



**MEDICAID EHR TEAM**  
ANALYSIS, TRAINING & TECHNICAL ASSISTANCE

# Learning through Implementation of the Medicaid EHR Incentive Program

**Medicaid EHR Team**

M. René Bostick, Principal  
Lisa Maiuro, Senior Consultant  
Health Management Associates  
December 23, 2011

Contract Number: HHSM-500-201 0-00024T  
Contractor: Urban Institute  
2100 M Street, NW  
Washington, DC 20037

## Contents

I.	Executive Summary.....	1
II.	Background .....	3
III.	Implementation Status .....	3
IV.	Approach.....	4
V.	Learning.....	5
A.	Primary Challenges and Enablers of Implementation.....	5
B.	Key “Ah-Ha” Learning.....	8
C.	Progress and Performance Measures of Success .....	9
D.	Collaboration.....	11
E.	New Initiatives on Horizon .....	11
VI.	Conclusion.....	12
VII.	Special Thanks.....	13

## I. Executive Summary

This paper provides tips for states beginning to implement their Medicaid EHR Incentive Program, based on interviews with officials in a sample of states at varying stages of program implementation. Enablers of successful implementation are clustered into seven general areas: communication and collaboration with providers; securing state staff and leveraging state resources; using CMS resources, particularly technical assistance; anticipating and planning for higher-than-anticipated provider participation; considering automating provider attestation data through MMIS changes; developing alternative eligibility verification processes; and using process measures to assess early program implementation. Specific enablers in these areas are listed below.

### 1. Communicate and collaborate with providers

- **Educate providers frequently.** One state found “you can never communicate too much or too early” to providers about the Medicaid EHR Incentive Program. States that thought they had engaged in early provider education learned they had to communicate key elements of the program multiple times through several channels to be effective. Provider education is an ongoing process.
- **Collect provider feedback – and use it.** Texas received feedback at one point through its provider portal about the process for medical groups to become eligible for the Medicaid EHR Incentive Program: the state had tried to make it easier for “ghost providers” (who provide Medicaid services under another provider’s certification number) to participate in the program, but had inadvertently made it harder. The state then worked with providers to modify their policies to bring medical groups’ experiences in line with the intent of the state’s policies.
- **Leverage provider associations and Regional Extension Centers (RECs) to reach providers.** All states interviewed were exploring new ways to help providers learn about the program and successfully complete attestation, and many were working with provider associations (who had been very responsive and resourceful) and HITECH Regional Extension Centers (RECs). Some states experienced bumpy starts in figuring out how to work with RECs, but nearly all were pleased with their progress and now viewed RECs as essential partners.

### 2. Secure and leverage state staff and infrastructure

- **Staff-up for implementation... if you can.** At least two states indicated the need for additional staff resources once they launched their Medicaid EHR Incentive Program. In one state, providers’ limited computer and electronic-scanning capabilities complicated the attestation process, requiring greater technical assistance than anticipated. States also found the process of verifying provider eligibility time-consuming. Of course, given current budget constraints in most states, increasing staff assigned to the Medicaid EHR Incentive Program may not be possible.
- **Leverage assistance from other state agency departments.** By demonstrating the importance and value of the Medicaid EHR Incentive Program to other departments of their state agency, one state’s EHR Incentive Program was able to leverage assistance from other departments to implement their program.

### 3. Use CMS resources

- **Use CMS technical assistance.** States valued technical assistance received from CMS and CMS's technical assistance contractors,<sup>1</sup> including group training and individual follow-up.
- **Participate in the "Hospital Calculation Community of Practice."** States interviewed found this community of practice<sup>2</sup> particularly helpful in understanding the basics of the complicated formula used to determine hospitals' eligibility for Medicaid EHR incentive payments, though they tended to also communicate directly with CMS staff to understand unique calculation scenarios. States cautioned that the numerous data sources involved and the fact that hospitals can amend their cost reports are complicating factors states should be aware of when preparing to begin disbursing hospital incentive payments.

