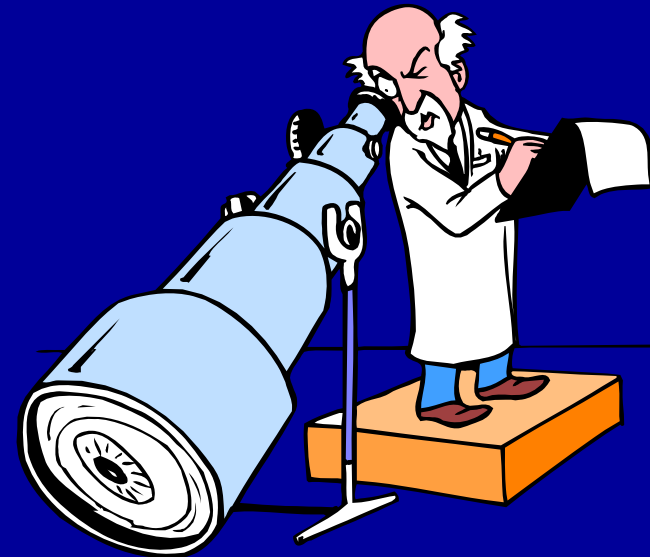


Improving Data Interoperability: Opportunities for States

*MITA: Medicaid Information
Technology Architecture
and Mental Health*



*Rick Friedman
Director, Division of State Systems
Centers for Medicare & Medicaid Services
U.S. Dept. of Health & Human Services*

Medicaid Background

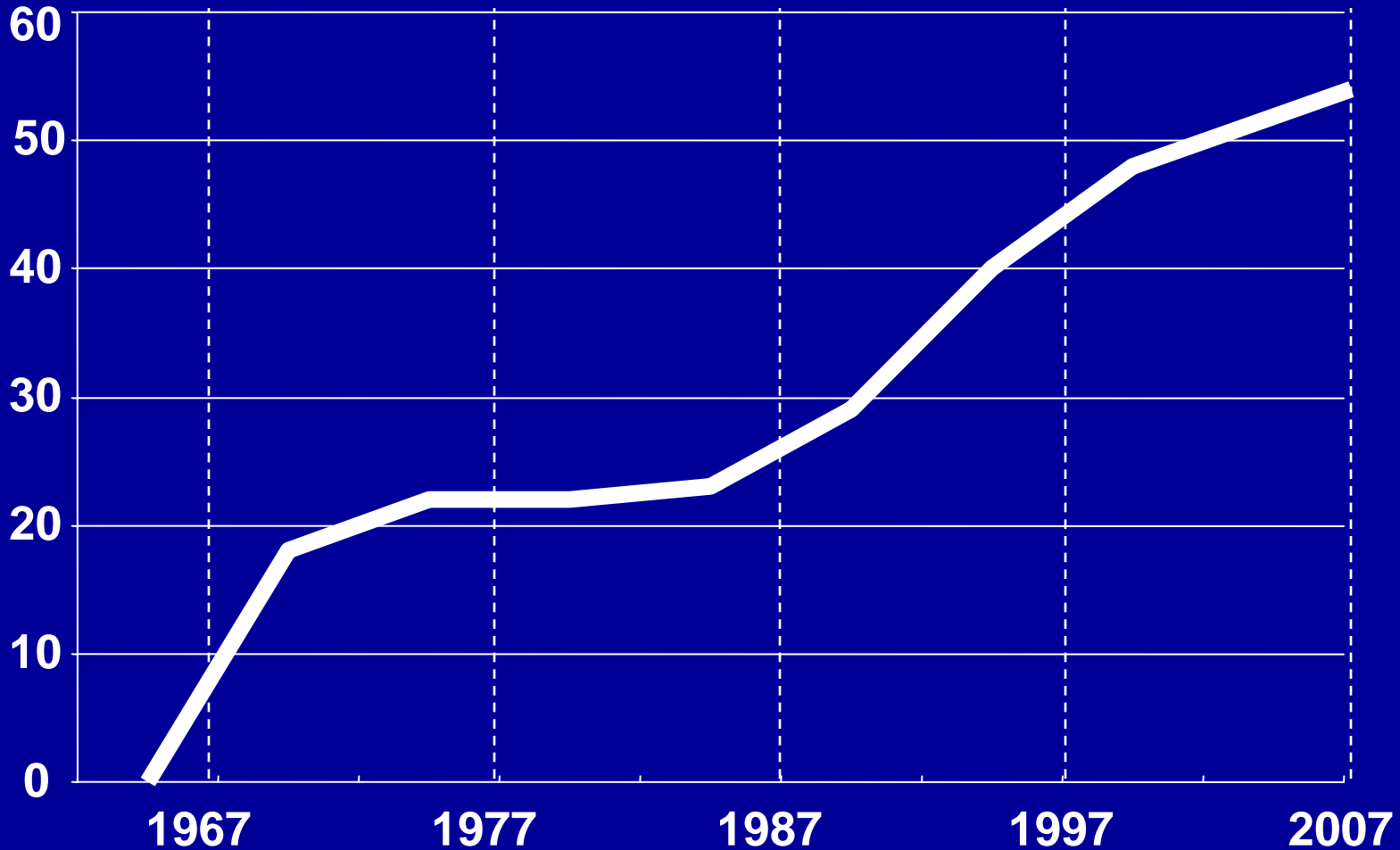
Medicaid Today

	<u>People</u>	<u>Money</u>
U.S. Totals	294 million	\$1.54 trillion
Medicaid	52 million <i>(covers 1 out of every 6 Americans)</i>	\$305 billion <i>(1 out of every 5 health care dollars spent on Medicaid)</i>
Medicare	42 million	\$ 297 billion

