CMS Medicaid Transformation Grants: Health Information Technology
Early Lessons Learned

Background

The Deficit Reduction Act (DRA) of 2005 establishes a new grant program, called the Medicaid Transformation Grants (MTG) for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under Medicaid. Funding was appropriated for Federal fiscal years 2007 and 2008, with authorization for additional funds extending through 2010.

The DRA encourages states to "adopt innovative methods to improve the effectiveness and efficiency in providing Medicaid." The implementation of the DRA provided new opportunities for States to work with the Federal Government to build on effective reforms to slow spending growth while providing needed and quality healthcare coverage.

Which States Received a Medicaid Transformation Grant Award?

CMS issued two solicitations during Federal fiscal year 2007. Thirty-five States plus the District of Columbia and Puerto Rico were awarded a total of $150 million in Medicaid Transformation Grants[1]. Overall 22 States' grants (63%) are focused on Health Information Technology (HIT), including electronic health records, e-prescribing, clinical decision support and health information exchange.

Early Lessons Learned from Medicaid Transformation Grants

- *The Original Grant Timeframe was Too Short: Grants were either 18 or 24 months in duration*
    - 99% of the Medicaid Transformation Grants will request a no-cost extension.
    - 3 years is a minimum for broad HIT implementation projects.

- *Establishing Governance for Health Information Technology/Exchange (HIT/E) is Challenging*
    - Public/Private partnerships often spur broad provider adoption but it may not be easy to bring private payers to the table with start-up funding.
    - Medicaid HIT/E efforts have to be coordinated, and timed, with other State e-Health initiatives. This can cause delays as the stakeholder groups can be quite large.
    - CMS supports the philosophy of service-oriented architecture for IT projects. For HIT/E efforts, this requires States to define the business enterprise within their state agency, and it can be challenging to build consensus.

- *Legal Hurdles & Delays Should Not Be Underestimated*
    - Privacy, security and consent are all issues that must be well-defined, established and negotiated to be compliant with Federal and State laws and to gain/maintain beneficiary trust.
    - States have varying approaches towards beneficiary consent (opt-in, opt-out, levels of participation, etc) and the consent process can also be mitigated by caregivers, patients with cognitive disabilities, limited English proficiency and health literacy etc.
    - HIPAA considerations must be addressed.
    - Many States have laws restricting the exchange of sensitive treatment data, such as substance abuse, mental health, HIV/AIDS, etc. This requires specific programming to hide those fields.
    - Business Agreements and Data Use Agreements typically take longer to negotiate than originally anticipated.[2]

- *Procurement Moves At The Speed of Molasses*
    - Many States have experienced significant delays in project implementation due to the necessary, but time-consuming, competitive procurement process.

---

[1] For detailed information on the Medicaid Transformation Grants, visit: www.cms.hhs.gov/MedicaidTransGrants

[2] The Office of the National Coordinator for HIT's National Privacy and Security Framework for the Electronic Exchange of Individually Identifiable Health Information can be found at: http://www.hhs.gov/healthit/documents/NationwidePS_Framework.pdf

- *Automating Manual Processes Takes Time, User Training and User Follow-Up*
  - Technically, it is not an insignificant task to automate what has been a manual process.
  - In order to evaluate the efficacy of the newly automated system, time and motion studies may be needed at baseline to measure improvements in staff/process efficiencies.
  - Users need to be trained, retrained and followed up regularly, especially in the beginning and after system improvements/enhancements have been made.

- *Provider Adoption is Slow*
  - Even in States with broad provider involvement in the design of their EHR/e-Prescribing projects, utilization has started more slowly than was originally anticipated.

- *Provider Utilization is Unpredictable*
  - States have observed variations in provider utilization of HIT/E that do not fall easily within predictable categories, such as rural vs. urban or by different provider types or by previous level of project involvement. In other words, there are many variables that affect whether or not a provider utilizes an HIT/E tool, including office workflow, staffing levels, incentives (or lack thereof), etc.

- *Incentives Do Matter To Spur Provider Adoption and Utilization*
  - Incentives are not limited to higher reimbursement (i.e. pay for use) but can also include provision of computer hardware (such as computers, personal handheld devices, etc), personalized training, administrative conveniences (such as co-locating electronic health records and prior authorization systems on the same web portal), pay-for-performance incentives, technical assistance (ex. With workflow redesign) and peer recognition.

- *Establishing a Business Model/Sustainability Plan is a Critical Early Step*
  - Many State Medicaid agencies will need additional funding after their Medicaid Transformation Grant funding expires-to scale up their projects statewide, implement provider incentives, focus on broad provider utilization, or enhance their systems, etc.
  - Some CMS matching funds may be available, under certain conditions, but States must follow the request process and have sufficient State funds available.
  - State Medicaid agencies must evaluate the cost savings of their HIT/E efforts in order to redirect those funds back into the program for on-going sustainability. However, tracking return on investment requires sufficient implementation time in order to demonstrate a valid result and necessitates on-going evaluation resources.
  - HIE models that are independent of the State Medicaid agencies must develop a strong business case for health information exchange in order to garner on-going funding from both Medicaid and private payers of health care services.

- *The One-Stop Shop HIT/E Model is Attractive to Providers*
  - Providers' preference is for there to be multiple reasons to use the HIT/E tool. These include:
    - Being able to obtain electronic health information for their patients across more than one payer;
    - Having administrative functions co-located to streamline their office workflow;
    - Being able to not just view patients' claims histories but to be able to view laboratory and radiology results as well and;
    - Having the capacity to actively interact with and add data to the electronic health record.

The States have proven to be fertile laboratories for testing and evaluating strategies for HIT adoption, provider incentives, privacy and security and beneficiary/stakeholder involvement. The lessons learned derived from the Medicaid Transformation Grants have broad applicability for HIT/E implementation in the United States.