**4. Anticipate high participation rates.** All states, with one exception, experienced much higher rates of provider participation in the program than projected; many had to revise their CMS-37 Quarterly Budget Estimate to account for the large amount (and size, for hospitals) of Medicaid EHR incentive payments disbursed. This meant state staff had to modify existing financial planning routines, and financial managers needed to include EHR Incentive Program leaders in their communications workflow.

**5. Consider automating the collection of provider attestation data.** Two states interviewed are changing their Medicaid Management Information System (MMIS) to capture providers' meaningful use attestations. States in the process of updating their MMIS may want to consider adding this capability.

**6. Consider setting up an alternative eligibility verification process to pre-qualify health care professionals.** California developed and received Federal approval of an alternative eligibility verification process that allows them to pre-qualify approximately 50% of eligible health care professionals, thus freeing the state to focus more energy on outreach and collaboration with RECs.<sup>3</sup>

**7. Use process measures to assess early program implementation.** States interviewed are using process-oriented (as opposed to outcomes-oriented) measures to assess program performance, such as:

- Time taken to submit and/or gain approval of State Medicaid Health IT Plan and Health IT Implementation Advance Planning Document
- Time taken to launch EHR Incentive Program
- Projected-to-actual number of providers completing attestation as meaningful users
- Number of applications reviewed and approved
- Length of time to verify provider eligibility for program
- Number, timing, and size of Incentive Payments disbursed

This paper also describes challenges identified by states, and concludes by offering some advice for CMS.

---

<sup>1</sup> To access this technical assistance, go to [www.medicaidhitechta.org](http://www.medicaidhitechta.org). To obtain a login as a state Medicaid agency staff member, email [CMS.MeT.CoP@briljent.com](mailto:CMS.MeT.CoP@briljent.com).

<sup>2</sup> To join this Community of Practice (CoP), go to [www.medicaidhitechta.org](http://www.medicaidhitechta.org), login as an authorized user, and then click on the "Communities of Practice" tab.

<sup>3</sup> See Appendix A of the Patient Volume and Practicing Predominantly Report, available at <http://www.medicaidhitechta.org/ResourcebrLibrary/ReportsandWhitePapers.aspx?EntryId=469>. To access this report, go to [www.medicaidhitechta.org](http://www.medicaidhitechta.org). To obtain a login as a state Medicaid agency staff member, email [CMS.MeT.CoP@briljent.com](mailto:CMS.MeT.CoP@briljent.com).

## II. Background

On February 17, 2009, President Obama signed the American Recovery and Reinvestment Act of 2009 (Recovery Act). The Health Information Technology for Economic and Clinical Health (HITECH) Act comprises two Titles within the Recovery Act: Title XIII of Division A—Health Information Technology, and Title IV of Division B—Medicare and Medicaid Health Information Technology. The Medicaid EHR Incentive program is one component of the HITECH Act. It is a voluntary program administered through a partnership of the Centers for Medicare and Medicaid Services (CMS) and state Medicaid agencies (SMAs) to provide incentives to eligible professionals and hospitals to “meaningfully use” certified EHR technology (CEHRT). It represents a new paradigm for the Medicaid program.

State and Federal partners and the eligible professionals and hospitals have worked hard to startup and advance this program this year. This paper shares their learning processes and experiences in the hope of making a positive contribution for other states engaged on the same journey. This paper focuses on five areas of learning by selected SMAs as they move their Medicaid EHR Incentive programs forward from the planning to the implementation phase.

## III. Implementation Status

The ultimate goal of the state-federal partnership under HITECH is to achieve better care for individuals, better health for the population and lower cost through quality improvements. The Medicaid EHR Incentive program contributes to this goal by encouraging and enabling the meaningful use of CEHRT to:

- improve care coordination
- reduce healthcare disparities
- engage patients and their families
- improve population and public health
- ensure adequate privacy and security.

