

# **CMS-ONC Health IT Toolkit for Medicaid Funded Home and Community Based Services (HCBS) Programs - State Toolkit**

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## Introduction

The “HCBS Health IT Toolkit” helps states examine some of the key building blocks needed to develop an optimized health IT ecosystem for advancing their HCBS Medicaid program objectives. Use of the toolkit by a state is voluntary and not mandatory. However, key considerations raised in this toolkit can be included by the state in its Medicaid funded HCBS program’s application (renewal, amendment, or new). An optimized health IT ecosystem includes widespread health IT adoption, health information exchange (HIE), and data interoperability within and between the state, providers (health and human services), beneficiaries and where applicable Managed Care Organizations (MCO) and or Accountable Care Organizations (ACO).

The Toolkit includes key questions related specifically to Medicaid HCBS program design as well as broader questions related to the inclusion of the HCBS programs into the larger discussions already underway within the state to advance the adoption of health IT, health information exchange and interoperability. The Toolkit reinforces the need for the state to align the HCBS program with other Federal programs or projects within the state such as State Innovation Models (SIM), Comprehensive Primary Care (CPC+), the EHR Incentive Program, Medicaid Management Information Systems (MMIS) and Medicare.

Within human services there is a growing recognition in the value of sharing person-centered data, meaning information that is more than EHR- or clinically-focused data. Person centered data can include an individual’s preference on how they want their services delivered, who they want to deliver their services, what their desired outcomes and goals are for their lives, and relevant assessment and functional status information relevant to the individual’s person-centered service plan (PCSP). It is seen as critical to improving service delivery and an individual’s experience. Sharing person-centered data can:

- Support sharing standardized assessment information across populations and settings of care,
- Support individuals with person centered service delivery through transitions,
- Facilitate quality monitoring across providers and settings, and
- Leverage existing standards developed for the interoperable exchange of healthcare and human services person-level information.

Medicaid HCBS providers have been excluded as eligible professionals or providers from the EHR Incentive Program, and thus did not receive those incentives to assist in the acquisition of IT systems. However, there are opportunities to advance health IT, health information exchange and interoperability. This can include 1) CMS’s 16-003 state Medicaid Director letter that provides opportunities for states to access 90:10 funding for HCBS providers to connect with eligible MU providers or 2) through Medicaid program design in a section 1915(c) waiver, section 1915(b/c) waiver, a section 1915(i) State Plan Amendment, or a section 1115(a) demonstration that can include LTSS (institutional, and HCBS) providers and services and the acquisition of the health IT to support those providers.<sup>1</sup>

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<sup>1</sup><https://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html>

For interested states, the major health IT goals for states in their Medicaid program should include:

- 1) Ensuring all relevant assessment and planning activities have shared and aligned strategies for health IT systems and their governance (including State Medicaid Health IT Plans, State Innovation Model Plans, State Plan Amendments, and demonstrations, waivers, and other relevant work).
- 2) Requiring or encouraging health IT use and information exchange where feasible (either directly with providers or indirectly through managed care organization (MCO) or advanced payment models (APM) participation requirements). This should ensure that all relevant privacy and security measures are also in place.
- 3) Enabling electronic quality data (including incident management) collection for performance reporting and feedback and ultimately for the basis of payment.

By using the toolkit, states can ensure that they have thought through some of the most frequent or mature health IT, HIE, and interoperability use cases to advance their Medicaid program objectives and/or sustain delivery system and payment improvements. Using the toolkit is not a requirement. The toolkit may, however, assist states with questions that the CMS may ask the state to clarify during its review of the state's HCBS program application, and in general during the review process.

CMS and the Office of the National Coordinator for Health IT (ONC) staff are available to discuss the use of the toolkit, general health IT, HIE, and interoperability considerations and state-specific issues to consider upon request and can offer state-specific technical assistance (TA). TA requests in the past have ranged in intensity and duration from issue-specific conference calls to larger, multi-day ONC and CMCS on-site visits.

CMS and ONC are eager to receive additional feedback and refine this toolkit through future iterations. For questions, technical assistance requests, or suggestions, please contact [Arun.Natarajan@hhs.gov](mailto:Arun.Natarajan@hhs.gov).

## Background

CMS and ONC are committed to ensuring that we are supporting states to develop a health IT infrastructure able to sustain and deliver on our shared program objectives, including robust Medicaid HCBS.

