana

Connect the nodes - Infrastructure, standards, policies and services to connect existing exchange networks

• Indiana has five operational HIEs: HealthBridge, HealthLINC, IHIE, MHIN, and The Med-Web

• The state HIE program is funding these exchange organizations to begin sharing information across exchange entities, with the goal that patient information can securely follow patients wherever and whenever they seek care in the state

• The state’s HIEs are working together to agree on a shared set of privacy and security requirements and implement the NwHIN Exchange service stack

• While the state’s SDE is facilitating the work between HIEs and holding them accountable for deliverables and consensus, the resulting connected nodes will each maintain independent architectures and governance processes
Ohio

REC for HIE - Grants and technical support for CAHs, independent labs, rural pharmacies to participate in exchange

- Many hospital labs in Ohio currently do not exchange electronic laboratory data in a structured format.
- Ohio Health Information Partnership (OHIP) is focusing on enabling this capability for 69 hospital labs located in the underserved area.
- OHIP will support “lab over Direct” and provide a data management service to enable LOINC coding.
- OHIP, the Ohio Department of Health and the CDC-funded Laboratory Interoperability Cooperative are working collaboratively with the Ohio Hospital Association (OHA) in these efforts.
Kentucky

Serve reporting needs of State - Support public health and quality reporting to state agencies

- Providers can use the Kentucky Health Information Exchange (KHIE) to submit data to the KY Immunization Registry. To date, nine providers have tested immunization messages via KHIE to facilitate their MU attestation to Medicare.

- The state will use KHIE to transmit electronic results from newborn screening to providers across the state. This functionality will go live the first quarter of 2012.

- Approximately 55,000 babies are born every year in Kentucky and all of them have 48 metabolic screening tests performed in the Kentucky State Laboratory. The results are currently paper-based and are either mailed or faxed to providers.
Rhode Island
Accreditation and validation of exchange entities against consensus technical and policy requirements

• The Rhode Island Quality Institute created a “HISP Vendor Marketplace” and RI trust community to support rapid scaling of directed exchange to support providers sharing care summaries for referrals and other uses

• HISP Marketplace: Chose 4 vendors to be listed in the Marketplace www.docEHRtalk.org and available at a discount to Rhode Island providers. Selected based on meeting technical, process, and organizational best practice criteria

• RI Trust Community: Validates and authenticates users and issues digital certificates
Measuring Progress

Lab Results Exchange
- % of hospitals sharing laboratory results electronically with providers outside their system (AHA, starts 2010, 11 reported out in January)
- % of office-based physicians able to view lab results electronically (NAMCS, starts 2009, 11 reported out in January)
- % of office-based physicians able to send lab orders electronically (NAMCS, starts 2009, 11 reported out in January)

Care Summary Exchange
- % of hospitals exchanging clinical care summaries with providers outside their system (AHA, starts 2010, 11 available in January)
- % of physicians exchanging patient clinical summaries with other providers (NAMCS, starts 2011, 11 available in January)

eRX
- % of physicians actively e-prescribing via SS network (determining denominator; will likely obtain annually starting 2008)
- % of pharmacies actively e-prescribing via SS network (SS, 2008-2010 annual; monthly, beginning December, 2010)
- % of prescriptions e-prescribed (SS, waiting on Surescripts for denominator, will likely obtain annually starting 2008)

Patient Engagement
- % of ambulatory care physicians able to provide patients with clinical summaries for each visit (NAMCS, starts 2011, 11 reported out in January)
- % of hospitals capable of providing patients with an electronic copy of their health information (AHA, starts 2010, 11 available in January)

Number of “gap pharmacies” that are connected*
* Identify pharmacies that need to be connected to allow REC-registered EPs to achieve MU. Track these pharmacies over time, aiming for reduction
Emerging Issues

• Provider adoption and workflow for key exchange tasks
• Alignment with care transformation and payment reform efforts
• Scaling directed exchange
• Broader adoption of query-based exchange
• Sustainability
• Business practices
Contact Information

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