National Growth in Medicaid

Beneficiaries 1965 to 2007

*Millions of
Medicaid
Beneficiaries*



Growth in Medicaid Program's Complexity

- Waivers
- HIPAA—Privacy, NPI, etc.
- Focus on Quality
- Rising Concerns re Privacy and Security
- Duals
- Medicare Part D

Medicaid's Data Needs Are Evolving

NEW SYSTEMS
Design & Implement

HEALTH CARE DELIVERY
Improve Quality & Efficiency

HEALTH CARE OUTCOMES
Improve Beneficiary & Population

Medicaid's Data Systems Have Not Kept Pace

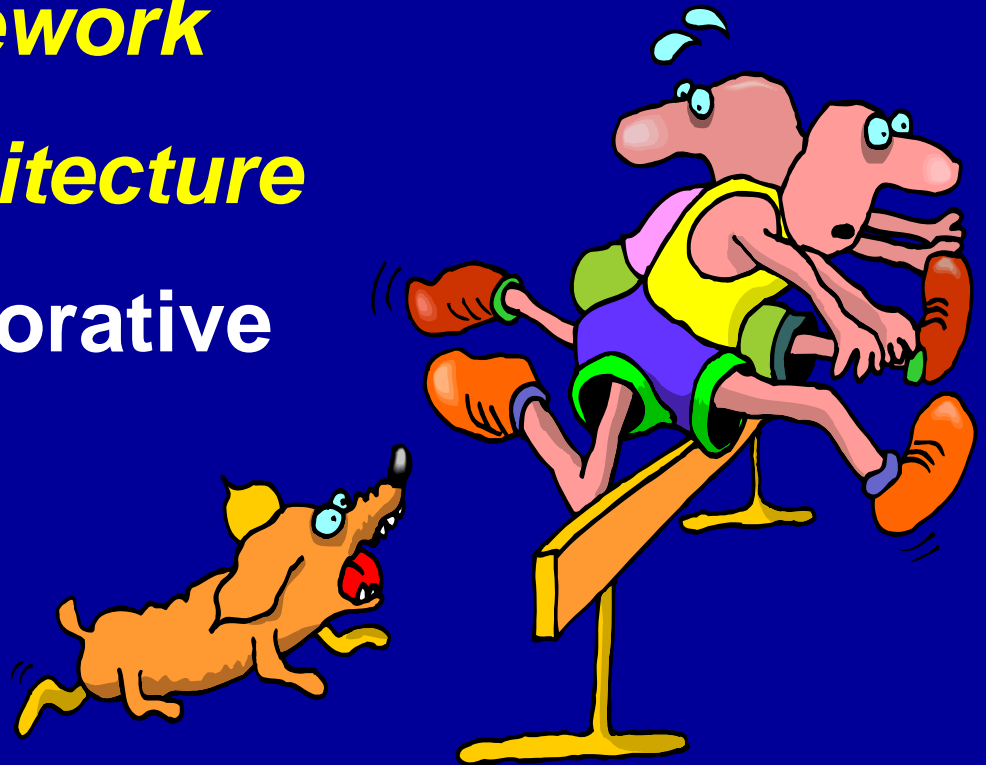
- Program began in the late 1960's
- Medicaid Management Information System (MMIS) was designed in the early 1970's
- The focus of the MMIS has been on claims, specifically claims payment for the last 35 years
 - *Accuracy*
 - *Timeliness*
- Many new MMIS enhancements but focus has remained on inputs (claims) rather than outputs (improved outcomes)

Enter MITA...

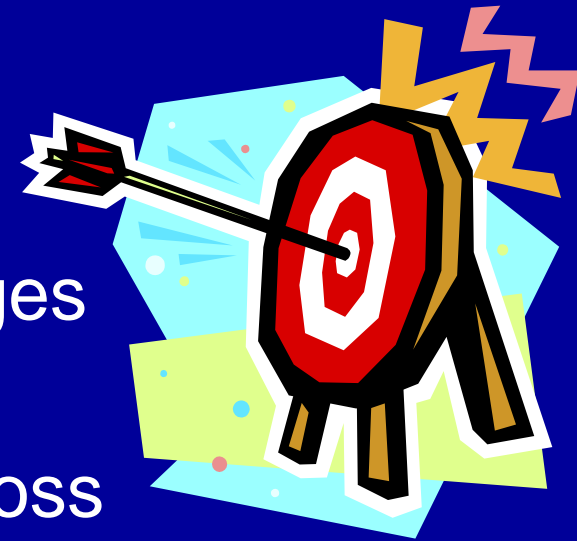


What is MITA?

- MITA is an **Approach** to transform Medicaid
- MITA is a **Framework**
- MITA is an **Architecture**
- MITA is a collaborative **Process**



MITA Goals



- Free but protected data exchanges among partners
- Blueprint for inter-operability across Medicaid enterprise and new data exchange partners
- Access to multiple data bases without rebuilding the data sources
- Meet state/CMS goals of client-centric, outcome- oriented BUT without dictating structural changes to the individual states

What Are Some of MITA's Characteristics?