The measures for meaningful use objectives are staged over the life of the EHR Incentive program, as are the measures of program performance. In the first year of the Medicaid EHR Incentive program, CMS’ primary objective has been to assist SMAs to successfully plan and launch their program and enable eligible providers to register, attest and receive incentive payments. The measures of success for these basic objectives are the following metrics:

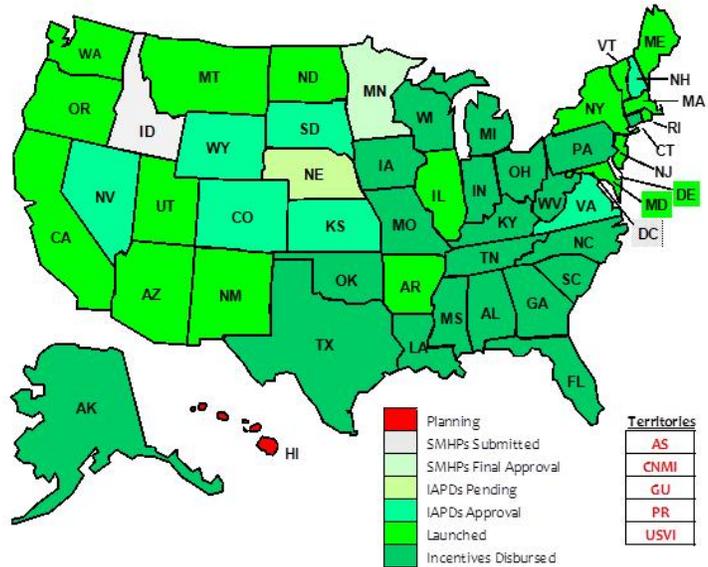
1. Eligible Professionals Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use,
2. Eligible Hospitals and Critical Access Hospitals (CAHs) Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use and
3. Providers Receiving Incentive Payments to Adopt, Implement or Upgrade (AIU) EHRs.<sup>4</sup>

---

<sup>4</sup> Department of Health and Human Services, CMS, *2012 Online Performance Appendix – (1) MCR27.2: Medicaid, (2) MCR27.4: Medicaid and (3) MCR27.5: Eligible Professionals, MCR27.6 Eligible Hospitals.*

As of October 31, 2011, thirty-three (33) SMAs had launched their EHR Incentive program. Twenty-three (23) SMAs had disbursed incentive payments totaling more than \$711,620,108 to:

- 8,684 (28%) of the 31,265 registered eligible professionals,
- 21 (40%) of 52 registered Medicaid-only eligible hospitals, and
- 601 (25%) of the 2,405 registered Medicaid/ Medicare eligible hospitals.<sup>5</sup>



#### IV. Approach

During October and November 2011, the Medicaid EHR Team<sup>6</sup> (MeT) interviewed leaders from a diverse group of Medicaid EHR Incentive programs to identify key issues in the implementation process from the eleven months since the Incentive program began nationwide. These findings build on a paper MeT released in May 2011 on early implementers in the program. According to Guy Kawasaki, noted technologist, consultant and author, “A good idea is about ten percent, and implementation, hard work and luck is 90 percent.” This paper focuses on the hard work it takes to move a good policy idea from conception into implementation.

The states that we consulted in the data gathering process ranged in size, population, geography, and stage of implementation. The states are, sorted by implementation timeframe:

- Texas - early implementer in January 2011,
- Alabama, Michigan and Missouri - mid-term implementers in August 2011, and
- California and Utah - recent implementers in October 2011.

