REPORT FROM THE HEALTH INFORMATION COMMUNICATION AND DATA EXCHANGE TASKFORCE TO THE STATE ALLIANCE FOR E-HEALTH

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LETTER FROM THE TASKFORCE CO-CHAIRS

Dear Members of the State Alliance,

The members of the Health Information Communication and Data Exchange Taskforce are pleased to submit this report to the State Alliance for e-Health. The report describes the accomplishments of the taskforce to date, and advances recommendations it believes are necessary for states to enhance publicly funded health programs through participation in interoperable, electronic health information exchange initiatives.

The Taskforce worked under the charge provided by the State Alliance for e-Health when assessing the issues and developing recommendations outlined in this report. The Taskforce planned on addressing the Medicaid and SCHIP programs first, and will continue its examination of public health and state employee health benefits programs through the fall.

The taskforce sought the expertise and perspectives of Medicaid/SCHIP stakeholders to inform its deliberations and in crafting the recommendations. The report outlines findings and recommendations with respect to the challenges and opportunities for Medicaid and SCHIP programs to facilitate electronic health information exchange and to coordinate with public and private health information exchange activities.

We present the following report for your consideration and look forward to speaking with you at the meeting of the State Alliance for e-Health.

Sincerely,

Rhonda Medows, MD

and

Tony Rodgers

Health Information Communication and Data Exchange Taskforce Co-Chairs

SUMMARY OF THE TASKFORCE RECOMMENDATIONS

Recommendation 1.0: The State Alliance should direct NGA to provide states guidance for the development of executive orders and direct NCSL to provide guidance related to legislation. Relative to public programs, components should, at a minimum, include:

- A set of specific objectives for Medicaid/SCHIP participation in eHIE, particularly as it relates to quality, transparency, and cost containment;
- Procedures for designing an eHIE roadmap;
- Indemnity;
- Requirement that all state agencies adopt and utilize interoperable HIT;
- Consumer protections to ensure appropriate access to health data;
- Commitment to inclusiveness and diversity in eHIE activities amongst health care providers, payers, and consumers; and
- State procurement rules that enable fair and flexible innovations, require the adoption of interoperable HIT applications, and align with any state-wide eHIE/HIT policies.

Recommendation 2.0: Each state should develop or adopt a vision for state eHIE that leverages existing and planned public and private eHIE efforts and outline an eHIE roadmap by the end of 2008 that must be implemented by 2014. Components of the roadmap should, at the least, include how the state plans to (1) organize the implementation of eHIE in the state; (2) engage diverse stakeholders, including consumers, providers and payers; (3) develop and test exchange architectures incorporating existing and approved standards; (4) build financial, political support, and legislative authority for eHIE development; (5) ensure consumer protections are in place; (6) train and sustain an eHIE-capable workforce; and (7) enable intrastate collaboration and data exchange.

Recommendation 2.1: In close coordination with ONC and other federal agencies (e.g. CMS), NGA should play a leadership role on behalf of all governors to facilitate the coordination of individual state roadmaps in the context of a national interstate eHIE strategy.

Recommendation 3.0: Governors should designate a single authority for the state to coordinate state government based eHIE implementation activities and work, in collaboration, with public/private eHIE efforts.

Recommendation 4.0: Governors and state legislatures should align to establish flexible financial mechanisms to support and ensure sustainable eHIE.

Recommendation 5.0: To successfully implement HIT and eHIE initiatives and to adopt MITA, state Medicaid agencies will require new technology, project management, policy, legal, consumer protection and programmatic competency development. Therefore, states should fund greater development of technical assistance resources for state Medicaid/SCHIP and information technology agencies to build workforce competency for eHIE. Such resources could be aligned with the Health Resources and Services Administration technical assistance toolbox modules:

- Introduction to HIT
- Getting Started
- Opportunities for Collaboration
- Project Management and Oversight
- Planning for Technology Implementation
- Organizational Change Management and Training
- System Implementation
- Evaluating, Optimizing, and Sustaining
- Advanced Topics

Recommendation 6.0: State Medicaid agencies implementing electronic health record systems in the Medicaid program, should implement a standards-based personal health record function that is portable and includes appropriate privacy and other consumer protections. When available, state Medicaid programs should require use of certified electronic health records and networks with standards-based information exchange capabilities.

