DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
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SMD # 18-006

RE: Leveraging Medicaid Technology to Address the Opioid Crisis

June 11, 2018

Dear State Medicaid Director:

On November 1, 2017, the President's Commission on Combating Drug Addiction and the Opioid Crisis released its final report[1] with specific health information technology references. This report, as well as the October 26, 2017 announcement[2] of the Acting Secretary of Health and Human Services' declaration of a nationwide public health emergency[3] to address the opioid crisis, singles out telemedicine and prescription monitoring tools as useful in the effort to combat the opioid crisis. Also, the Department of Health and Human Services' 5-Point Strategy to Combat the Opioid Crisis[4] emphasizes the importance of improving access to prevention, treatment, and recovery services, including the full range of medication-assisted treatments, and strengthening our understanding of the crisis through better public health data and reporting. All applicable federal and state regulations relevant to information sharing, patient privacy, or consent requirements must be carefully considered in developing such technologies.

This State Medicaid Director letter (SMD) provides guidance to the States on which funding authorities might support these health information technology efforts, with an emphasis on leveraging existing authority contained in the final rule entitled "Mechanized Claims Processing and Information Retrieval Systems (90/10)"[5] and in the Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009 (Pub. L. 111-5). In the case of systems supporting Medicaid Information Technology Architecture (MITA) business processes two concurrent match rates may be available for states to utlize; a 90 percent enhanced funding to design, develop and implement systems might be available with a 75 percent enhanced match available for the

[1] The President's Commission on Combating Drug Addiction and the Opioid Crisis, final report, November 1, 2017: https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Meeting%20Draft%20of%20Final%20Report%20-%20November%201%2C%202017.pdf
[2] HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis, October 26, 2017: https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html
[3] https://www.hhs.gov/sites/default/files/opioid%20PHE%20Declaration-no-sig.pdf
[4] https://www.hhs.gov/opioids
[5] 80 FR 75817 (Dec. 4, 2015).

maintenance and operation of such systems. The HITECH Act makes available a 90 percent enhanced funding match for state expenditures on activities to promote health information exchange and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers until 2021, if certain criteria are met, as discussed in SMD 16-003.[6] States should discuss with their CMS contacts as to whether HITECH funding or MITA funding might be more appropriate for the proposed activities, or a combination of both. As described below, there are several ways these enhanced federal funding opportunities for health information technology can be leveraged by states to support their ongoing efforts to address the opioid crisis.

CMS issued a State Medicaid Director letter, "Strategies to Address the Opioid Epidemic" (SMD 17-003)[7] on November 1, 2017, to describe state flexibility in addressing the opioid crisis via demonstration projects under section 1115 of the Social Security Act. There are a number of ways technology might support those efforts, but a state need not be participating in an section 1115 demonstration project to take advantage of the enhanced federal funding opportunities described in this SMD. The enhanced federal match for MITA and the HITECH Act applies to all states and territories irrespective of participation in a section 1115 demonstration project.

Prescription Drug Monitoring Programs

The President's Commission is aligned with public health experts[8], the recent SMD letter on "Strategies to Address the Opioid Epidemic"[9], Overdose Prevention in States (OPIS) effort by the Centers for Disease Control and Prevention (CDC), and previous CMS guidance[10] in emphasizing the importance of enhancing prescription drug monitoring programs (PDMPs) to help improve appropriate and safer prescribing of prescription opioid medications, and integrating connections to PDMP data into EHRs to limit provider burden and improve interstate Health Information Exchange (HIE). This integration removes the requirement for providers to log in to a separate system, manage a separate log in, and disrupt their workflow to query the PDMP. Single sign-on interoperability between EHR and PDMP such that PDMP results are displayed when the EHR indicates a controlled substance is prescribed could be supported, as an example. States may consider integrating PDMPs into HIEs, where further integration with pharmacy data, shared care plans, drug utilization review (DUR) programs, Emergency Medical Services (EMS) data, Medication Assisted Therapy (MAT) data, advanced directives, and other EHR data might assist clinical decision making. Similarly, states may develop or leverage

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[6] "Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers" (Feb. 29, 2016). https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16003.pdf

[7] https://www.medicaid.gov/federal-policy-guidance/downloads/SMD17003.pdf

[8] "States With Prescription Drug Monitoring Mandates Saw A Reduction In Opioids Prescribed To Medicaid Enrollees," Health Affairs Vol 36, No. 4: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2016.1141

[9] https://www.medicaid.gov/federal-policy-guidance/downloads/SMD17003.pdf

[10] "Centers for Medicare and Medicaid Services (CMS) Opioid Misuse Strategy 2016, =" January 5, 2017: https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/CMS-Opioid-Misuse-Strategy-2016.pdf

technology which might incorporate the CDC's Prescribing Guidelines[11] into workflows, or facilitates the ability of a prescriber to review previous prescriptions. For the purposes of administering the Medicaid EHR Incentive Program under the HITECH Act, a PDMP that declares itself a specialized registry ready to accept data can be considered, per previous guidance,[12] a specialized registry for purposes of the meaningful use requirements under 42 CFR §§ 495.22 and 495.24.