For each of the SMAs, the MeT provided the following set of topics and questions for Medicaid EHR Incentive program leaders before informal, conversational telephone interviews to solicit impressions and gather responses:

<sup>5</sup> CMS Medicaid EHR Incentive program *Payment and Registration Report*, October 2011. Accessed at: [https://www.cms.gov/EHRIncentivePrograms/Downloads/Monthly\\_Payment\\_Registration\\_Report\\_Updated.pdf](https://www.cms.gov/EHRIncentivePrograms/Downloads/Monthly_Payment_Registration_Report_Updated.pdf)

<sup>6</sup> A team of four firms (Urban Institute, American Institutes for Research, Brilljont and Health Management Associates, Inc.) under contract with CMS to provide analysis, training and technical assistance for the Medicaid EHR Incentive program.

- A. Primary Challenges and Enablers of Implementation**
- B. Key “Ah-Ha” Learning**
- C. Progress and Performance Measures of Success** - *What are the current reporting processes and measures for EHR Incentive program? How are you assessing success and measuring performance and meaningful use of certified EHR technology in the future?*
- D. Collaboration** – *Since the meaningful use of CEHRT is dependent on many factors beyond the scope of the EHR Incentive program, what entities have been most helpful in this collaborative process (Regional Extension Centers (RECs), State Designated Health Information Exchange (HIE), Public Health (PH), other SMA programs, etc.)*
- E. New Initiatives on Horizon** - *How is your SMA planning to align the EHR Incentive program with or define how it will contribute to quality care initiatives in the Patient Protection and Affordable Care Act (ACA) (e.g. patient-centered health homes, accountable care)? What are your state’s plans for expanding technology capabilities, such as receiving meaningful use attestations, or MMIS modules or enhancements?*

The findings in this paper represent a snapshot of the primary implementation learning processes and trends identified by this diverse group of SMAs. The findings are not all-inclusive but appear to be representative of issues, challenges and process of implementing a complex new program in a changing environment.

## V. Learning

From the interviews, MeT staff identified the primary implementation challenges and enablers, key learning, measures of progress and performance, significant collaborations and new initiatives. In the sections below, we have highlighted the key themes from these five areas. We use the term “learning” to convey the experience of SMAs and their partners as they startup this new program in their unique state environments, rather than “lessons learned,” a phrase that implies that lessons of implementation can always be applied uniformly.

### A. Primary Challenges and Enablers of Implementation

**Communication** – SMAs indicated that communication remains the primary challenge and enabler of this program. One state indicated that “you could never communicate too much or too early” to providers about this program. States that thought they had engaged in early provider education learned that they had to communicate key elements of this program multiple times through several channels to be effective. They found that, similar to CMS technical assistance with SMAs, provider education is an ongoing process.

Another SMA spoke of the challenges of “getting the attention” of other state staff and departments to demonstrate the importance of this program. Through consistent efforts, they were able to demonstrate the value of the program and to leverage assistance needed to implement the program.

Nearly all states had positive comments about the accessibility of CMS team and contractors, the training and technical assistance, as well as individual responsiveness and follow up. States appreciated the collaborative approach taken by CMS and its contractors in exploring and addressing issues. They are hopeful that the sense of collaboration will continue into the next implementation phases. Many states are particularly apprehensive about the audit process and the possibility of the state being found in error and responsible for recoupment of incentive payments.

**Complexity** – Nearly all SMAs raised concerns about the complexity of program planning and implementation. For most, the issue of eligibility verification presented a challenging dilemma. For example, establishing clear policies, identifying auditable data sources, and defining patient volume or determining compliance with the program’s Physician Assistant-led requirement are challenging in the face of limited data sources. Managing the hospital calculation process posed another distinct set of challenges and staffing issues. States were clearly concerned about the amount of time and resources they had to spend trying to define their policy parameters and auditable data sources for eligibility verification. In many cases, they later realized they were trying to identify data sources that they did not have or to make up processes that were not completely effective in eliminating the risk of an audit finding. Some states that chose to establish policies or procedures given the best information available at the time expressed some frustration with the subsequent interpretations of the Final Rule that caused them to spend limited staff resources on refining these policies to comply with more certain interpretations.