- Web-based
- Patient-centric, interoperable systems
- Based on industry IT and data standards
- Enterprise-oriented, rather than a limited, organization-centric focus
- Data shared across boundaries
- Provides basis for HIT/E -- EHR, eRx, PHR, among other things



MITA's Components

- **Business Architecture**
 - Operations Concept
 - MITA Maturity Model
 - Business Process Model
 - Business Capability Matrix
 - MITA Self-Assessment
 - MITA Business Services
- **Information/Data Architecture**
- **Technical Architecture**
 - MITA Application Architecture
 - MITA Data Architecture
 - Technology Architecture
 - Technical Capability Matrix
 - MITA Standards

Evolutionary Pathway

MITA Maturity Model

MITA MATURITY MODEL DESCRIPTION

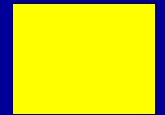
General Description	Level 1	Level 2	Level 3	Level 4	Level 5
High Level Description	<p>Meet compliance thresholds dictated by State/Federal regulations.</p> <p>Accurate enrollment of program eligibles; timely and accurate payment of claims for appropriate services.</p>	<p>Focus on cost management, improving quality and access to care within structures designed to manage costs, e.g., managed care, catastrophic care management, disease management.</p>	<p>Coordination with other agencies in adopting national stds, developing shared business services to improve cost effectiveness of HC service delivery.</p> <p>Promotes use of intra-state data exchanges.</p>	<p>Widespread and secure access to clinical data; improve HC outcomes, empower beneficiary and provider stakeholders, measure quantitative objectives, and focus on program improvement.</p>	<p>National (and international) interoperability allows the Medicaid enterprise to focus on fine tuning and optimizing program management, planning, and evaluation.</p>

PURPOSE OF THE SS-A

- Provides a structured method for documenting and analyzing a State's current Medicaid business enterprise
- Aligns States' Medicaid business areas to MITA's business areas & sub-areas
- Enables the State to use defined levels of business maturity to help shape the future vision of their Medicaid Enterprise
- Provides the foundation for a gap analysis that will support the State's transition planning
- Focuses the APD to reflect the States current project funding request and what is achievable

State Self Assessment IT Profile Example

<i>Business Area</i>	Business Process	1	2	3	4	5
<i>Member Management</i>	Enroll Member	As Is	To Be	As Is	As Is	As Is
<i>Provider Management</i>	Enroll Provider	As Is	As Is	As Is	As Is	As Is
<i>Contractor Management</i>	Manage Contract Information	As Is	As Is	To Be	As Is	As Is
<i>Operations Management</i>	Edit/Claim Encounter	As Is	As Is	To Be	As Is	As Is
<i>Program Management</i>	Maintain Benefit / Reference Info	As Is	As Is	To Be	As Is	As Is
<i>Care Management</i>	Establish Case	As Is	As Is	As Is	To Be	As Is
<i>Program Integrity</i>	Identify Case	As Is	As Is	To Be	As Is	As Is
<i>Relationship Management</i>	Manage Business Relationship	As Is	To Be	As Is	As Is	As Is

