

State Experiences with HITECH Federal Financial Participation Opportunities for Public Health Related Activities

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Introduction

The Centers for Medicare and Medicaid Services (CMS) offer funding under the American Recovery and Reinvestment Act of 2009 to state Medicaid programs that can be used to support state public health informatics activities. State public health agencies (PHAs) throughout the country have collaborated with their Medicaid offices to secure these funds for critical public health activities. This report provides an overview of this funding opportunity, as well as lessons learned and recommendations from states that have applied for and implemented the funding.

Background

The American Recovery and Reinvestment Act of 2009 established the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs as part of the Health Information Technology for Economic and Clinical Health (HITECH) Act. In addition to the 100% federal financial participation (FFP) for incentive payments to Medicaid providers that meet Meaningful Use, section 4201 of the Recovery Act also provides “90 percent FFP for State administrative expenses related to the program [...] that are proper and efficient (as defined by OMB Circular A-87) for the administration of the Medicaid EHR Incentive Program” (p. 1 of State Medicaid Director Letter # 11-004). CMS first announced this new HITECH FFP funding with potential public health implications in a 2009 State Medicaid Directors letter (SMDL) (SMDL #09-006). Since then, CMS has release additional SMDLs and supporting documentation to further define the funding.

To receive these HITECH FFP (also known as “90/10 Match Funds”) from CMS, states first submit an HIT Planning Advance Planning Document (HIT P-PAD) and then an HIT Implementation Advance Planning Document (HIT IAPD) detailing their plans including how they meet three criteria:

- (1) “Administration of Medicaid incentive payments to Medicaid EPs [eligible professionals] and eligible hospitals;
- (2) Oversight of the Medicaid EHR Incentive Program, including routine tracking of meaningful use attestations and reporting mechanisms; and
- (3) Pursuit of initiatives that encourage the adoption of certified EHR technology for the promotion of health care quality and the electronic exchange of health information.” (p. 1 of SMD #10-016, emphasis in the original).

Public health and relevant HIE information are primarily captured in Appendix D of the IAPD template (CMS FAQ September 2013).

States are required to create State Medicaid HIT Plans (SMHP) for approval by regional and central CMS offices, as well as the Office of the National Coordinator for Health Information Technology (ONC) (SMD #09-006). State Medicaid offices are also tasked by CMS to “collaborate and coordinate with other HIT initiatives in the public and private sector, such as those being conducted by [...] public health” (Enclosure C of SMDL #09-006).

CMS defined the following categories of time-limited activities that are potentially eligible for HITECH FFP: activities related to provider payment, oversight, and outreach; planning activities; outreach and

education activities; trainings/meetings; travel; hardware; software; oversight and reports; and other (Enclosure E of SMDL#09-006). These activities can be classified in two broad categories:

1. On-boarding activities that connect providers to an HIE and enable them to use HIE services; and
2. Activities pertaining to infrastructure design, development, and implementation to support health information exchange and Meaningful Use (CMS FAQ September 2013).

As part of the IAPD, states must determine cost allocation based on the “fair share principle” of the Office of Management and Budget Circular A-87 (SMDL #10-016). CMS encourages states to involve a variety of funders, including private entities that stand to benefit from sustainable health information exchange for the 10% funding (SMDL #11-004).

CMS has published additional detailed instructions, examples, and CMS oversight information, which, for brevity, are not presented in this report. The SMDLs and a related CMS FAQ from 2013 are listed in the [Resources and Tools](#) section.

On February 29, 2016, CMS published updated guidance that expanded the scope of activities that could be eligible for 90/10 matching funds to support the goals of ONC’s Nationwide Interoperability Roadmap published in October 2015, considering the greater emphasis on care coordination across providers in Meaningful Use modified Stage 2 and Stage 3 (SMDL #16-003). This updated guidance explained that matching funds could be used for connecting Eligible Providers to Medicaid providers that are not eligible for Medicaid EHR incentive payments, with prior approval by CMS and as long as these activities help Eligible Providers meet Meaningful Use objectives. States may be able to use HITECH match funds to connect Eligible Providers to behavioral health providers, substance abuse treatment providers, long-term care providers (including nursing facilities), home health providers, pharmacies, laboratories, correctional health providers, emergency medical service providers, public health providers, and other Medicaid providers, including community-based Medicaid providers.