To this end, CMS and ONC have developed a series of state-facing program-authority-specific health IT toolkits in conjunction with multiple federal and state partners. States can use these toolkits as they are designing their Medicaid HCBS programs.

Use of these tool kits will help states:

- Ensure they have the health IT capacity and infrastructure to accomplish their Medicaid program goals.
- Identify and adopt a common set of health IT standards (where federally recognized standards exist (<https://www.healthit.gov/standards-advisory>) among states to promote information sharing and interoperability.

CMS in coordination with ONC has already created two toolkits (for the Medicaid Health Home State Plan Amendment and section 1115 Demonstration waivers) that are focused on health information exchange, health IT, and interoperability. They can be found at:

<https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html>

## **General Health IT Considerations within an HCBS LTSS Medicaid Program**

*Question 1: Are health IT Considerations being included in the Medicaid Program's service definitions, provider qualifications, and payment rates? If so, how?*

Health IT, HIE, and interoperability considerations can be included as part of a waiver, demonstration or State Plan Amendment's (SPA) Service Definitions, Provider Qualifications or payment Rates (required elements of the CMS review process). At the broadest level, Health IT considerations can be included within the application as part of a service definition, provider qualification, and or payment rate. A service definition can include a specific health IT-related functionality such as the ability to send and receive (admission, discharge and transfer) ADT notifications, or engage in more efficient care coordination through electronic care plan sharing and exchange. If the state in its provider(s) qualifications includes a requirement to adopt certified health IT or connect to a state's HIE the payment rates set by the state can be increased by the state for those services and providers that are using health IT to improve beneficiary outcomes and meet performance measure expectations, and share information with relevant partners or entities.

## **Program-Specific Health IT, Health Information Exchange or Interoperability Use in an HCBS LTSS Medicaid Program**

*Question 2: How is the HCBS Medicaid program promoting the electronic capturing and sharing of "assessment data" and "PCSP" information with relevant members of the team (including the individual)?*

- a. "Assessment data" and "service plan" information collected and developed through a person-centered planning process and part of an Individualized Service Plan is a defining characteristic of an HCBS Medicaid funded program. The development of the PCSP is based on "assessments" which can cover anything from functional status such as IADL (independent activities of daily living), ADL (activities of daily living), to behavioral health or level of care assessment information. The "assessments" are a critical component in developing the plan of care. It is important that the electronic PCSP as well as pertinent assessment information used to develop that PCSP is shared with relevant team members (.). This is critical for more effective care coordination. Ensuring that all the members of the 'team' have access to the PCSP, that the PCSP is kept current, that all service providers have agreed to render the services and have signed the plan, and that it reflects the preferences, needs, and goals of an individual as identified by them are critical to a person centered service plan and are essential to ensuring that providers understand how best to support the individual's integration into the community. The HCBS program can provide a requirement to MCOs to develop an interface for HCBS programs to be able to capture and share relevant PCSP information with members of the team.

- b. The HCBS program can include a requirement for providers to be able to read an e-LTSS PCSP as developed by the individual with assistance by the case manager / service coordinator. National standards are forthcoming for an e-LTSS PCSP but that does not prevent a state from developing or using their own standards (e.g. such as a modified continuity of care document “CCD”).<sup>23</sup>

*Question 3.1: Have ADT requirements been included as part of the state’s provider qualifications for all HCBS and institutional providers?*

*Question 3.2: If so, can the state include higher payment rates for providers that are able to send or receive ADT notifications?*

Certain HCBS providers can benefit from real-time access to ADT notifications. Notifications can provide updates to a provider or group of providers serving an individual when that individual changes their status and moves from one service setting to another. Historically, this functionality alerts providers when a person goes in and out of an institutional setting like a hospital or nursing home. Understanding its applicability within LTSS HCBS services represents an enormous opportunity to improve information sharing between providers. For example, this functionality can be particularly helpful for residential habilitation and adult day care providers that are impacted by staffing ratio requirements based on actual number of individuals attending a program or living in a group home. Generally understanding an individual’s service requirements on any given day can impact staffing, transportation and other person-centered plan requirements while reducing the amount of time staff spend on ascertaining why a person is not in attendance or receiving a given service.