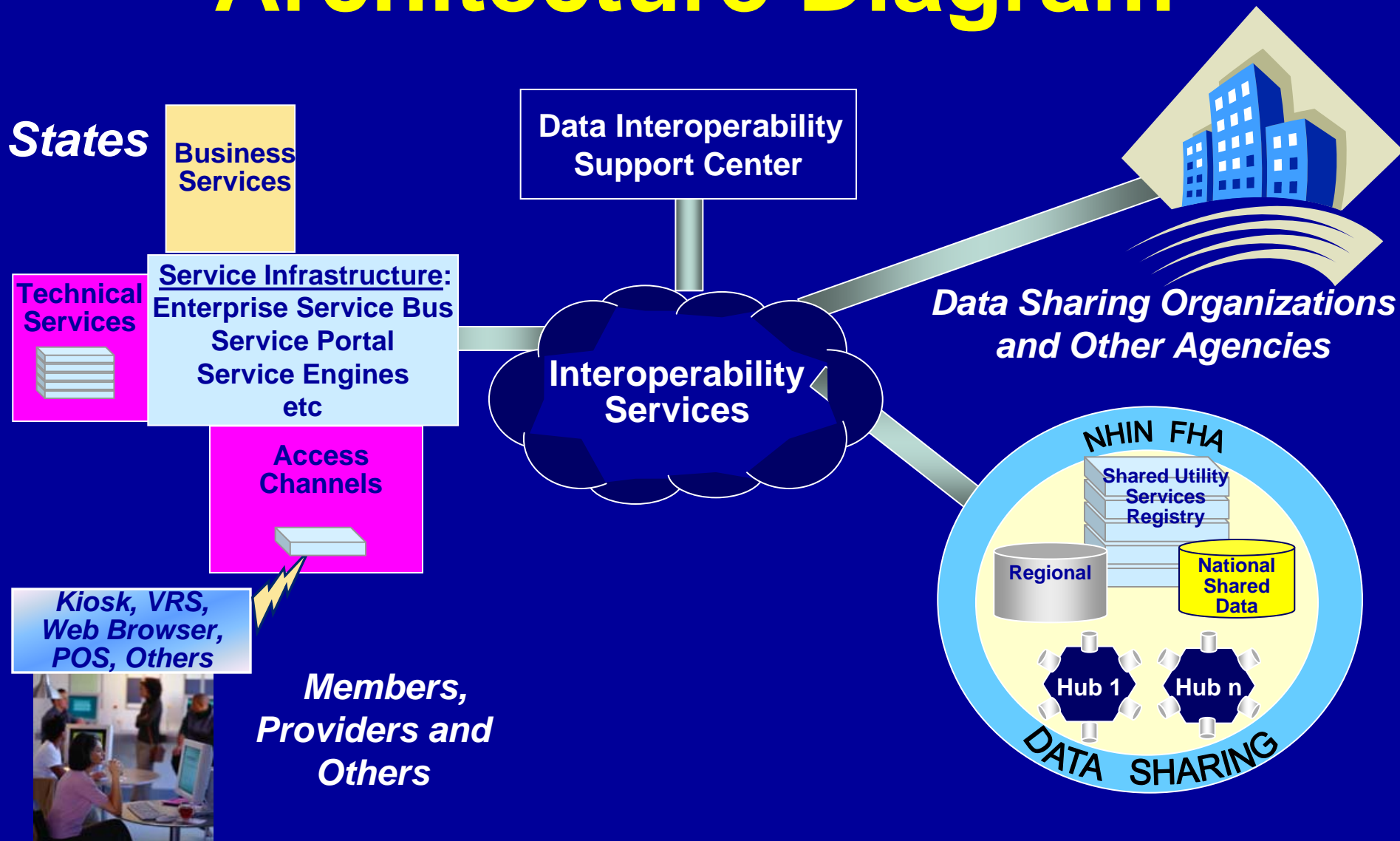


“As Is”

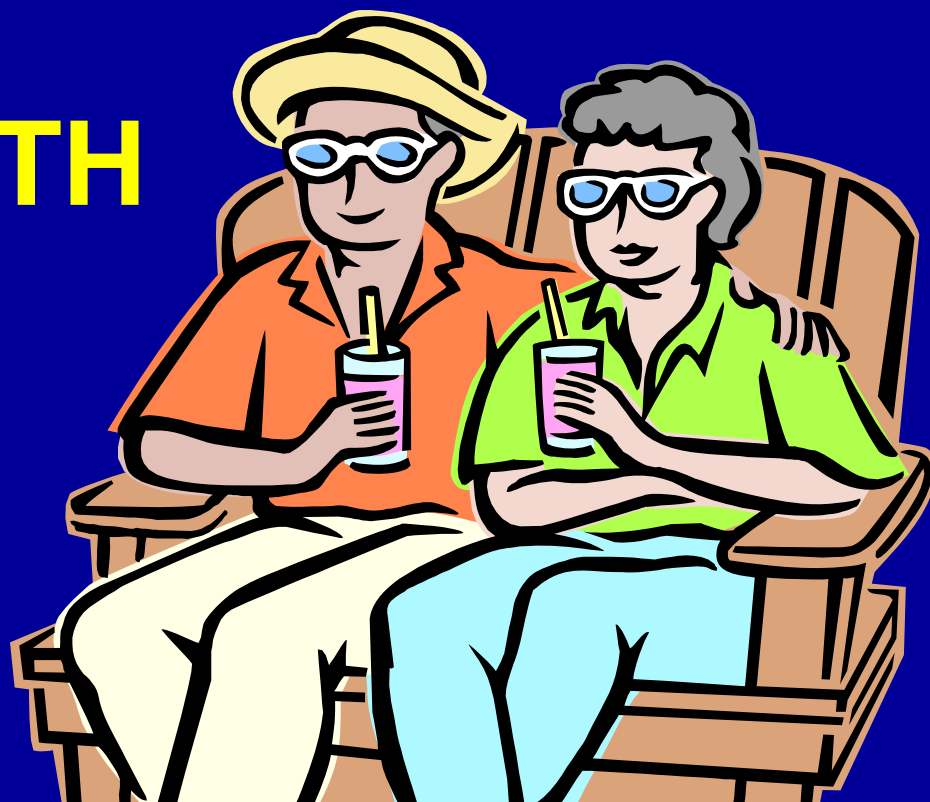


“To Be”

Conceptual Technical Architecture Diagram



**Opportunities
for Data Interoperability
between
MENTAL HEALTH
and
MEDICAID**



Our Perspective on Data

- Improved *data quality* and *interoperability* are critical to improving program performance.
- The value of data is realized only to the extent it can be *shared* with others.
- Because *system interoperability* is key to facilitating such exchanges, CMS is willing to invest in systems that support enterprise-wide IT initiatives



Why Work Together?

- Medicaid needs data from MH agencies that serve Medicaid clients to meet both of our programs' goals:
 - Improve program performance
 - Improve outreach and training opportunities with caseworkers, providers, and clients
 - Reduce costs
- ...and most importantly:
 - Contribute to a better life for our clients