Accordingly, a state can receive enhanced federal funding to build a PDMP or enhance PDMP functionality, as discussed in SMD 16-003. States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of PDMPs and connections to PDMPs so long as the cost controls described in SMD 16-003 are met and so long as these costs help Eligible Providers meet Meaningful Use measures focused on public health reporting and the exchange of public health data described in 42 CFR 495.22 and 495.24. However, Medicaid Management Information System (MMIS) matching funds may be a more appropriate source of federal funding for costs related to developing a PDMP in some cases, and states should not claim 90 percent HITECH match for costs that could otherwise be matched with MMIS matching funds.

In addition to the enhanced federal funding opportunities for PDMP development made available through the Medicaid EHR Incentive Program, a state may also consider developing or enhancing PDMPs in support of the "Manage Registry"[13] business process in MITA, which allows states to support specialized registries that receive an individual's health outcome information, prepare updates for a specific registry (like the PDMP), and supply information in response to inquiries. In the context of MITA, the registry must consolidate related records from multiple sources (e.g., intrastate, interstate, or federal agencies) into one comprehensive data store, which may or may not reside within the state's Medicaid information system. States may wish to enhance PDMPs that do not currently meet MITA requirements to comply with these standards, such as by incorporating industry standards as required under 42 CFR 433.112(b)(12), or by further integrating outside data (such as pharmacy data). To better capture interstate data, states may also consider connecting to multi-state data hubs such as RxCheck developed by the US Bureau of Justice Assistance or the PDMP Interconnect, developed by the National Association of Boards of Pharmacy. Consistent with the recommendations of the President's Commission, integrating pharmacy and other data in PDMPs could help facilitate the provision of non-opioid pharmaceutical treatments for acute and chronic pain management. In considering which industry standards are applicable when integrating PDMPs with EHRs, states should refer to the Interoperability Standards Advisory (ISA) published by the Office of the National Coordinator for Health IT. Specifically, the section describing, "A Prescriber's Ability to Obtain

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[11] https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

[12] FAQ# 13413: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/FAQs.pdf

[13] Guidance regarding MITA 3.0 and the "Manage Registry" business process are contained in .zip files located at https://www.medicaid.gov/medicaid/data-and-systems/mita/mita-30/index.html. See page 26 of the file named, "MITA 3.0 Part 1" for a description of the "Manage Registry" business process. PDMPs may also be relevant to supporting other businesses processes, as well.

a Patient's Medication History from a Prescription Drug Monitoring Program[14]," speaks to the standards for PDMP and EHR integration. States are reminded they are required to adhere to industry standards in designing such interfaces and the states should coordinate with their regional CMS lead or the Office of the National Coordinator for Health IT if they are unsure which standard or standards in the ISA might be appropriate for their efforts. States are also reminded of 42 CFR 433.112(b)(10) which requires the use of open interfaces and exposed application programming interfaces as appropriate.

States are encouraged to minimize provider burden by integrating PDMP data into EHRs, as may be practicable, and to consider complementing PDMPs with provider onboarding and training, as discussed in SMD 16-003; some evidence suggests[15] that a PDMP alone is not as effective as a PDMP deployed in conjunction with thoughtfully designed clinical workflows with the prescriber's participation. States have the opportunity to design programs where the state-supported PDMP practices are developed in conjunction with business process modeling to help minimize provider burden related to implementing new workflows, and to further make investments in systems with appropriate linkages to provider delegates such as case managers or social workers. State law varies with respect to which entities are allowed access to a PDMP, but some states might find value in also connecting law enforcement, licensing and regulatory boards, state medical examiners, and/or research organizations, consistent with applicable federal and state law.

Finally, States should ensure PDMP integration activities supported by Medicaid resources do not duplicate activities funded under CDC, SAMHSA, and DOJ authorities.

