The American Recovery and Reinvestment Act (ARRA) of 2009: Opportunities for AF4Q Alliances to Partner with Medicaid Agencies

Introduction
On February 17, 2009, President Obama approved the American Recovery and Reinvestment Act (ARRA) of 2009, a $787 billion economic stimulus bill. ARRA contains many health-related components, including additional and temporary federal funds for Medicaid programs. These dollars are designed to maintain funding for needed Medicaid coverage and to invest in much-needed health care infrastructure. ARRA’s single-largest infrastructure investment is in health information technology (HIT), with the vast majority of funding – approximately $44 billion – in provider incentives for adoption, implementation, and use of electronic health records (EHRs). Of that, approximately $21.6 billion is for Medicaid providers, and $23.1 billion for Medicare providers.

The following summarizes four ways that federal ARRA funding will impact Medicaid.

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<th>Award/Grant</th>
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<th>Timeframe for Funding</th>
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<td>Design and administration of Medicaid provider incentive program for EHRs</td>
<td>90% of Medicaid’s costs to design and administer program</td>
<td>Medicaid agencies are starting to receive funding</td>
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<td>Medicaid provider incentive programs for meaningful use of EHRs</td>
<td>$21.6 billion to eligible Medicaid providers</td>
<td>Eligible providers will start receiving incentive payments in 2011</td>
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<td>Development of statewide HIEs</td>
<td>$564 million to grantees</td>
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<td>Regional extension centers (RECs)</td>
<td>$640 million to RECs</td>
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This issue brief describes the unprecedented opportunity that ARRA presents Medicaid agencies to advance quality in the safety net delivery system, and how Aligning Forces for Quality (AF4Q) alliances can play a key role in that advancement.

Key Medicaid HIT Components of ARRA
ARRA will support the transformation of Medicaid by providing:

1. Funding to Medicaid agencies to administer a program for the widespread adoption and meaningful use of EHRs – A state Medicaid agency can access federal dollars to design, implement, and oversee a program of adoption, implementation, and “meaningful EHR use” in high-volume Medicaid practices. The Department of Health and Human Services’ (DHHS) Centers for Medicare and Medicaid Services (CMS) will pay 90 percent of the Medicaid agency’s costs to administer this program, and the state will pay 10 percent.
To trigger the flow of federal funds, states are developing and submitting an advance planning documents (APD) to CMS. As of mid-December 2009, California, New York, Georgia, Texas, Idaho, Iowa, Montana, and the U.S. Virgin Islands have successfully submitted an APD and are receiving federal funds. Funding for additional Medicaid programs appears to be imminent.

2. Incentive payments to eligible providers who adopt EHRs and use them in a meaningful way to improve the quality of care – Certain high-volume Medicaid providers who demonstrate meaningful EHR use (to be determined by each Medicaid program and approved by DHHS) can receive incentive payments beginning in 2011. ARRA establishes 100 percent Federal Financial Participation (FFP) for states as incentive payments for Medicaid providers to purchase, implement, and operate certified EHR technology.

   • Non-hospital based professionals with at least 30 percent of their patient volume comprising Medicaid patients are eligible for incentive payments if they are: physicians, dentists, certified nurse midwives, nurse practitioners, or physician assistants (if they lead a rural health clinic or are on staff of a federally qualified health center). Federally qualified health centers with 30 percent Medicaid, CHIP, or other low-income patients who are not charged full fees are also eligible. These entities can receive up to $64,000 in incentive payments over six years: $21,250 for the first year, and up to $8,500 for each of the subsequent five years.

   • Non-hospital based pediatricians whose Medicaid patient volume is at least 20 percent are eligible for up to $42,500 in incentive payments.

   • Children’s and other acute care hospitals with at least 10 percent Medicaid patient volume are also eligible.

Medicare providers are also eligible for incentives, but with different eligibility requirements (not covered in this issue brief). A provider must choose whether to participate in the incentive program under Medicaid or Medicare – not both.

3. Funding for state health information exchange (HIE) planning and implementation necessary to support needed infrastructure for meaningful use – Entities such as regional health information organizations (RHIOs) have submitted applications to DHHS to receive federal funding to become statewide HIEs. The ONC’s budget includes $564 million to support the further expansion of local and regional HIEs; approximately 50 awards will be given.
4. **Grants for RECs across the country that will work directly with providers to implement and use EHRs** – A total of 70 RECs will outreach to, educate and train providers, helping them to choose and purchase EHRs, manage EHR implementation, redesign practice workflow, and ensure meaningful use progress. Priority for REC services will be given to public, not-for-profit, and critical access hospitals; federally qualified health centers; entities in rural or underserved areas; and small primary care practices. Accordingly, the RECs will critical to a successful Medicaid provider incentive program.

The RECs will have access to $640 million in federal funding, to be supplemented by matching funds they are required to generate. The average award will be $8.5 million, and the largest will be $30 million. There are two application cycles for RECs: Cycle 1 awards will be announced on January 21, 2010. Preliminary applications for Cycle 2 are due December 22, 2009, with full proposals due January 29, 2010. Several AF4Q alliances were included in applications submitted during Cycle 1. Entities such as area health education centers, universities, primary care coalitions, public health agencies, and quality improvement organizations are applying.