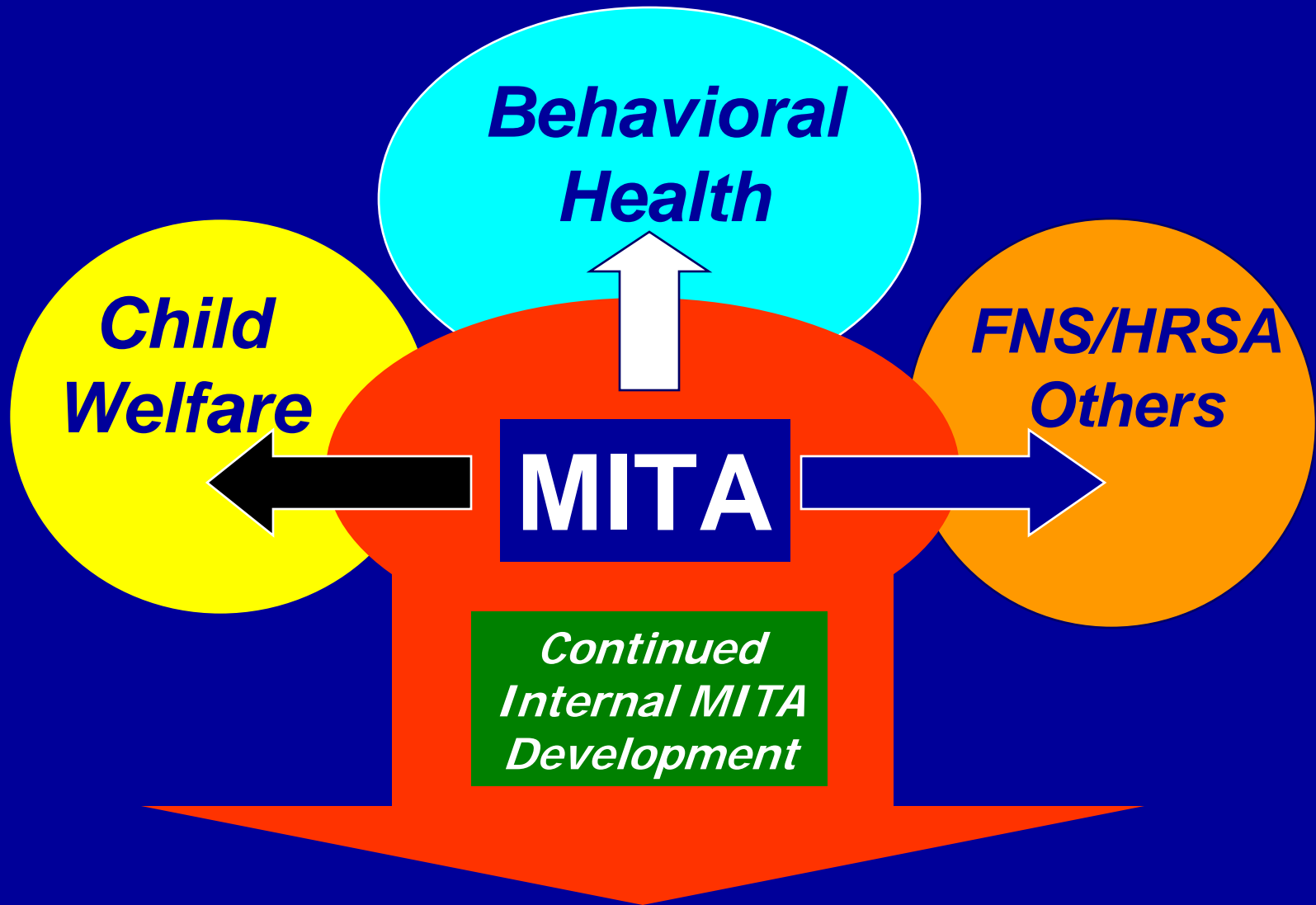


Medicaid and Behavioral Health Face Common IT and Data Challenges

- Incompatible systems, data, cultures
- Change requires time, money, leadership and institutional knowledge...all of which are in very short supply
- Paradigm shift will require an accountability horizon longer than the next quarter, this fiscal year, or the life span of the next Administration
- Legal safeguards re data exchanges



Expansions of MITA Initiative Vertical and Lateral



SAMHSA / CMS IT Contract

FY 2007-2008

1. CMS working with SAMHSA to create their BH version of MITA
2. Currently documenting Current BH “As-Is” Landscape
3. BH Concept of Operations
4. BH Maturity Model
5. High level MITA/BH Business Process and Data Models
6. Pilot Behavioral Health State Self-Assessment



**How Can
Medicaid IT
Dollars Support
Mental Health
Systems?**

Step 1: Obtain Federal Prior Approval

- **Utilize Planning APDs to communicate your intentions prior to incurring costs for which you anticipate receiving Federal \$**
- **P-APD = Plan for Planning**
- **P-APD requirements described in 45 CFR, Subpart F**
- **Rely on State MMIS staff and CMS Regional Office systems staff to help**

Step 2: Allocate Costs to All Benefiting Parties

- Medicaid FFP can only be used to support IT services for people eligible for Medicaid
- Cost allocation principles are described at:

http://www.acf.hhs.gov/programs/cse/stsys/ref/CAM_Handbook.doc

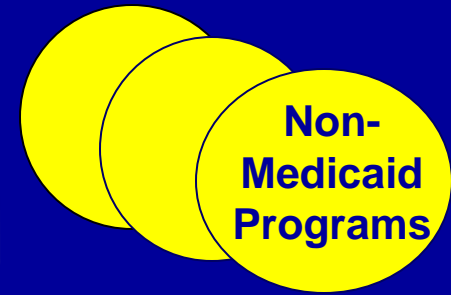
Step 3: Assign Appropriate FFP Rates

- Most Medicaid-IT related administrative costs are matched at 50% FFP
- MMIS rates are carefully scrutinized by the CMS Regional Offices; i.e., 75% FFP for operations, 90% for DDI
- MMIS rates can ONLY be applied to enhancements to the state-wide MMIS as defined in Part 11 of the State Medicaid Manual (SMM)

Step 4: Role of State Medicaid Office

- CMS looks to the State's Medicaid Director (SMD) as our primary customer
- If you want to receive Medicaid FFP, make sure your SMD understands and supports your data sharing project(s)
- MMIS FFP is not available for pilots, demonstrations, provider-based IT activities or less than fully-state-wide IT activities

Four Examples of How This Could Work



1. Medicaid Agency and Non-Medicaid Agency Both Build Their Own Data Warehouses
2. Medicaid Agency Builds DW and Allows Others to Store, Analyze and Retrieve Data from It
3. Shared DW Built Outside Both Medicaid and Non-Medicaid State Agencies and Jointly Governed
4. Shared DW Built Outside Medicaid and Non-Medicaid State Agencies and Governed by Medicaid