Advanced Analytics and Public Health Data

The President's Commission, as well as the strategy described in the October 27, 2017 declaration of a nationwide public health emergency to address the opioid crisis, emphasizes the importance of data-driven approaches to both prevention and treatment of negative opioid outcomes. States are encouraged to consider linking screening data from risk assessment tools such as the Opioid Risk Tool[16] into EHRs and/or HIEs to facilitate targeted case management or to deploy other resources or follow up interventions. Such integration might be incorporated into Certified Electronic Health Record Technology (CEHRT) in a manner consistent with Objective 6, Measure 3[17] of the Stage 3 meaningful use objectives and measures under 42 CFR § 495.24, and thus potentially be supported by a 90 percent federal match, as discussed in SMD 10-016, "Federal Funding for Medicaid HIT Activities" (Aug. 17, 2010).[18]. Also, MITA design, development and implementation at an enhanced 90 percent match, and maintenance and

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[14] https://www.healthit.gov/isa/a-prescribers-ability-obtain-a-patients-medication-history-a-prescription-drug-monitoring-program
[15] State Legal Restrictions and Prescription-Opioid Use among Disabled Adults (Meara, Horwitz, Powell, McClelland, Zhou, O'Malley, Morden, 2016) http://www.nejm.org/doi/full/10.1056/NEJMsa1514387
[16] https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf
[17] https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MedicaidEPStage3_Obj6.pdf
[18] https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd10016.pdf

operational support at 75 percent match, might be available, such as with respect to a data-populated prediction model or risk profile to support the MITA business processes described in the MITA Business Architecture Supplement, Appendix C, Establish Case for Case Management.[19] This document directs states to support systems that leverage data and interoperability across Medicaid and non-Medicaid data sources to:

- Identify target members for specific programs
- Assign a care manager
- Assess member needs
- Select a program
- Establish a treatment plan
- Identify and confirm provider

In considering data sources for case management, states should consider the interoperability standards under 42 CFR § 433.112(b)(16), which requires MITA systems to support seamless coordination and integration with the Health Insurance Marketplace and the Federal Data Services Hub, and to allow interoperability with HIE, public health agencies, human services programs, and community organizations. Connecting these various data sources could leverage technology to help close referral loops, enable appropriate follow up, and leverage existing data and services elsewhere in a state. Adding data sources to the Medicaid system, such as human services programs, community organizations, EMS providers, Medicare, or justice-related systems, may be helpful and eligible for support related to the implementation of interoperability as required under 42 CFR 433.112(b)(16), per previous guidance.[20]

Technologies for Coordinating Care and Increasing Access to Care

Access to substance use disorder (SUD) treatment providers remains a challenge for states and, appropriately, the President's Commission supports leveraging telemedicine and telepsychiatry to facilitate more coordinated care. States are reminded that they need not necessarily submit a state plan amendment to begin delivering covered Medicaid services through telehealth modalities. State plan amendments are only required if a state decides to reimburse for telemedicine services differently than they pay for face-to-face services, visits, and consultations. States should also consider telehealth optimized Medication Assisted Treatment[21] given access considerations. Virtual treatment centers or remote counseling options integrated into care coordination technology might help with addressing provider shortages, particularly in rural areas. Many behavioral health providers lack access to EHRs; states may consider reviewing what app-based technologies might be appropriate as described in the Office of the National Coordinator for Health IT's Health IT Playbook in the module addressing Behavioral Health Providers.[22] Under MITA, a state might consider developing telehealth-enabling technology,

[19]Guidance regarding the "Case Management" business process are located in .zip files located at https://www.medicaid.gov/medicaid/data-and-systems/mita/mita-30/index.html. See page 18 of the file named, "MITA 3.0 Part 1" for the details on "Establish Case."
[20] https://www.gpo.gov/fdsys/pkg/FR-2015-12-04/pdf/2015-30591.pdf
[21] https://www.samhsa.gov/medication-assisted-treatment
[22] https://www.healthit.gov/playbook/pdf/educational-module-Behavioral-Health-Providers.pdf

including patient facing technology, to be used by Medicaid service providers for coordinating the care of Medicaid beneficiaries, which might support the "Managing Case Information[23]" business process, which includes activities in connecting providers to patients and facilitating services. Specifically, the Managing Case Information business process might include activities such as:

- Service planning and coordination
- Facilitation of services (e.g., finding providers or establishing limits or maximums)
- Advocating for the member
- Monitoring and reassessment of services for need and cost effectiveness
    - This includes assessing and taking necessary action to ensure that services and placement are appropriate to meet the program's needs

Similarly, states might also leverage this or other business processes to facilitate shared electronic care plans used to coordinate care between providers, with an emphasis on connecting to SUD treatment providers. Similarly, enhanced federal funding under the HITECH Act might also be leveraged to support the design, development, and implementation of interoperable systems and HIEs that facilitate the exchange of electronic care plans between Medicaid providers, as discussed in SMD 16-003.

States might also consider using Medicaid support to add systems supporting the Electronic Prescribing of Controlled Substances (EPCS). These systems might be integrated into other pharmacy systems or health information exchange architecture and complement broader state initiatives around securing prescribing processes. Workflow analysis and thoughtful on-boarding of Medicaid providers as described in SMD# 16-003 could help reduce the burden which might be associated with adopting the two-factor authentication in EPCS as well.