Recommendation 6.1: State Medicaid agencies should ensure portable, private and secure access to personal health information to their enrollees through HIT systems such as personal health records. The State Alliance should encourage states to provide human and financial resources to develop cultural and linguistic competency required to engage diverse Medicaid/SCHIP enrollees.

Recommendation 7.0: State Medicaid agencies should implement incentive programs and, or reimbursement policies such as pay for participation, rate adjustment, case management, and quality pay for performance that will encourage provider adoption and use of HIT systems and participation in eHIE.

I. Introduction

The Health Information Communication and Data Exchange Taskforce is charged by the State Alliance for e-Health with assessing the challenges in and identifying opportunities for the participation of publicly funded health programs in interoperable, electronic health information exchange (eHIE) initiatives. The charge specifically requires that the Taskforce:

> "Develop and advance actionable policy statements, resolutions, and recommendations for referral to the State Alliance to information their decision-making process in addressing ways in which states can enhance Medicaid, employee health benefits, and public health through cooperative eHIE activities with the private sector."

The Taskforce met three times (May, July, and September) this year and has presented initial deliberations and findings to the State Alliance at its August 15, 2007 meeting. The Taskforce would like to note that they included the State Children's Health Insurance Program (SCHIP) in their review of opportunities and challenges of publicly funded health programs in eHIE. Over the past few months, the Taskforce focused their examination on the challenges and opportunities in eHIE for Medicaid and SCHIP.

This report highlights key issues related to Medicaid and SCHIP that were identified by the Taskforce members during their deliberations and advances proposed recommendations for consideration by the State Alliance. A final report that integrates findings and recommendations related to Medicaid, SCHIP, public health and state employees health benefits programs will be provided to the State Alliance at its meeting in January 2008.

Analytical Process

In response to the charge, the Taskforce explored the issues pertaining to publicly funded health programs' participation in eHIE through:

1) **Analytical Principles:** To focus their work, the Taskforce identified the following principles of analysis to use as a lens through which to conduct their assessment of the issues and development of recommendations.
    - **Leadership** – opportunities and challenges for publicly funded programs to drive the HIT agenda.
    - **Financial and Contributory Responsibility** – appropriate roles and levers of publicly funded health programs to facilitate the development and sustainability of eHIE initiatives.
    - **Consumer Involvement and Information Sharing** – the extent to which consumers are engaged by publicly funded programs in the decision-making process and development of eHIE efforts.

- **Interoperability** – relates to determining the level of technical connectivity between state health agencies with each other and with public/private electronic health information exchanges.
- **Structure of the HIT/HIE Initiative** – relates to determining the level of integration or alignment of publicly funded health programs with each other (e.g. Medicaid and public health) in terms of common policies and procedures for appropriately sharing health data. Assesses the cultural and technological barriers that impede public program participation in eHIE efforts.

2) **Hearings and testimony:** The Taskforce received testimony from representatives of state Medicaid agencies, state public health officials, representatives of state-level health information exchange efforts, representatives from the Centers for Medicare and Medicaid Services, Centers for Disease Control and Prevention, Health Resources and Services Administration, and chairs and staff of relevant American Health Information Community workgroups such as the Personalized Medicine Workgroup and Population Health and Clinical Care Connections Workgroup.