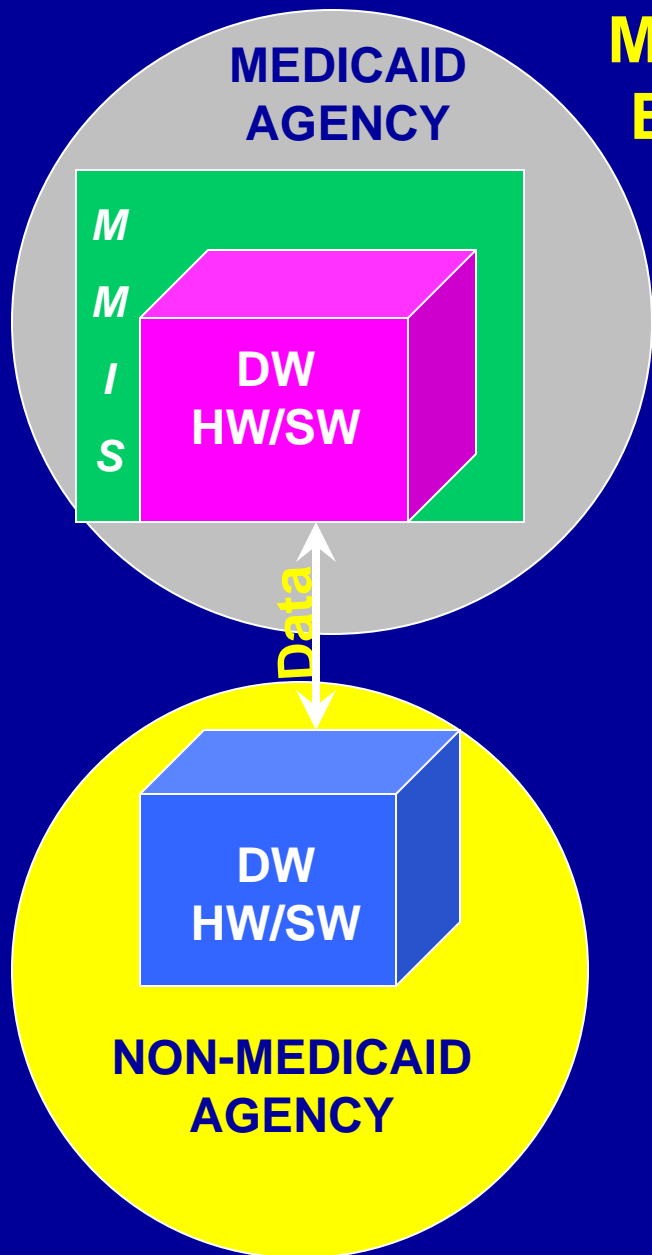
Example 1: Medicaid Agency and Non-Medicaid Agency Both Build Their Own E-Health Hardware/Software Facilities

ACTIONS:

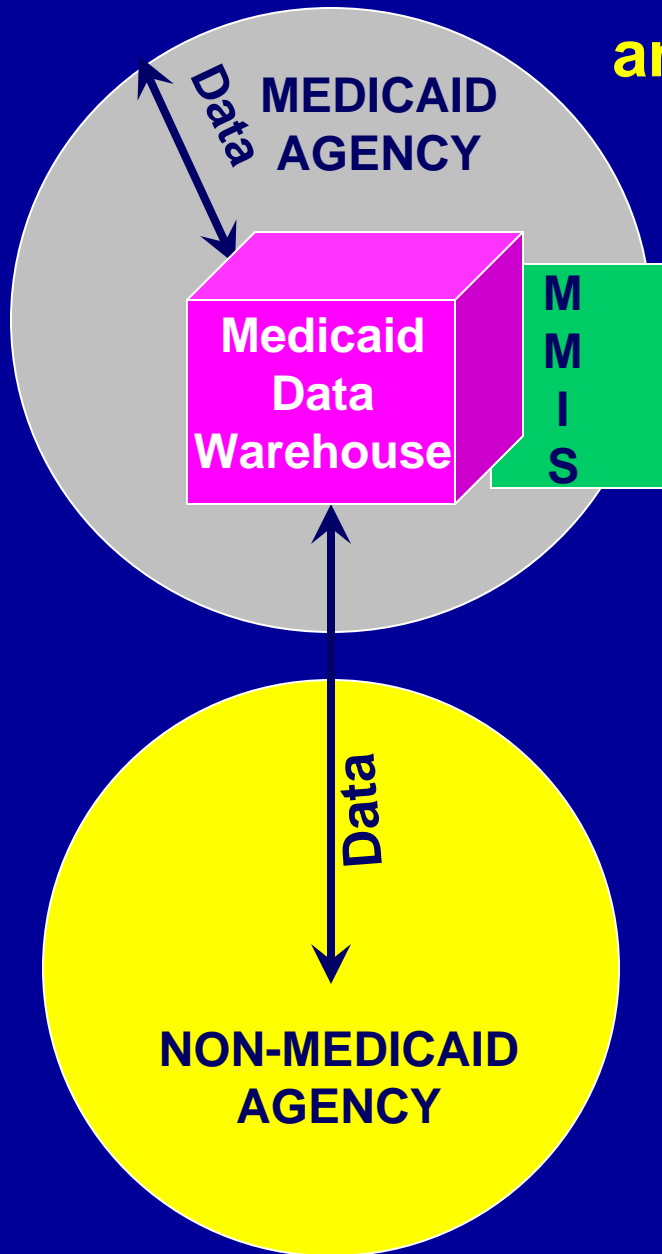
1. Medicaid Agency builds a data warehouse (DW) as a part of its MMIS.
2. Non-Medicaid agency builds its own DW
3. Both parties agree to build an electronic bridge linking both DWs

CURRENT FFP AVAILABILITY:

1. Medicaid Agency receives 90% FFP to build the DW, and 75% FFP to operate it
2. Non-Medicaid Agency uses own funds to build and operate DW
3. Jointly built electronic bridge paid for by both parties in proportion to projected use, etc. per Federal CAP Principles. Medicaid receives enhanced 90/75 FFP rates for its share of costs.