Enhanced Statewide Interoperability

States are reminded that some portion of the costs of the systems outside of the Medicaid enterprise that perform a MITA business process may be eligible for enhanced match[24]. Medicaid may pay for the proportion of costs related to its access and use of such systems consistent with an approved cost allocation methodology. This might include public health systems, such as a birth data registry that could support case management or treatment for pregnant women with opioid use disorder who are at increased risk of delivering a newborn with neonatal abstinence syndrome (NAS). NAS was highlighted by the President's Commission and is a condition likely to disproportionately affect the Medicaid population.

States might also consider linking care coordination platforms, PDMPs, or electronic care plans with other data sources to support the Case Management business process in MITA. Specifically, business process steps described in, "Manage Population Health Outreach," or, "Manage

[23] Guidance regarding the "Case Management" business processes is located in .zip files located at https://www.medicaid.gov/medicaid/data-and-systems/mita/mita-30/index.html. See page 18-23 of the file named, "MITA 3.0 Part 1" for the full details of supported business processes.
[24] https://www.gpo.gov/fdsys/pkg/CFR-2012-title2-vol1/pdf/CFR-2012-title2-vol1-part225.pdf

Registry," might support such targeted efforts[25]. For example, emergency management systems with structured data could be integrated with PDMPs or pharmacy benefit management systems (PBMs), e-prescribing systems, other pharmacy systems providing first-responders access to medication history, including pain management regimens, with compliance history. These types of data integration and others can provide the states better technical tools to provide Medication-Assisted Treatment[26]. As states leverage technology to improve care coordination for justice-involved individuals, linking correctional health systems to care coordination platforms, PDMPs, HIEs, or electronic care plans becomes increasingly valuable as such connections allow providers to appropriately manage prescription opioid medication, improve pain management and patient safety, and provide treatment for substance use disorders, including opioid use disorder, as the patients move between care settings.

States interested in developing prediction models or deploying advanced analytical approaches to data-driven interventions might also look to complement Medicaid data with data from human services programs, consistent with the above discussion of interoperability under 42 CFR § 433.112(b)(16). Certain social determinants of health can be partially predictive of potential negative outcomes from pain management regimens, and states are encouraged to appropriately leverage available data, consistent with applicable law. Factors such as poor housing, unemployment or underemployment, poverty, and certain occupations might contribute to negative opioid outcomes, and states should consider integrating such data for purposes of refining approaches to opioid risk profiling, prevention strategies, and targeted care management[27].

As state Medicaid agencies design systems with greater focus on value-based payment, Medicaid systems will continue to have more modules and processes tied to HIE. States are reminded of SMD # 18-005 published on April 18, 2018, which specifically states can achieve reuse, and add functionality to systems supported by enhanced funding association with the HITECH Act as appropriate[28].

CMS hopes states will use this information to improve the technological capacity of state Medicaid agencies, providers, and partners to address the opioid crisis and improve the health outcomes for Medicaid beneficiaries. CMS is available to provide technical assistance to states on the matters described in this letter. States should err on the side of reaching out to CMS with questions about support for technologies which might assist with the prevention and management of acute and chronic nonmalignant pain, which includes non-pharmacologic approaches to pain prevention and management. Questions regarding this guidance may be directed to the appropriate regional CMS office.

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[25] Guidance regarding the "Case Management" business processes is located in .zip files located at https://www.medicaid.gov/medicaid/data-and-systems/mita/mita-30/index.html. See page 24-31 of the file named, "MITA 3.0 Part 1" for the full details of the business processes, "Manage Population Health," and, "Manage Registry"

[26] https://www.samhsa.gov/medication-assisted-treatment

[27] "Opioid Crisis: No Easy Fix to Its Social and Economic Determinants," AJPH February 2018, Vol 108, No. 2: https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.2017.304187

[28] https://www.medicaid.gov/federal-policy-guidance/downloads/smd18005.pdf

Sincerely,

/S/

Tim Hill
Acting Director

cc:
National Association of Medicaid Directors
National Academy for State Health Policy
National Governors Association
American Public Human Services Association
Association of State Territorial Health Officials
Council of State Governments
National Conference of State Legislatures
Academy Health
National Council for Behavioral Health
National Association of County Behavioral Health & Developmental Disabilities Directors
National Association of Boards of Pharmacy
Federation of State Medical Boards
American Medical Association
Pharmacy Care Management Association
National Council for Prescription Drug Programs
High Intensity Drug Trafficking Areas National HIDTA Assistance Center
National Association of State Alcohol and Drug Abuse Directors