Accepting and sending ADT notifications are one of the least complicated ways to introduce a provider to adopting and using health IT. Also such providers will then have an easier time adopting more robust health IT functionalities. As described in a State Medicaid Director Letter, SMD 16-003, states can also leverage 90:10 funding to develop out this functionality within their HCBS provider community and support health information exchange and interoperability systems across a broader range of provider types.

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<sup>2</sup> <https://oncprojectracking.healthit.gov/wiki/display/TechLabSC/eLTSS+Home> - The electronic Long-Term Services & Supports (eLTSS) Initiative is an ONC-CMS partnership that will focus on identifying and harmonizing electronic standards that can enable the creation, exchange and re-use of interoperable service plans for use by health care and community-based long-term services and supports providers, payers and the individuals they serve.

<sup>3</sup> <https://www.medicaid.gov/medicaid/ltss/teft-program/index.html> - In March 2014, the Centers for Medicare & Medicaid Services (CMS) awarded Testing Experience and Functional Tools (TEFT) grants to nine states to test quality measurement tools and demonstrate e-health in Medicaid community-based long term services and supports (CB-LTSS).

*Question 4: If the Medicaid program includes an MCO and or ACO as part of the service delivery system, has the state committed to include any requirements for the use of standards identified in the ONC ISA and or 45 CFR 170 subpart B where appropriate for the MCO and or ACO, not barring any other compelling state interest?*

States have an opportunity to advance interoperability through including federally recognized standards within HCBS MCO contract procurements. Creating an interoperable environment where relevant, actionable, and accurate information is being shared between and amongst key players is a primary goal of interoperability. Medicaid State Systems are currently governed by the MITA requirements which require State Systems build outs be based on 'Industry Standards' currently defined by ONC. These are specified in 45 CFR 170 subpart B<sup>4</sup>. Harmonizing the standards used in State Systems with the standards being used in any federally funded health IT build out occurring at the delivery system level within an MCO or ACO is a simple, albeit challenging step states can take to support interoperability.

*Question 5.1: As part of discussions with a state, has the state identified the maturity level of the state's HIE(s) and whether it would promote Medicaid program objective to include a requirement for HCBS provider to be able to send or view information from or to the relevant HIE(s)?*

*Question 5.2: If opportunities exist, can the state include as part of the provider qualifications the requirement to initially send information into the HIE and subsequently to also view information from the HIE or vice versa?*

A state can gradually increase the requirements through amendments to the waiver to phase in this approach. At first the HCBS Medicaid program can include a requirement to send information into an HIE. Through an amendment to the waiver or Medicaid program, a subsequent requirement could be added to the provider qualifications to view information from the HIE or vice versa. It is important for the state to understand the capacity of the existing HIEs within the state, the level of penetration of health IT capacity within its HCBS provider communities by provider type and to have a situational awareness of when there is sufficient penetration of health IT capacity to increase the requirements through an amendment to the Medicaid program's provider qualifications to ensure that providers do not drop out of the program and adversely impact a beneficiaries' ability to access services and supports.

*Question 5.3: If opportunities exist, can the state include higher payment rates for providers that are able to communicate with the identified HIEs?*

Points to Consider: This could result in a waiver service such as residential habilitation being broken into two similar services such as "standard residential habilitation" and an "enhanced

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<sup>4</sup> <http://www.ecfr.gov/cgi-bin/text-idx?SID=a4de621ecd0d22d79dccb88b8cabb00b&mc=true&node=sp45.1.170.b&rgn=div6>

residential habilitation” associated with two types of providers with two corresponding payment rates, a lower rate for non-health IT enabled providers and a higher payment rate for those providers that can send and or view information to or from the identified HIEs. This is consistent with tiered rates based upon provider qualifications.

Another important consideration is the ability of a state’s provider base to use the HCBS taxonomy codes to standardize the way in which HCBS are referenced or identified.

Connecting HCBS Providers to a local or state HIE to send and receive information can improve care or service delivery for an individual. It is important for a State Medicaid Agency (SMA) to understand the maturity level of relevant health information exchange(s) within the state. After understanding which HIEs are functioning within a state, the SMA should consider what opportunities may exist for connecting HCBS providers to local or state wide HIEs.