Most states indicated that they had had no idea how complicated the hospital calculation was until they began receiving hospital attestations. Several states attempted to perform the calculation without realizing that they first had to check to see if they have the most recent approved hospital cost report. Many shared concerns about trying to get access to busy Medicaid hospital financial managers. SMAs have found the Hospital Calculation Communities of Practice helpful in understanding the basics of a complicated formula but still require technical assistance on many of the unique calculation scenarios. Again, EHR Incentive program leaders praised CMS staff for their accessibility, approach and follow through. Specifically, they found it helpful for CMS staff to be willing to talk through a unique situation, rather than just instructing them to follow a template.

Given these challenges, some states slowed implementation to pursue policy options that could streamline future processes and include more professionals in the eligibility process. One state, California, developed and received Federal approval of an alternative eligibility verification process that allowed them to pre-qualify approximately 50% of eligible professionals, thus freeing them to focus more energy on outreach and collaboration with the RECs. California sought to broaden the categories of eligible professionals to include optometrists. As an example of the ways unique state circumstances drive program implementation, the state both agrees that this modification was the correct course of action for their state and regrets the amount of time and energy it took to develop, submit and revise the State Plan Amendment required to make the change.

Several states remarked that the level of complexity dramatically expanded when they launched their EHR Incentive program. Questions were no longer abstract policy principles but were pressing issues raised by providers or provider associations that required answers and actions in real-time. At least two states indicated the need for additional staff resources once they had launched, but the state's hiring freeze prevented additional resources. One state discussed how providers' limited computer and scanning capabilities complicated the basic attestation process and required greater technical assistance than anticipated.

Most states, particularly the larger ones, experienced a new appreciation of the complexity of their state's health care delivery systems once they moved into implementation. States where beneficiaries are covered by both fee-for-service and multiple, distinct models of managed care encountered the most significant challenges in verifying provider eligibility. States with limited managed care encounter databases also noted significant challenges in accessing verification and other data.

All states, with one exception, experienced much higher rates of provider participation in the program than projected. In addition to a higher than expected number of eligible professionals, most states were surprised by hospital incentive payment amounts. Many indicated that they did not fully understand the hospital calculation methodology until they worked through the calculation process during implementation. In fact, many states had to revise their CMS-37 Quarterly Budget Estimate prior to the end of the quarter because of projection issues. In addition, states found it difficult to work through this update process within their own agencies. The startup nature of the program required staff to modify existing financial planning routines, and financial managers needed to include EHR Incentive program leaders in their communication workflow. Several states suggested the need to improve and streamline program administration between CMS and SMAs by electronic communication and authorization workflow.

**Changes** – The very nature of program implementation is change management. States found it easier to adapt to change earlier in the planning process, rather than after they had started implementation. Changes in rules or interpretation of rules after launch were more complicated and required rework.

The state's phase of implementation and its staffing capabilities directly affected whether states perceived changes as a positive or negative. Earlier in the implementation cycle is typically easier for the state to adjust to changing interpretations of the rule. However, many of the more detailed questions and issues were not exposed or understood until states delved further into implementation. Although SMAs routinely experience strained resources, the time-sensitive nature of this particular implementation created serious challenges since states had to continue implementation activities as well as rework parts of the program.

Some SMAs experienced challenges in obtaining staff resources and others indicated growing levels of staff turnover. Three of the top leaders in the Texas EHR Incentive program will have all departed from the program by the end of the year. Other SMAs not in this cohort are experiencing similar

changes in EHR Incentive program leadership. In response, CMS and its contractors may need to broaden and customize their technical assistance approaches to anticipate and address staff needs across this continuum of staff experience. In addition, Texas stressed the need for CMS to focus more support for leading edge states, rather than maintaining a primary focus on the technical assistance needs of later implementers.

Several states expressed a desire for technical support for both advanced and less-advanced states. States observed that the public sector often focuses on making sure all states have the same access and support to achieve implementation, which at times may come at the price of innovation support for leading edge states. Several suggested the need for a more customized approach in the coming year. The challenge for ongoing training and technical assistance will be balancing support for both ends of the spectrum of change.