The February 29, 2016, SMD letter also describes examples of interoperability and HIE architecture activities that may be eligible for the 90/10 HITECH match if they assist Eligible Providers in meeting Meaningful Use and meet other existing requirements for matching funds. These examples include provider directories, secure electronic messaging solutions, query-based health information exchange, care plan exchange, encounter alerting, public health systems and connections to public health systems, and Health Information Services Provider (HISP) services.

[Related Funding Opportunities](#)

In 2009, ONC announced grant funding under the Public Health Service Act to create Health Information Technology Regional Extension Centers and State Health Information Exchanges (enclosure D of SMDL #09-006). State Medicaid Directors were encouraged to coordinate amongst the involved parties to ensure complementary and non-duplicative statewide activities.

An additional FFP opportunity for Medicaid Management Information Systems (MMIS) has similarities to HITECH FFP and may be part of a state’s SMHP, but MMIS activities are not funded under the Recovery Act (SMDL #09-006). CMS encourages states to consider MMIS funding first before HITECH funding “because HITECH funds should be targeted toward scenarios that contribute to the transformation of

the MMIS into a clinical- and claims-based engine that supports Medicaid’s broader health care reform goals” (p. 13 of SMDL #10-016). The states that were interviewed for this report did not discuss any MMIS funding received by their state and MMIS funding is not further detailed in this report.

In addition to CMS FOAs, HITECH funds have also been distributed via the Centers for Disease Control and Prevention (CDC) for Meaningful Use activities (e.g., CDC awards for Epidemiology and Laboratory Capacity for Infectious Diseases (CDC-RFA-CI10-1009) and for Enhancing the Interoperability of Electronic Health Records and Immunization Information Systems (CDC-RFA-IP10-1002ARRA10) [Thomas Frieden letter, 2010].

Methods

In April 2014, ASTHO’s Informatics Directors Peer Network (IDPN) recognized the need for a dedicated workgroup to communicate this funding information to PHAs. This IDPN workgroup was tasked with creating reference materials to guide states in their applications and to communicate the challenges that states have encountered to CMS. To that end, in April and May 2015 ASTHO interviewed one state in each of the 10 CMS regions about their experiences with HITECH FFP for public health work.

ASTHO observed that states were reluctant to publicly disclose their experiences with the HITECH FFP process; therefore, interviewees were granted anonymity and the findings are presented in aggregate. ASTHO also used applications for the ASTHO Public Health-Medicaid Collaboration award to identify project work that was funded under the HITECH FFP.

Results

Funded Public Health Projects

Interviewed states described utilizing HITECH FFP funding for the following public health activities (note: this list is illustrative and not exhaustive):

- **Health Information Exchange (HIE) activities**
 - Technical and business support for public health and/or Medicaid’s connection to the state HIE.
 - Connecting the state cancer registry to an HIE.
 - Connecting the state notifiable disease reporting system with an HIE and managing communications with external data providers.
 - Building connections to enable Medicaid providers to query public health registries (e.g., the immunization registry).
 - Assessing readiness of county health departments to connect to the HIE.
 - Incentives for Medicaid hospitals and providers to participate in the HIE.
- **Infrastructure activities**
 - Adding staff to support onboarding to public health programs that are Meaningful Use objectives (immunization, electronic lab reporting, cancer, and/or syndromic surveillance).

- Modifying the state laboratory information management system to receive electronic orders and transmit results.
- Developing a crosswalk of local laboratory codes to LOINC codes.
- Adding staff to analyze increased message volume submitted under Meaningful Use.
- Upgrade immunization information system to accept HL7 2.5.1 messages.
- Install WebServices to augment PHINMS.
- Enhance immunization registry for bi-directional data exchange.

Interviewees also shared proposed project ideas that were either not included in the IAPD or were not approved by CMS:

- Enhancing cancer registry—not included in the IAPD because it is run by a local university and public health was unclear about if this would qualify for HITECH FFP.
- Creating a chronic disease registry—not included in the IAPD due to 10% funding match and scoping issues.
- Creating birth defects registry—not included in the IAPD because the registry is not ready for electronic submissions.
- Enhancing the cancer registry— not approved by CMS because the Medicaid patient percentage was too low.
- Creating an HIE gateway—not approved by CMS because it was not included in the first SMHP.

Medicaid and Public Health Collaboration

The interviewed states represent a broad range of administrative organization, with public health and Medicaid housed in the same agency in four of the interviewed states, and administratively distinct in the other six interviewed states. A few states reported that their HITECH FFP IAPDs involved additional offices or agencies beyond public health and Medicaid. Public health initiated the HITECH FFP collaboration in most states.

