1. **use of MES to fund hie services**

**Background**

We are recommending that DHCS use MES to fund the HIO infrastructure component of our budget request. The state share would be $51 million (of the total $95 million general fund requested) for 2022-23. You requested additional information on how other states are using MES to fund HIE services.

[State Medicaid Director Letter (SMDL) #22-001](https://www.medicaid.gov/federal-policy-guidance/downloads/smd22001.pdf) “establishes a MES certification process for each modular component system of the MES…the MES represents a system composed of the sum total of MES modules, which are the discrete Medicaid IT systems or services used by the Medicaid agency to manage, monitor, and administer the state’s Medicaid program. The MES modules that support a state’s Medicaid operations…**include Health Information Exchange (including patient identification, data standards and security).**”

The SMDL also reiterates that each state’s streamlined modular certification for MES must include the following elements:

* **Outcomes** describe the measurable improvements to a state’s Medicaid program that should result from the delivery of a new module or enhancement to an existing module. Outcomes should support Medicaid program priorities.
* **Metrics** provide evidence about whether the intended outcomes are achieved through the delivery of a new module or enhancement to an existing module. States must submit operational reports to CMS containing metrics annually

“**State-specific outcomes** reflect the unique circumstances or characteristics of the state or territory and its Medicaid program and focuses on improvements to the program not specifically addressed by the CMS-required outcomes…Additionally, state-specific outcomes may reflect the unique circumstances or characteristics of the state or territory and its Medicaid program.”

CMS maintains an [MES Certification Repository](https://cmsgov.github.io/CMCS-DSG-DSS-Certification/) and within that resource, a subpage devoted to the [Health Information Exchange MES business area/module](https://cmsgov.github.io/CMCS-DSG-DSS-Certification/Outcomes%20and%20Metrics/Health%20Information%20Exchange%20%28HIE%29/). Because there are “no CMS-Required outcomes for HIE, **for an HIE system to be certified states will need to create or reuse State-Specific Outcomes which target state-specific problems and derive Medicaid program benefits**.” The purpose of CMS’ repository is to “collect and share the best examples” of state-specific outcomes statements for the HIE module.

**State examples**

Per that repository, the two HIE “modules” most often certified by states are:

* **Longitudinal Patient Records** – The HIE aggregates data from many sources to produce unified patient health histories, made available on a portal and sometimes through bulk data feeds
* **Event Notifications** – The HIE integrates hospital admit, discharge and transfer data, attributes the data to patient panels and pushes out hospital encounter alerts to PCPs, MCOs and other recipients

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| **HIE Module** | **States that have certified this type of module**  | **Sample outcome metrics** |
| Longitudinal Patient Records | Alabama, Kentucky, North Dakota, Rhode Island, Wyoming | Number of Medicaid patients with longitudinal records in the HIE systemThe number of ADTs, labs, radiology reports and transcribed notes submitted to the HIE system |
| Event Notifications | Alabama, Arkansas, DC, Kentucky, Maryland, Oregon, Rhode Island, Wyoming | Monthly count of ADT messages sent by HIE event notification system for Medicaid members  |

Rather than certifying multiple services and components, many states certify one or two overarching HIE modules, bundling the needed infrastructure components (building and maintaining inbound and outbound data feeds, clinical data repository and data warehouse, patient matching, portal, cleaning and de-duplicating data, data storage, security) into this overall service.

Overall, the two most common HIE modules are well aligned with Medi-Cal needs for Cal-AIM, quality improvement and population health management and with the capabilities of our state’s HIOs.

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| **HIE Module** | **Needed for this Medi-Cal priority/function** |
| Longitudinal patient records | * Clinical data needed for population health management (to calculate risk scores and identify gaps in care)
* Unified health records to support care coordination and transitional care services
* Clinical data needed for quality improvement and reporting
* Demographic data including race and ethnicity, contact information and preferred language needed to address equity gaps
 |
| Event notifications | * ADT data needed for population health management
* Event notifications to support transitional care services, readmission reduction and administrative functions such as prior authorization
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After funding is approved in the Final Budget, DHCS will need to develop a plan for:

1. Which HIE modules will be submitted for MES funding?
2. What will be the associated outcomes and metrics?
3. What new HIE capabilities will be developed under design and development (90% match) vs implementation?
4. How should DHCS approach funding multiple HIOs?
5. **PROVIDER COUNTS FOR PROVIDER DATA SHARING PERFORMANCE PAYMENTS**

Our budget proposal includes $44 million general fund for 2022-23 for data sharing performance payments to PCPs and hospitals (through directed payments). You asked for additional information on provider counts.

The table below shows the provider counts we used to calculate this amount.

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| --- | --- | --- | --- | --- | --- |
| **Type of Entity** | **Number** | **Projected Participation Rate** | **Payment Per Entity** | **Total Annual Budget** | **State Share (general fund)** |
| Hospitals | 350 | 80% | $100,000 | $28 million | $14 million |
| PCP Practices  | 5,000 | 80% | $15,000 | $60 million | $30 million |

Here is more detail on assumptions:

* Each individual hospital (not system) or PCP “practice” (not individual clinician) would be paid the amount if it meets the data sharing requirements. Paying per “EHR interface” might spark concern since it looks like a “provider onboarding” payment, which CMS is no longer supporting. PCP “practices” would include FQHCs.
* We used 350 as the number of Medi-Cal hospitals.
* We used 5,000 as the number of Medi-Cal PCP practices. We extrapolated this number from two different estimates.

Based on Medi-Cal plan counts

* + - One of our participating Medi-Cal plans has a rate of .077 individual PCP clinicians per member
		- We used an estimate of 14.3 million Medi-Cal enrollees in California
		- This produces a total estimate of 10,214 Medi-Cal PCP clinicians in California
		- We estimate there are 2 PCPs per practice
		- Producing a final estimate of 5,107 Medi-Cal PCP practices
	+ Based on [CHCF statistics](https://www.chcf.org/wp-content/uploads/2021/03/PhysiciansAlmanac2021.pdf)
		- Total practicing primary care doctors in California = 22,007
		- Percent of PCPs taking Medi-Cal = 62%
		- Total number of Medi-Cal primary care doctors = 13,644
		- Assume 70 percent of these are assigned by plans as PCPs = 9,551
		- We estimate there are 2 PCPs per practice
		- Producing a final estimate of 4,775 Medi-Cal PCP practices
* We projected that 80% of hospitals would meet the requirements of and receive performance payments. This is lower than the share of hospitals receiving performance payments in the Inland Empire—where all hospitals but Kaiser participate in the IEHP incentive payment for data sharing—but that level took several years to achieve and the IEHP per-hospital payments are higher.
* We used the same estimated participation rate for PCPs.

We did not cost out additional provider types such as SNFs and specialists. The model could easily be applied to additional provider types, which of course would result in a higher budget. We recommend initially limiting the program to PCPs and hospitals for the following reasons:

* Hospital and primary care data are most critical from a care coordination, gap in care and quality reporting perspective.
* It’s a good idea to test this model for a year or two before expanding it.
* Given the dispersion and infrequency of specialty care, the cost/benefit for including specialists may not be as great as for primary care providers.
* Many skilled nursing facilities do not use electronic health records so would not be able to participate in electronic data sharing.