*Question 6.1: Can the State leverage measures already specified in other federal programs for use in the quality framework of the HCBS Medicaid program? (e.g. is the State able to leverage any of the electronic clinical quality measures (e-CQM) or the Comprehensive Primary Care Initiative (CPC+) measures as part of a health and welfare performance measure)?*

With over \$10B in payments made to Medicaid providers through the “Meaningful Use” Electronic Health Record (MU EHR) Incentive Program over the last five years, a significant provider-based health IT infrastructure has been created within states. Leveraging the electronic clinical quality measure (e-CQM) MU requirements already advanced through this health IT infrastructure is a clear way to accelerate advancement of DSR and value-based payments.

Some CMS alternative payment models such as the Comprehensive Primary Care Initiative<sup>5</sup> and the Medicare Shared Savings Program<sup>6</sup> include e-CQMs in their design. The Medicare Access and CHIP Reauthorization Act (MACRA) also reinforces this shift to using e-CQMs.

In order to allow participants to successfully report CQMs electronically, CMS provides a set of electronic specifications for clinical quality measures (e-CQMs) for eligible professionals (EPs) and eligible hospitals (EHs) for use in the EHR Incentive program for electronic reporting. These electronic specifications contain multiple parts which allow certified EHR technology from which eCQM data must be submitted to be programmed to accurately capture, calculate, and report clinical quality measures electronically. A concrete way to reinforce the adoption and use of

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<sup>5</sup> <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus> - Comprehensive Primary Care Plus (CPC+) is a national advanced primary care medical home model that aims to strengthen primary care through regionally-based multi-payer payment reform and care delivery transformation. CPC+ includes two primary care practice tracks with incrementally advanced care delivery requirements and payment options to meet the diverse needs of primary care practices in the United States (U.S.).

<sup>6</sup> <https://innovation.cms.gov/initiatives/ACO-Investment-Model/> - CMS is encouraging providers to participate in ACOs through the Medicare Shared Savings Program, which creates financial incentives for ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting Medicare beneficiaries first.

eCQMs would be for a State to include them in a HCBS program as part of its quality strategy. It is important to note that although clinical measures are important, they do not necessarily measure the quality of the LTSS delivery. Care should be taken to ensure that any eCQMs that are identified for inclusion in an HCBS program's quality framework are relevant and appropriate. For Medicaid, Meaningful Use stage 3 includes reporting requirement for patient generated health data or outside generated EHR data.

Finally, on November 29, the National Quality Forum (NQF) informed the Centers for Medicare & Medicaid Services that the CAHPS Home and Community-Based Services (HCBS) Measures were fully endorsed and available on the National Quality Forum home page. These 19 measures are derived from the CAHPS® Home and Community-Based Services Survey and consist of 7 composites, 3 global ratings, 3 recommendation measures, and 6 single-item measures (5 unmet need and 1 physical safety). These are the first NQF-endorsed measures specific to the HCBS setting. NQF-endorsed measures are considered the gold standard for health care measurement in the United States. An NQF endorsement provides the user with assurance that measures were rigorously tested. Because the CAHPS HCBS Measures align with some of CMS's quality requirements for the various HCBS Medicaid authorities, the measures and the underlying CAHPS survey can assist states in gauging compliance with regulatory requirements pertaining to HCBS programs. For more details about the CAHPS HCBS Measures, go to: <https://www.medicaid.gov/medicaid/ltss/teft-program/index.html>

*Question 6.2: Is the State using any of the CMS electronically specified clinical quality measures (eCQMS) as part of the Medicaid HCBS program's payment methodology?*

As part of MU Stage 3, CMS notes that four of the eight requirements for this phase of the program "are clearly focused on the electronic exchange of health information through interoperable systems."

They are:

- Patient Electronic Access
- Coordination of Care through Patient Engagement
- Health Information Exchange
- Public Health and Clinical Data Registry Reporting

These areas can have implications for beneficiaries being served in HCBS LTSS programs and their providers.

Moreover, across the eight categories of objectives, CMS has identified three activities of the program that rely on promoting health care interoperability:

- Provider to provider exchange through the transmission of an electronic summary of care document (e.g., when an individual is moving from an institutional setting such as a nursing home or hospital to a home and community based setting and needs nursing staff and home health coverage to facilitate a successful transition);
- Provider to patient exchange through the provision of electronic access to view, download, or transmit health information (e.g., when an individual has a team meeting

and wants to see how electronically their person-centered plan of care has been updated based on that meeting); and

- Provider to public health agency exchange through the public health reporting objectives (e.g., to ensure provider updates of syndromic surveillance or immunization histories to public health registries if applicable).