Resources

Early HITECH FFP applicants reported that they felt like they were “going blind” with the application process. They said that the State Medicaid Directors letters provided insufficient guidance and there were no national level workgroups to facilitate the sharing of best practices and successful IAPDs.

States heavily relied on the experiences of other states to decide what projects to include in their IAPD and how to frame their projects. Of particular benefit were IAPDs from Washington State (*see [Resources and Tools](#)*), Maryland, and Arizona. One state was encouraged by their CMS regional representative to contact another state to repurpose their application; however, the state HIE models were found to be too different for much of the language to be applicable. States also based their IAPDs off of existing IAPDs for non-public health related projects in their state.

Two interviewed states used CMS-issued templates and guidance (the Medicaid IAPD template, the HIE IAPD Tip Sheet, and the IAPD Companion Addendum; *see [Resources and Tools](#)*).

One state reported using no reference materials, while another solely relied on the guidance of experienced consultants. These consultants were knowledgeable of HITECH FFP activities that had been approved in other states and had contacts within CMS.

Roles of Public Health and Medicaid in Writing and Revising the IAPD

Interviewees expressed great variation in the degree of public health's involvement with writing the IAPD due to a combination of agency organization, their state Medicaid's preferences, and concentrated IAPD expertise in Medicaid. Most states had similar approaches to writing the IAPD: public health provided the public health content (i.e. project descriptions, position descriptions, and budgets) and Medicaid incorporated it into the IAPD. One state even set up a SharePoint site for public health and Medicaid to collaboratively write the IAPD. Conversely, several other states said that public health did not see the final IAPD until after it had been approved by CMS and implementation began.

One state said that writing the IAPD Appendix D was a fast process because it was dictated by the state's public health Meaningful Use activities. The Medicaid and public health partnership deliberately kept their IAPD high-level so that they would have greater flexibility with implementing the funding.

The states reported that the initial version of the IAPD that was submitted to CMS took about 4-6 months to write. In some states this process took longer, and several states reported that the IAPD update process took many months to finalize.

Of the states where Medicaid and public health were administratively distinct and did establish a contracting mechanism, most used a memorandum of understanding (MOU) to define funding sources and data use. One state was able to build on an existing MOU among all of the state health agencies to define how the IAPD would be financed and administered. Two states used an inter-agency agreement. Three states did not need to create any internal contracting mechanisms.

Characteristics of Successful Collaborations

The majority of respondents characterized their public health and Medicaid collaboration as successful. A common reason for this success is capitalizing on existing relationships between public health and Medicaid staff for different reasons, including staff that moved from one agency to the other, earlier collaborations, co-location in the same building, and previous agency organization that combined the two into one agency. Other characteristics of successful collaboration are frequent communication, such as the weekly meetings between public health and Medicaid that one state held while writing the IAPD, and early involvement of public health in the IAPD writing process.

Challenges to Collaborations

The IAPD writing process had a steep learning curve for both public health and Medicaid: public health educated Medicaid about their activities, priorities, and challenges, while Medicaid educated public health about IAPD requirements as well as the requirements of the Medicaid Information Technology Architecture (MITA). MITA is intended to create a national framework of "integrated systems that communicate effectively through interoperability and common standards" for Medicaid [CMS MITA website]. As part of their MITA compliance, one state noted the complexity of determining which HIPAA requirements applied to public health since it is a Medicaid covered entity in that state. One public

health respondent described the risk of unequal IAPD knowledge: “if we are reliant on a sister agency and then there is turmoil, we don't always get what we need from them.”

An additional complication is that HITECH FFP awards represent relatively small dollar amounts from a state Medicaid agency's perspective but a large award for public health. Furthermore, the reimbursement mechanism was novel for public health, which primarily receives funding via grants and cooperatives agreements. A Medicaid representative said that public health may not be used to working on a “cash basis” in which they need to spend and draw down money in one year.

In several states, public health was excluded from Medicaid's conversations with CMS. This resulted in an information imbalance where public health was unaware of with the status of the IAPD. In some states, public health did not see the final IAPD until after it was approved by CMS (one respondent described the IAPD as a “black box”). Having all CMS communications go via Medicaid introduced delays and complications. Public health was explicitly excluded by Medicaid from interacting with CMS in some states, while in other public health elected not to pursue direct involvement and left the IAPD finalization to Medicaid. A further cause for delay was the multiple layers of IAPD approval within Medicaid, which was not reported as an issue within public health.