Example 2: Medicaid Agency Builds DW and Allows Others to Store, Analyze and Retrieve Data from It



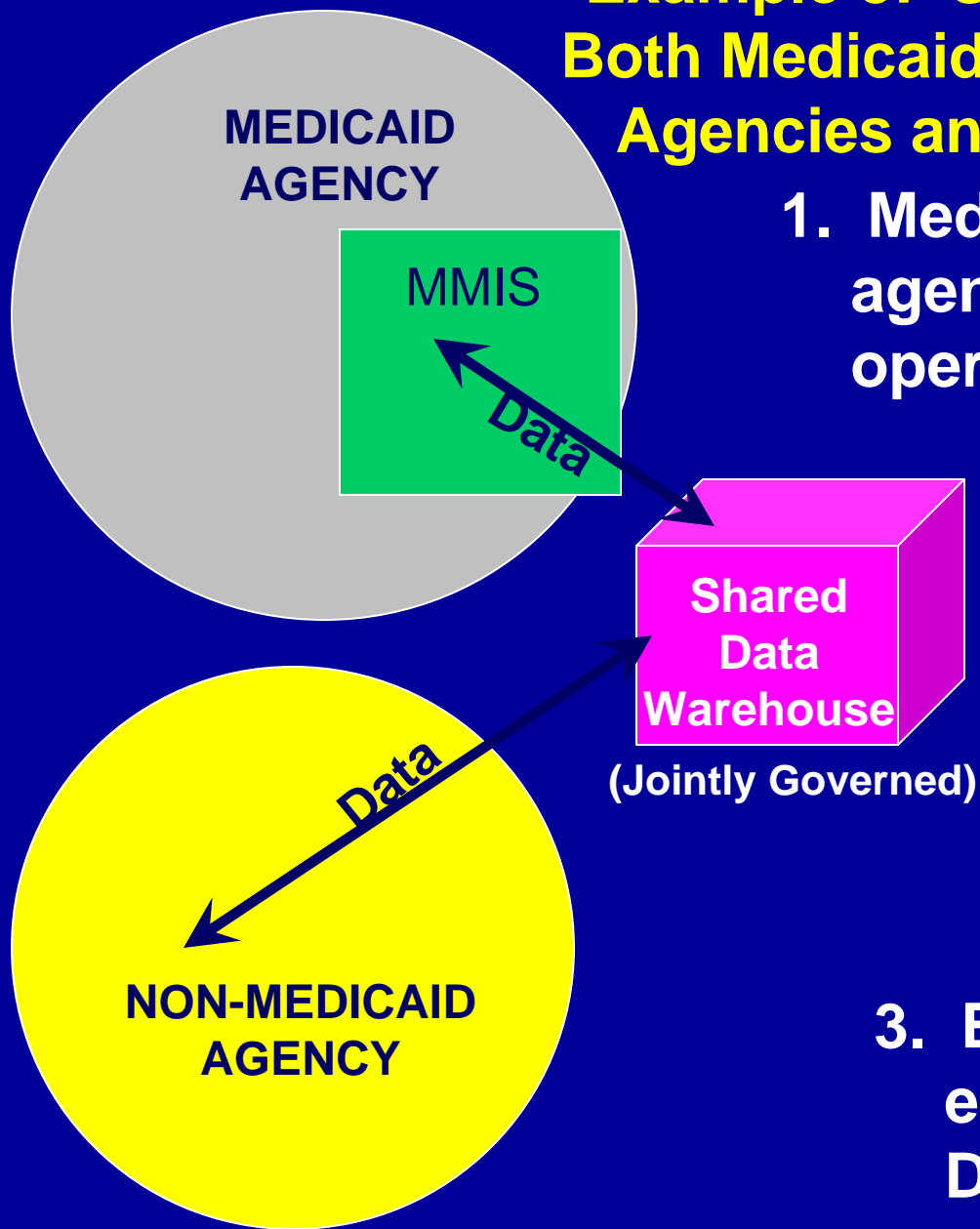
Actions:

1. Medicaid Agency builds a Medicaid data warehouse (DW) inside its MMIS.
2. Non-Medicaid agency builds electronic bridge to Medicaid DW/DSS and uses Medicaid DW as a repository for its data

Current FFP Rules:

1. Medicaid Agency receives 90% FFP to build DW + its share of electronic bridge and 75% FFP to operate both. Non-MA jointly builds and pays for its share of the electronic bridge to the Medicaid DW/DSS
2. Non-Medicaid pays for storage and operational costs associated with accessing its data for its own purposes on an allocated basis

Example 3: Shared DW Built Outside Both Medicaid and Non-Medicaid State Agencies and Jointly Administered