## **B. Key “Ah-Ha” Learning**

**Coordination and Collaboration** – Nearly all states noted the importance of coordination and collaboration for successful implementation. States indicated that it was important to continue collaborating with providers throughout the implementation process. At one point, Texas received feedback through provider portal about the group eligibility. They had tried to “tried to make it easier, but it turned out to be harder” for “ghost providers” who provide Medicaid services under another provider’s certification number. It was important to work with providers in modify policies to the extent possible. As previously mentioned, changing rule interpretations were difficult for states in implementation. More than one state discussed the challenges of trying to coordinate with providers in a fluid policy environment.

**Projections** – Nearly all states discussed the challenges in projecting the numbers or types of participating providers and incentive payment amounts by quarter as required by the APD and CMS 37 report. States have not been able to reconcile the CMS-37 and CMS-64 reports, and have found it difficult to identify data sources that could aid in their projections of provider participation. SMAs found it even more difficult to estimate provider incentive payments due to both the lack of solid provider projection data and the complexity of the hospital payment calculation. Only Missouri indicated any degree of accuracy in their projections, and they did not attribute that to a repeatable methodology.

**Calculation** - One of the largest states only realized the limitations in the early CMS hospital calculation instructions after they walked several major hospitals through the attestation process. They realized that they had to work directly with many hospital Financial Officers to map the hospital cost reporting and amendment process, map the calculation process and draft a detailed process flow, which they then used to revise the state’s User Guide for other hospitals.

Although CMS provided information on the calculation process early in the program, many states did not realize the complications in the calculation, the numerous data sources, and the fact that hospitals can amend their cost reports. Those realities will likely result in further complications in the

future. The CMS Hospital Calculation Community of Practice has been helpful in preparing SMAs that implemented more recently.

### **C. Progress and Performance Measures of Success**

Most SMAs indicated that they have few standardized measures of success. Most states are focusing on measures of progress or process in the startup phase. State performance reporting has utilized standard metrics, such as:

- Projected timelines for submission and/or approval of SMHP and HIT IAPD,
- Projected timeline for EHR Incentive program launch,
- Projected to Actual number of Eligible Providers and Eligible Hospitals registered and completing attestation
  - Activity at Federal and State level (number of eligible professionals and hospitals that registered vs. attested)
  - Number of applications reviewed and approved
- Length of time to verify eligibility,
- Number and type of Help Desk calls,
- Projected to Actual Incentive Payment Amount by Federal Fiscal Year quarter,
  - Comparison to Quarterly Cap,
- Number, timing and size of Incentive payment amounts,
- Reconciliation of CMS-37 and CMS-64 reports

States have also reported progress utilizing a variety of means to monitor implementation and program success on an ongoing basis?, including:

- Webinar Updates,
- “Week Ahead” reports to Governor’s office,
- Advisory and Stakeholder Committee reports,
- Webinars, e-Mail Blasts and Press Releases, and
- CMS Regional Communities of Practice.

These measures and reporting approaches help to form a foundation or baseline from which SMAs can assess program growth. However, assessing the meaningful use of EHRs will require measuring the results of the use of information in practice change. Most states indicated they are thinking about future measures, and a few have ventured beyond these standard process measures to explore the use of available, limited, multi-sourced data to develop a profile of selected communities to engage them in the “startup” process.

**One innovative approach to measuring, engaging and learning about the startup of the Medicaid EHR Incentive program.**

“A startup” according to Eric Reis entrepreneur, author and leader of *The Lean Startup*, “is a human institution designed to create a new product or service under conditions of extreme uncertainty.”<sup>7</sup> In the Medicaid EHR Incentive program, the ultimate product or service is the meaningful use of CEHRT for improved health, care and cost efficiency. States like Utah are engaging their community resources to help figure out how to close the gap between their current community picture and the e-Healthy Community Profile of the future. We have highlighted key elements of that process here.