All three of these objectives have applicability to individuals being served in HCBS LTSS programs.

Additionally, the state could tie any e-specified measure reporting or, more specifically, eCQM reporting to cost savings calculations and payment reform. It is important to use caution in any measure selection process. Measures should be evidence based and sensitive to LTSS considerations. For example, regular medical preventive care can be enhanced through LTSS, but the quality of that care would generally be a measure of the appropriate clinician/clinical service, not necessarily the LTSS provider/supports. When appropriate, Health IT could be used to document cost savings. When Health IT is used to document reporting of 'shared savings,' the same Health IT could be used to document cost savings.

When a state is developing out the measures for inclusion within the quality framework there are opportunities for leveraging electronically-specified measures. Creating Medicaid programs that dynamically use performance measures that are real-time, accurate, and actionable to optimize program operations is a core principal underlying the quality framework. Asking state to highlight which measures in the quality framework are e-specified and which are not is a first step in this direction. CMS wants states to move towards using quality measures that provide insight into ways in which to improve program operations while also providing the Agency with a means for monitoring and ensuring compliance with the Medicaid program.

The breadth and scope of quality measures includes measures that can provide performance oversight as well as improved service delivery. The breadth and scope of what this represents includes data that comes out of reporting and collection systems associated with incident management tracking and resolution as well as clinical, claims, and person generated data.

Medicaid programs are slowly making the shift to using e-specified measures for the basis of quality measurement and ultimately for the basis of payment.

By definition, quality measurement and value-based payments are integral to delivery system reform and incentive payment programs. Ensuring health IT is leveraging state and provider health IT assets (e.g., provider health IT infrastructure and reporting acquired through the EHR Incentive Program) is critical for advancing the transformation of our nation's Medicaid health care enterprise from volume-based payments to value-based payments and affordable quality healthcare that promotes innovation.

## General Questions for the State to Consider related to how the HCBS Programs fits into a State Medicaid Agency's (SMA) Larger HIT, HIE, and Interoperability Framework

The next sections reviews general issues that SMAs or their operating agency can consider as part of the larger goal of ensuring HCBS delivery systems and their providers are included in the larger health IT, HIE, and interoperability discussions occurring within the state.

*Question 7: Does the State have a plan to provide technical assistance to their HCBS providers to adopt and use health IT (i.e. similar to the role Regional Extension Centers played under HITECH? If not, what is the state's plan to ultimately support Health IT adoption amongst HCBS providers?*

It is important to develop a plan to support HCBS providers to successfully adopt and use Health IT use in HCBS providers (e.g., Regional Extension Center-like services). A Regional Extension Center (REC) is an organization that received funding under the Health Information Technology for Economic and Clinical Health Act (HITECH Act) to assist health care providers with the selection and implementation of electronic health record (EHR) technology.<sup>7</sup> Every state was covered by a regional extension center and at one point every state had federal grant funding for a State Health IT Coordinator. Even with the ending of the HHS funded HIE grant program, many state still have a State Health IT coordination and Regional extension centers that support provider Health IT adoption and use. It can be useful to reach out to your current State Health IT Coordinator if your state has one as you think though supporting HCBS providers with Health IT adoption and use.

*Question 8: Specifically, is the state planning on using an advanced planning document (APD) for 90:10 funding to support HCBS providers (e.g., through funding connections or developing an HCBS specific registry)?*

This should include consumers in a meaningful way and is not just limited to the State Medicaid Agency making this available for public comment. Beneficiaries, advocacy groups, and other stakeholders should be consulted during the planning process.

States have an opportunity to leverage 90:10 funding per State Medicaid Director Letter (SMDL) 16-003<sup>8</sup> for HCBS Providers. The SMDL 16-003 allows states to claim 90:10 funding for any provider including HCBS providers. This updated guidance allows Medicaid HITECH funds to support connections to all Medicaid providers with whom EPs or EHs want to coordinate care. Medicaid HITECH funds can now support HIE onboarding and systems for behavioral health

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<sup>7</sup> <https://www.healthit.gov/providers-professionals/regional-extension-centers-recs> - The ONC's Regional Extension Centers (RECs), located in every region of the country, served as a support and resource center to assist providers in EHR implementation and HealthIT needs. As trusted advisors, RECs "bridged the technology gap" by helping providers navigate the EHR adoption process from vendor selection and workflow analysis to implementation and meaningful use. Many RECs still perform these same functions albeit without ONC grant support.