1. Medicaid Agency and another agency agree to build and operate a DW together.

2. Governance is a shared responsibility among participating agencies.

3. Both agencies build electronic pathways to the DW for sending and receiving data

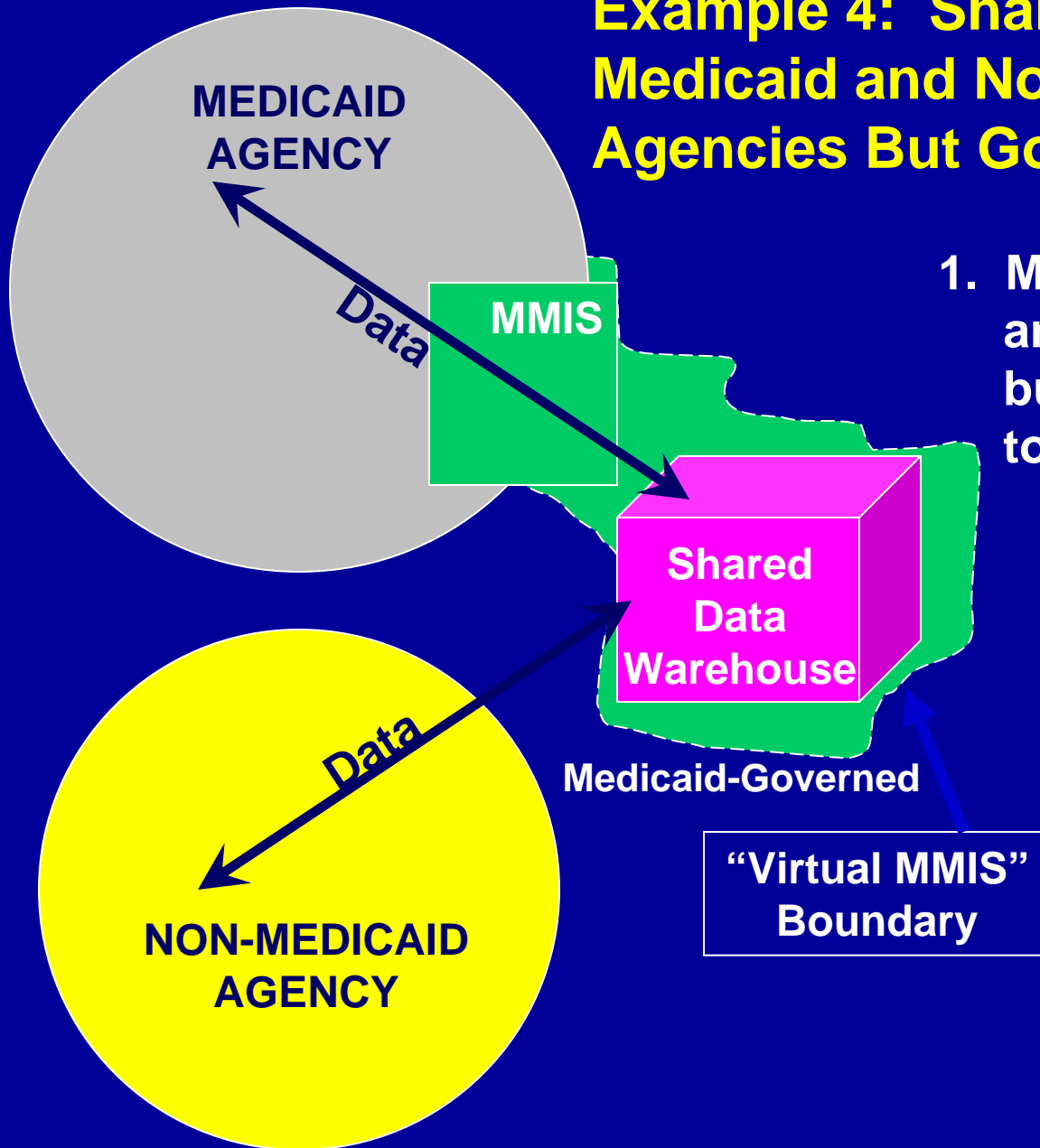


Example 3: Shared DW Built Outside Both Medicaid and Non-Medicaid State Agencies and Jointly Administered

All costs are allocated among benefiting programs based on CAP (Cost Allocation Principles – OMB Circular A-87)

**Medicaid Agency receives 50% FFP for its share of development and operating costs; other agency pays its share.
Medicaid electronic link eligible for 90/75 FFP**

Example 4: Shared DW Built Outside Medicaid and Non-Medicaid State Agencies But Governed by Medicaid



1. Medicaid Agency and another agency agree to build and operate a DW together.

2. Governance is controlled by Medicaid agency.

3. Both agencies build electronic pathways to the DW for sending and receiving data



Example 4: Shared DW Built Outside Medicaid and Non-Medicaid State Agencies But Governed by Medicaid

All costs are allocated among benefiting programs based on CAP Principles

Medicaid Agency receives 90% FFP for its share of development and 75% operating costs of DW because it is considered part of the “virtual MMIS”; other agency pays its share.

Interoperability Between Medicaid and Behavioral Health Systems



2 Examples

Example 1: Texas Electronic Health Passport for Children

- Medicaid Transformation Grant (\$ 4M for 2 yr. period) + 3 additional yrs with MMITA funding support
- 5 State agencies administer an array of programs:
 - Medicaid
 - Women, Infants and Children
 - Newborn /Children Health Screening
 - Adult and Child Protective Services
 - Food Stamps
 - Epidemiology
 - SCHIP
- Data currently resides in different organizational silos that are neither linked nor integrated
- Texas is building an enterprise data warehouse consistent with MITA

Example 2: Out of-State Placement in Therapeutic Foster Care or Special Behavioral Health Programs/Facilities

- Such children typically get complete physicals all over again in a new State because that State doesn't have the data
- Easy access to claims data would eliminate the need for getting a completely new baseline, thereby saving time and money
- Information about pharmaceutical use (for reactions and history) is critical for medication management --without it you don't know if they are on a brand name because the generic didn't work or a generic wasn't tried.

Conclusion



*If you want to travel fast,
travel alone.*

*If you want to travel far,
travel together.*



Wangari Maathai
Nobel Peace Prize Laureate 2004

East African Proverb