Todd Parks, the Department of Health and Human Services (HHS) Chief Information Officer is also known as the Entrepreneur-in-Residence, and is a keen practitioner of the Lean Startup. Within HHS, Parks has engaged in a process he calls data liberation by stimulating “innovators to use [HHS] data as fuel in applications, products, and services that improve health and health care,” and “the emergence of an ecosystem of innovation that sits on top of open health data.”<sup>8</sup> HHS has already implemented innovative projects that have “liberated” data and challenged developers to use information, technology and innovation to improve health, such as Community Health Initiative, HealthData.gov, Blue Button, and Clinical Trials.gov.

The Utah Department of Health has engaged in a similar approach. Since the award of HITECH infrastructure grants and the startup of Medicaid EHR Incentive program, key statewide Utah stakeholders including the REC, Beacon, Public Health, State Health Coordinator in Public Health, the Medical Director and Medicaid EHR Incentive program leader have met together twice a month. They briefly report on the status of their individual initiatives, and spend the majority of their time focusing on how they would define and report future success.

They realized that they would not be able to define fully this picture without engaging the community. So they worked together to complete a first data-driven brief iteration of the “e-Healthy Community Profile” for selected communities. It included data across provider types (hospitals, clinics, primary care clinics and nursing facilities), and across e-Health measures (EHR adoption, HIE participation, REC use and status toward meaningful use, e-Prescribing and Patient Consent). They shared this profile with community health leaders and hosted the e-Health Community Meeting to:

- Bring together a diverse group of health care stakeholders,
- Provide a keynote by the head of the Medical Association,
- Present the Community Profile and
- Engage an e-Health Champions Panel and Open Forum on challenges, successes and next steps.

They agreed to conduct a round of these meetings with selected local communities and then evaluate the approach to determine whether to proceed or change (“pivot”) their strategy.

---

<sup>7</sup> Eric Ries, *The Lean Startup: How Today's Entrepreneurs Use Continuous Innovation to Create Radically Successful Businesses*, Crown Business, 2011, p. 28.

<sup>8</sup> Brian Klein, Harnessing the Power of Data: Todd Park's Vision for Rebooting U.S. Healthcare, MedGadget, September 26, 2011. Accessed at: <http://medgadget.com/2011/09/harnessing-the-power-of-data-todd-park%E2%80%99s-vision-for-rebooting-u-s-healthcare.html>

## **D. Collaboration**

Since we have already described many of the areas of collaboration between state and CMS, among states, and between states and providers in this paper, we will focus on two key areas in this section. All states discussed the new and different levels of engagement with the provider community, provider associations and RECs in the implementation process. All states were engaged in exploring new ways to help providers learn about the program and successfully complete attestation. Provider associations have been very responsive and resourceful supporting providers' progress. Most of the SMAs appreciated the communication and collaboration of the RECs. Some indicated bumpy starts in figuring out how to work together, but nearly all were pleased with the progress and now view RECs as essential partners in helping providers adopt and meaningful use CEHRTs.

Collaboration with the state-designated Health Information Exchange (HIE) entities or other state departments had mixed results. In a couple of states, SMAs expressed frustrations due to little to no involvement with or knowledge of the statewide HIE plans, despite efforts to make connections. Some thought that was due to negative perception about Medicaid and concern that, due to its size, Medicaid would "try to take over and control everything." Other SMAs expressed concern that the State HIT Coordinator appeared to "bring Medicaid to the table only when they were talking about how to fund what others had decided." In another state, they were concerned about how to "get Public Health to respond to Medicaid's inquires about the workflow notification for the Immunization Registry."<sup>9</sup> In these cases, SMAs indicated they would appreciate the opportunity to learn about successful engagement strategies from other states through Communities of Practice or other interactive forums, and even suggested involving these other entities at some point in the future.