While there will be 70 RECs across the U.S., Medicaid agencies have concerns that the RECs will not be able to reach and impact all eligible Medicaid practices. As a result, Medicaid agencies are considering whether and how to supplement REC resources to reach all high-volume Medicaid practices.

**What Medicaid Programs Are Doing Now**

It is important to note that state Medicaid agencies are not required to participate in the widespread adoption of EHRs. Accordingly, some states are considering whether they can afford to do so as Medicaid program expansion, budget deficits, and staffing/hiring shortages make it challenging to contribute a 10 percent state match. At the same time, all states are considering whether they can afford not to participate, recognizing this unprecedented opportunity to enhance the Medicaid delivery system with a critical tool for measuring and improving quality and reducing disparities in health care.

As noted above, states are submitting HIT APDs to CMS and are starting to receive federal funding needed to create a State Medicaid HIT Plan (“SMHP”) and support related planning. CMS requires that the SMHP include the following four items:

1. An assessment of the state’s current HIT environment (“as is”) and its effect on beneficiaries;
2. A vision of the future HIT landscape in 2014 (“to be”), and how it will be coordinated with public and private efforts throughout the state;
3. Steps to implement the provider incentive program (e.g., who is eligible, how payments will be processed, what are the measures, etc.); and
4. An HIT roadmap that will enable the transition from “as is” to “to be.”
States are expected to submit their SMHP once DHHS has issued final regulations and guidance regarding administration of the Medicaid incentive program. In addition, CMS’ guidance on the definition of meaningful use and the provider incentive program expected due by December 31, 2009. The SMHP is required for the state to receive implementation funding distinct from planning dollars.

To support implementation of the SMHP, the federal government will provide $9 for every $1 provided by the state. Beyond development of the SMHP, funded activities include design and implementation of the incentive program; outreach and education about the HIT effort; training and meetings; travel; HIT hardware and software; oversight; and others. (See Attachment 1, Enclosure E from the September 1, 2009, State Medicaid Director letter from the CMS Center for Medicaid and State Operations (CMSO) that provides related guidance to states.)

States are also discussing with their contractors, providers, regional CMS offices and other stakeholders, regional or state strategies for designing a provider incentive program and identifying entities to serve as RECs and HIEs. Critical to this planning will be collaboration with other stakeholders and leveraging of existing resources. CMS has specified that planning dollars must support coordination with the entity leading the state HIE and with the stakeholders affected by the SMHP.

What AF4Q Alliances Can Do Now
The opportunities posed by ARRA are significant for AF4Q alliances. ARRA resources can help “raise all boats” and improve the quality of health care throughout a state or region, particularly for providers who may be disenfranchised from quality improvement efforts.

Further, as Medicaid programs consider performance measures, reporting strategies, and HIT technology, AF4Q alliances can encourage alignment of these strategies across the public and private sectors, and partner with states to develop a common measurement strategy.

The alliances are well-positioned to provide services and support to Medicaid agencies, many of which will be seeking contractors to help make these efforts successful. AF4Q communities can be critical partners in Medicaid strategic planning and incentive implementation.

Here are five ways that AF4Q alliances can participate in their state’s Medicaid HIT activities:

1. Help the Medicaid agency to further define “meaningful use,” particularly for practices that may not be early adopters of EHRs, pending further expected guidance from CMS at the end of 2009.
2. Encourage Medicaid to adopt the common measurement set being used by AF4Q throughout the region.
3. Using the aggregated multi-payer data available within the alliance, help the Medicaid agency identify providers who are eligible for the Medicaid incentive program.
4. Collaborate with the Medicaid agency to develop an ambulatory quality improvement strategy that is aligned across the region or state – one that will both spread EHR adoption and support the regional transformation of primary care.

5. Using established relationships with the provider community, outreach to and educate practices about the provider incentive programs that will be available in 2011, as well as the above ambulatory quality improvement strategy.

For more information about ARRA’s Medicaid HIT components and/or related opportunities for your alliance, please contact Dianne Hasselman at dhasselman@chcs.org.

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3 American Recovery and Reinvestment Act of 2009, Division B, Title IV, Medicare and Medicaid Health Information Technology; Miscellaneous Medicare Provisions, Subtitle B – Medicaid Incentives, Section 4201, Medicaid provider HIT adoption and operation payments; implementation funding.


5 American Recovery and Reinvestment Act of 2009, Title XIII - Health Information Technology, Subtitle B—Incentives for the Use of Health Information Technology, Section 3013, State Grants to Promote Health Information Technology; State Health Information Exchange Cooperative Agreement Program; Funding Opportunity Announcement.

6 American Recovery and Reinvestment Act of 2009, Title XIII - Health Information Technology, Subtitle B—Incentives for the Use of Health Information Technology, Section 3012, Health Information Technology Implementation Assistance; Funding Announcement.

7 American Recovery and Reinvestment Act of 2009, Division B, Title IV, Medicare and Medicaid Health Information Technology; Miscellaneous Medicare Provisions, Subtitle B – Medicaid Incentives, Section 4201, Medicaid provider HIT adoption and operation payments; implementation funding.

8 American Recovery and Reinvestment Act of 2009, Title IV – Medicare and Medicaid Health Information Technology; Miscellaneous Medicare Provisions, Subtitle B – Medicaid Incentives, Section 4201 – Medicaid Provider HIT Adoption and Operation Payments; Implementation Funding.

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