<sup>8</sup> <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16003.pdf>

providers, long-term services and supports providers including HCBS providers, substance abuse treatment providers, home health providers, correctional health providers, social workers, etc. It may also support the HIE on-boarding of laboratory, pharmacy, and public health providers.

This funding goes directly to the state Medicaid agency in the same way existing Medicaid HITECH administrative funds are distributed. State must complete an IAPD (Implementation Advanced Planning Document) to be reviewed by CMS. States complete Appendix D (HIE information) for IAPD as appropriate. This funding is in place until 2021 and is a 90/10 Federal-State match. The state is still responsible for providing the 10%. The funding is for HIE and interoperability only, not to support adoption of EHRs. The funding is for implementation only, it is not for operational costs. The funding still must be cost allocated if other entities than the state Medicaid agency benefit. All providers or systems supported by this funding must connect to Medicaid EPs.

*Question 9: What is the current level of engagement with LTSS providers and operating agencies in the area of HIT Governance?*<sup>9</sup>

Does the SMA have a governance plan to figure out what information needs to be shared, with whom, and how? If so what is the role for including HCBS and HCBS providers in these plans? Are the HCBS programs represented in these state discussions?

Every state is at a different level with regards to the maturity of its shared decision making, rules of engagement and accountability, also known as ‘governance’<sup>10</sup> activities. Interoperability across the diverse health IT ecosystem requires stakeholders to agree to and follow a common set of standards, services, policies, and practices that facilitate the appropriate exchange and use of health information nationwide and do not limit competition. Once established, maintaining interoperability will also require ongoing coordination and collaborative decision-making about future change.

States are being called to integrate across all their CMS program and activities to expand interoperable health IT and users to improve health and lower costs<sup>11</sup>. As discussed in the

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<sup>9</sup> This ideally should include consumers in a meaningful way and is not just limited to the State Medicaid Agency making this available for public comment. Individuals advocated and beneficiaries should be consulted during the planning process.

<sup>10</sup> “Establishing a common set of standards, services, policies and practices [for health information technology interoperability] is best accomplished through an inclusive and transparent process that sets priorities, makes decisions, establishes authorities and rules of engagement and ensures accountability. This activity is often referred to as ‘governance.’ Governance processes also help establish trust between disparate data trading partners and build confidence in the practices of the other people or organizations with whom electronic health information is shared.” ONC Shared Nationwide Interoperability Roadmap, p.4.

<sup>11</sup> “Call to action: States should implement models for multi-payer payment and health care delivery system reform.” The Nationwide Interoperability Roadmap, p.44.

Nationwide Interoperability Roadmap<sup>12</sup>, States have had success in driving interoperability and data sharing through state activities related to delivery system reform efforts.

*Question 10: What are the State Medicaid Agency's or Operating Agency's plans are for including LTSS providers and beneficiaries in the state's overall provider directory and identity management strategies? Are HCBS considerations included in the state's provider directory and identity management strategies?*

Ensuring the state has a comprehensive approach to identity management and provider directories is a fundamental requirement for advancing the goals of the Medicaid enterprise. Ultimately any movement toward value-based payments and delivery system reform requires that the state fully understand who are the beneficiaries being served and what providers are part of the Medicaid program. This poses unique challenges for HCBS programs that focus on self-direction opportunities for beneficiaries and these considerations should be addressed.

*Question 11: What are the SMA's plans to support individuals receiving HCBS to access or perhaps have a more active user function with their PCSP or service encounters through a personal health record (PHR) like function? Can the HCBS Medicaid program encourage, fund, or support HCBS individual's access to a PHR for their human and health care services?*

Putting the individual first is a fundamental goal of person-centered planning and service delivery. Within multiple HCBS programs across the country, managed care organizations (MCOs), or SMAs and their Operating Agencies are making inroads into digitizing Plans of Care (PCSP) and creating portals for individuals and providers to access them. A simple way to operationalize this could include the state imposing a requirement to provide beneficiaries with a PHR functionality as part of the HCBS MCO procurement solicitation.

## **Conclusion**

There are many ways to incorporate health IT, health information exchange, and interoperability considerations into a HCBS Medicaid program. This toolkit attempts to provide states with some options for impactful ways to accomplish this goal.