Internal administrative hurdles included duplicative financial review by both Medicaid and public health, as well as burdensome legal approval that one state described as more onerous than the IAPD approval process. Identifying the 10% match money also involved significant deliberation, including an internal audit in one state.

One public health respondent noted that their Medicaid agency was more reliant on consultants than the public health agency. Although they found the consultants to be very knowledgeable and helpful with the IAPD creation, the consultants did not have decision-making authority, which led to delayed action.

States faced common staffing challenges including turnover, new leadership, and working with offices that are administratively under capacity. In one state, leadership within Medicaid and public health changed during their IAPD writing process, and the new leadership did not prioritize the IAPD, putting the public health projects in jeopardy. Public health and Medicaid had to educate the new leadership about the IAPD and the value of the proposed public health work.

Four states reported no challenges in their Medicaid and public health collaborations.

Seeking CMS Approval of an IAPD

Choosing Projects and Methods

States said that their project selection was motivated by the confines of the HITECH FFP, their state priorities, their state resources and existing infrastructure (e.g., if they had a state HIE), the maturity of their public health programs (e.g., if they were capable of accepting electronic data submissions), the ability to identify state match funds for the 10% of a project's cost, and pre-submission guidance from their CMS regional representatives.

Pre-Submission Interactions with CMS

CMS encourages states to contact their regional CMS HITECH representatives during initial planning for HITECH FFP activities to discuss “the state’s current IAPD landscape, the state’s technical model, and the state’s approach to meeting the fair share and cost allocation principles” (p. 2 of CMS FAQ Sept 2013). Most of the respondents reported having these preliminary conversations with CMS regional representatives prior to submission of a formal application. Some public health respondents did not directly communicate with CMS and thus did not know what interaction Medicaid had with CMS prior to the official application. In these preliminary conversations, states shared their HITECH FFP ideas and CMS provided guidance on the appropriateness of the proposed projects for a specific FOA. These state-specific conversations were done over email and by phone.

These pre-submission interactions with CMS were more helpful in some states than in others, as will be discussed in the next section, but several respondents did credit their CMS regional contact with facilitating their IAPD process.

Challenges to Working with CMS

While pre-submission interactions with CMS were generally reported to be very helpful in refining IAPD scope and expediting the approval process, one recurring challenge was the variation in CMS responsiveness. States attribute this variation to CMS staff preferences for communication and their ability to respond to complex requests from multiple states. Some states were further challenged by their uncertainty about whom to contact at CMS due to staff turnover and unclear chains of command. States were also challenged by the long IAPD approval process that may cause the IAPD to not be approved within the budgeted fiscal year.

All respondents noted that there is uncertainty about what projects CMS is willing to fund under HITECH FFP. One respondent believed that this variation in project approval was largely subject to the preferences of CMS regional staff. One state commented that IAPD approval “depends on your [CMS] region for how onerous it is. There is no straightforward CMS approach for review.” Another state noted that “there is no policy for approval” as similar projects are approved in one state and then denied in another, or a project might be approved and then later denied re-approval. States heavily rely on the experiences of other states to inform their own IAPDs; one respondent said this felt “gossip-y” since it was unofficial guidance. Another interviewer described their experience: “we put something in the IAPD and wait to see if someone complains. I hate working in that environment where you don’t know if it is right or wrong.”

One state was particularly challenged by a CMS staff inconsistency. The state wrote their IAPD based on the guidance that they had received during initial conversations with their CMS regional representative; however, by the time they submitted their first draft the CMS staff had changed and the new staff rejected the application. The new CMS representative’s instructions conflicted with the predecessor’s instructions, and the state was told that they needed a state HIE to receive HITECH FFP funds. The state has two competing HIEs and no state HIE; therefore, they have decided to not pursue the HITECH FFP further until they are able to create a state HIE plan. The state reported great frustration with this inconsistency, lamenting, “We did what they told us to do.”

Implementation

Medicaid and Public Health Collaboration

Two states reported that they continue to have check-in meetings with public health, Medicaid, and any other involved agencies for the HITECH FFP projects; however, most states do not hold regular meetings during the entire lifecycle of the projects.