## **E. New Initiatives on Horizon**

We asked program leaders how their states are aligning their Medicaid EHR Incentive program with quality initiatives in the ACA. All program leaders said that the states see tremendous opportunities and potential in aligning the EHR Incentives with other ACA quality programs. All reported that the Medicaid and Medical Directors were discussing these issues and would make these decisions. Only one individual shared that his state was considering working with a consulting firm to define plans for quality and financial gains. None of the EHR Incentive program leaders indicated that they were involved or consulted in these conversations, and none had received any details or directions on how this alignment might occur.

When asked about plans for Medicaid technology services or solutions, two states indicated they are pursuing Medicaid Management Information System (MMIS) changes to capture meaningful use attestations. One SMA suggested that as the states move forward they might develop plans to build

---

<sup>9</sup> For more information on EHRs and immunization registries, see "HITECH, Meaningful Use, and Public Health: Funding Opportunities for State Immunization Registries," available at <http://www.medicaidhitechta.org/Portals/0/Users/011/11/11/ImmunRegWhitePaper.pdf>. To obtain a login as a state Medicaid agency staff member, email CMS.MeT.CoP@briljent.com.

the state-level health information organization (HIO) as the state-level hub for the six different health information exchanges across the states. However, none of the SMAs knew who was responsible for key decisions, planning, and implementation for program alignment, enterprise architecture and technology integration plans.

## **VI. Conclusion**

The purpose of this paper was to identify key learning experiences and processes in the startup of the Medicaid EHR Incentive program. Communication, education and collaboration remain key themes at this stage of implementation. While the need for education and technical assistance continues, it appears that these efforts can be most effective if they are tailored or customized for staff at different stages of implementation. In addition, SMAs described more collaboration with entities outside of the Medicaid program, such as providers, providers associations and RECs, than within the Medicaid program where duties and decisions are divided by function or tier.

Change management continues to challenge many states. States recognized and appreciated the efforts of CMS and their contractors to provide timely training and technical assistance, as well as their being accessible and responsive to state questions. However, states were frustrated when they had implemented parts of the program based on the best information available at the time and had to change already implemented processes based on new or recently learned interpretations of the final rule. Most states understood this is a reality of startup programs but all wanted to avoid this to the maximum extent possible. Some suggested CMS consider ways to streamline the program in future rules.

Finally, based on SMA comments, it appears that there are opportunities to work with states on innovative approaches to align the Medicaid EHR Incentive program and quality initiatives authorized by ACA. Specifically, states may benefit from education about these programs that bring staffs together from differing functional areas within the Medicaid program and from collaborative forums or workgroups focused on assessing and measuring progress toward meaningful use. In addition, it may be beneficial for states to share enterprise architecture plans that help to map and translate business priorities into technology solutions.

SMAs have made significant progress in planning, launching and implementing their Medicaid EHR Incentive programs. The disbursement of incentives and standardization of data collection are key early milestones in this path to learning what works in these early phases of implementation, which is critical to accelerating progress toward the triple aim – better health, better health care, and reducing per capita costs.

## VII. Special Thanks

We would to offer a special thank you for the leaders of the SMA Medicaid EHR Incentive programs listed below who took time out of their busy implementation schedule to share their insights with us:

**Janice Miles**, *Associate Director Meaningful Use HIT*  
**Jacques Barber**, *Consultant*  
**Alabama** Medicaid Agency  
October 17, 2011

**Raul Ramirez**, *Chief Office of HIT*  
**California** Department of Health Care Services  
November 16, 2011

**Jason Werner**, *Analyst*  
**Michigan** Department of Community Health  
October 10, 2011

**Diana Jones**, *Director of Clinical Services*  
**Missouri** HealthNet Division  
October 26, 2011

**Kathleen Costello**, *Interim Medicaid/CHIP HIT Director*  
**Texas** Health & Human Services Commission  
November 2, 2011

**Charlene Frail-McGreever**, *EHR Incentive Manager*  
**Utah** Department of Health  
October 24, 2001