While it is true that health IT adoption and more specifically EHR penetration among HCBS providers and delivery systems is low, there are still tremendous opportunities available to SMAs to support health IT, HIE, and interoperability within HCBS programs. One of the lessons learned from the MU EHR incentive program is that just adopting EHRs and health IT incentives to providers does not ensure interoperability. There are in fact many foundational components that need to accompany EHR adoption to develop out a fully functioning health IT ecosystem to accomplish the Medicaid program objectives. This includes non-EHR considerations such as a robust identity management capabilities, provider directories which include all HCBS providers, data analytics platforms functioning in real time

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<sup>12</sup> The Nationwide Interoperability Roadmap can be found at: <https://www.healthit.gov/policy-researchers-implementers/interoperability>.

using e-specified measures for the basis of quality and payment to name only a few. All of these functionalities can develop and grow while simultaneously supporting HCBS providers in their efforts to digitize their service delivery systems (e.g. EHR adoption).

While these considerations are no means intended to provide an exhaustive list, it is hoped that SMAs can begin including HCBS programs, in the larger health IT discussions occurring within the state. Ensuring that there is a functioning health IT ecosystem within the state able to sustain and advance Medicaid program objectives is critical to improving care and bending the cost curve.

## Appendix A – Summary of HCBS Health IT Questions

Question 1: Are health IT Considerations being included in the Medicaid Program’s service definitions, provider qualifications, and payment rates? If so, how?

Question 2: How is the HCBS Medicaid program promoting the electronic capturing and sharing of “assessment data” and “care plan” information with relevant members of the team (including the individual)?

Question 3.1: Have ADT requirements been included as part of the state’s provider qualifications for all HCBS and institutional providers?

Question 3.2: If so, can the state include higher payment rates for providers that are able to send or receive ADT notifications?

Question 4: If the Medicaid program includes an MCO and or ACO as part of the service delivery system, has the state committed to include any requirements for the use of standards identified in the ONC ISA and or 45 CFR 170 subpart B where appropriate for the MCO and or ACO, not barring any other compelling state interest?

Question 5.1: As part of discussions with a state, has the state identified the maturity level of the state’s HIE(s) and whether it would promote Medicaid program objective to include a requirement for HCBS provider to be able to send or view information from or to the relevant HIE(s)?

Question 5.2: If opportunities exist, can the state include as part of the provider qualifications the requirement to initially send information into the HIE and subsequently to also view information from the HIE or vice versa?

Question 5.3: If opportunities exist, can the state include higher payment rates for providers that are able to communicate with the identified HIEs?

Question 6.1: Can the State leverage measures already specified in other federal programs for use in the quality framework of the HCBS Medicaid program? (e.g. is the State able to leverage any of the electronic clinical quality measures (e-CQM) or the Comprehensive Primary Care Initiative (CPC+) measures as part of a health and welfare performance measure)<sup>13</sup>?

Question 6.2: Is the State using any of the CMS electronically specified clinical quality measures (eCQMS) as part of the Medicaid HCBS program’s payment methodology?

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<sup>13</sup> As noted earlier, caution should be used to which of these measures could be attributed to being caused or influenced by LTSS.

Question 7: Does the State have a plan to provide technical assistance to their HCBS providers to adopt and use health IT (i.e. similar to the role Regional Extension Centers played under HITECH? If not, what is the state's plan to ultimately support Health IT adoption amongst HCBS providers?

Question 8: Specifically, is the state planning on using an advanced planning document (APD) for 90:10 funding to support HCBS providers (e.g., through funding connections or developing an HCBS specific registry)?

Question 9: What is the current level of engagement with LTSS providers and operating agencies in the area of HIT Governance?<sup>14</sup>

Question 10: What are the State Medicaid Agency's or Operating Agency's plans are for including LTSS providers and beneficiaries in the state's overall provider directory and identity management strategies? Are HCBS considerations included in the state's provider directory and identity management strategies?

Question 11: What are the SMA's plans to support individuals receiving HCBS to access or perhaps have a more active user function with their PCSP or service encounters through a personal health record (PHR) like function?<sup>15</sup>

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<sup>14</sup> This ideally should include consumers in a meaningful way and is not just limited to the State Medicaid Agency making this available for public comment. Individuals, advocacy groups and beneficiaries should be consulted during the planning process.

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