Unexpected Obstacles since IAPD Approval

One state found that even though their IAPD was approved, the project descriptions were not sufficiently explicit. This required that they submit additional documentation of the funding and contracts associated with the public health project work, which took additional time. They noted that states can submit an update page to clarify their project scope and logistics. Another state learned that the discount they used to incentivize providers to join the state HIE was too low to be effective; they rectified this when the IAPD was reapproved.

A public health respondent reported that public health did not see or approve the final IAPD, and after it was approved Medicaid approached their cancer registry offering a staff resource without having previously confirmed that the cancer registry needed additional staff. The respondent characterized this as a “backwards process” that was emblematic of the fact that the agencies did not have “a full partnership.”

Several states struggled with internal approval for new staff within the time constraints of the HITECH FFP funding. One state used a workaround by hiring staff through the state HIE rather than into the health agency. Another state that brought on contract workers was challenged by high staff turnover rates and the amount of time required to onboard new staff.

A recurring challenge for states is the short turnaround time for the IAPD approval and renewal processes; as one respondent said, “We have to start the resubmission process soon after approval.”

Lessons Learned and Recommendations

The HITECH FFP has been successful in allowing PHAs to make substantive advancements to their infrastructure and their ability to support Medicaid providers in meeting Meaningful Use. Medicaid and public health collaboration is a complex and sometimes arduous process, but on the whole respondents appear to be positive about the experience.

Lessons Learned and Recommendations for States

States identified the following lessons learned and recommendations for other states:

- Include public health early in the process.
- Initiate discussions with the regional CMS representative as early as possible to ensure that HITECH FFP are appropriate and complete.
- Public health should approach Medicaid with a comprehensive strategy, not as individual public health projects.

- Have frequent and transparent communications with all involved entities: “be open to what seems like too much communication.”
- Include public health in direct communications with CMS.
- Be prepared for a lengthy IAPD approval process that may extend into a subsequent fiscal year.
- Limit the number of people who are involved. One state recommended limiting the public health representation in this process to one person.
- Public health should have someone who is knowledgeable about CMS, other states’ IAPD work, and federal policy generally. This avoids over-reliance on Medicaid and has broader reaching benefits beyond the IAPD process. One public health respondent said, “Don’t take your state Medicaid’s word on something. They don’t always know what is accurate. Know the policies and facts yourself.”
- Don’t assume that your counterparts are knowledgeable about what you do, and share your priorities.
 - Public health should know about the limitations of this funding and the application requirements.
 - Medicaid should know about the relevant regulations and operational needs of the public health activities.

An unsurprising finding is that a collaborative IAPD is easiest when public health and Medicaid are in the same agency and share the same financial and administrative processes and staff.

Three states reported that this collaborative effort has led to improved working relationships between Medicaid and public health, including new thinking about a larger strategy of data integration and applying for the ASTHO Medicaid Collaboration award. One state reported that public health was recently included in an ONC grant application by the state HIE, which they believe would not have happened prior to the joint IAPD.

Lessons Learned and Recommendations for CMS

Many of the interviewed states found the IAPD process for the HITECH FFP to be a long and somewhat confusing process; however, there was no uniform experience. Despite these differences, states provided consistent recommendations for how CMS could improve the process:

- CMS should provide clear guidance on their websites and during webinars on what types of public health projects are acceptable for the HITECH FFP. CMS regional representatives should consistently communicate these rules to states.
 - Clarify if HIE is meant as a noun or a verb.
 - Bear in mind that public health may not be knowledgeable of CMS funding opportunities and may therefore require explicit instruction and background information.
- CMS should expedite the approval time for updates and contracts. The lengthy approval process may result in delayed project work.
- CMS should issue specific guidance on the HITECH FFP in light of Stage 3 of Meaningful Use. IAPDs will be due before the Stage 3 rule will be finalized.
- CMS should better communicate CMS staffing changes and hierarchies.

References

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Resources and Tools

1. Washington State Case Study and IAPD
2. California IAPD Documents
3. Maryland's IAPD
4. Medicaid IAPD template
5. A Step-by-Step Guide for Health Departments Seeking HIT/HITE Funding via the 90/10 Medicaid Match
6. IAPD Companion Guide
7. IAPD Addendum
8. State Medicaid Director Letter #09-006 (September 1, 2009) *No subject line*
9. State Medicaid Director Letter #10-016 (August 17, 2010) "Re: Federal Funding for Medicaid HIT Activities"
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