3) **Taskforce Work Product:** The Taskforce commissioned the University of Massachusetts Medical School Center for Health Policy and Research (UMASS) to analyze the issues and challenges faced by each of the publicly funded programs in eHIE. UMASS conducted in-depth interviews with 13 state Medicaid agencies to ascertain their level of participation in eHIE and health information technology (HIT) initiatives and identify challenges and potential recommendations. The UMASS draft report to the Taskforce is attached with this report. UMASS also is conducting similar interviews with representatives from public health and state employee health programs and will present these findings to the Taskforce to aid in development of comprehensive recommendations.

4) **e-Health Survey:** The Taskforce also is drawing from the results of a survey being conducted by Health Management Associates, in partnership with the National Governors Association, and funded by the Commonwealth Fund. The purposes of the survey are to identify what states are doing now in e-Health; highlight best practices, important activities, and accomplishments of states in this arena; identify the challenges and issues states have faced in pursuit of these activities; and to ask about current directions and goals for the future. Thus far, 34 states have responded to the survey. HMA and NGA are continuing to encourage the remaining states to respond. The survey asks questions specific to publicly funded programs and is intended to set a baseline of the level of e-Health activity that exists across these publicly funded programs. The survey instrument is appended to this report. The Taskforce members will continue to track the findings from this survey to help inform future recommendations, in addition to those presented in this report.

The Taskforce has completed its exploration of the opportunities for and challenges faced by SCHIP and state Medicaid programs in participating in eHIE. Findings and proposed recommendations pertaining to these programs are highlighted below. The Taskforce is continuing to examine issues pertaining to public health and state employee health benefits programs and their participation in eHIE. The Taskforce will present findings and proposed recommendations pertaining to these programs at the January 2008 meeting of the State Alliance. At that time, the Taskforce also will present on opportunities to leverage these programs collectively with SCHIP and Medicaid in order to maximize the state government's role in promoting HIT adoption and eHIE development within and across states.

II. Medicaid and SCHIP Findings

There are significant opportunities and relevant reasons for state Medicaid and SCHIP programs to participate in efforts to develop electronic health information exchanges and promote adoption of HIT systems by providers. Medicaid and SCHIP are state-administered programs that are jointly funded by the federal and state governments. Established in 1965, Medicaid is a means-tested health insurance entitlement program that provides health-related and long term care coverage primarily for low-income pregnant women, children and their parents, elderly, and persons with disabilities.[1] SCHIP, established in 1997, was designed to build on Medicaid to provide insurance coverage for targeted, low-income uninsured children who are not eligible to receive coverage through Medicaid. Typically, these are families with incomes up to 200 percent of the federal poverty level or approximately $41,300 for a family of four (2007 dollars).[2]

Medicaid spending consumes an increasing portion of federal and state budgets. Federal and state spending for Medicaid amounted to $304 billion in 2006. The average portion of state funds spent on Medicaid was 17.9 percent in 2005 – a figure that continues to increase each year. [3] Over half of Medicaid spending in 2006 was on account of acute care costs (57.7 percent). The remaining 36.6 percent funded long-term care costs and 5.6 percent was spent on disproportionate share hospital (DSH) payments. DSH payments fund much of the uninsured's access to health care services.[4] Total federal and state SCHIP expenditures in 2006 were also high – over $7.8 billion in 2006.[5]

Medicaid and SCHIP serve as the safety-net for the nation's most vulnerable populations. Together, they provide coverage for 30 million low-income children in the United States. Medicaid also covers approximately 14 million parents and 14 million elderly and people with disabilities.[6] These populations are often those with the greatest need for access to care and preventive services. Approximately 30 percent of the enrollees in Medicaid and SCHIP suffer from multiple chronic conditions that require coordination of care and case management. [7]

The Medicaid and SCHIP programs must be modernized in order to effectively respond to the needs of the vulnerable populations they serve. One opportunity to enhance Medicaid and SCHIP programs is through widespread adoption and use of HIT systems

and electronic sharing of health information for the purposes of coordinating care and quality improvement. Use of HIT and eHIE also may contribute to reducing health care costs in Medicaid and SCHIP by reducing medical errors and increasing the efficiency of administrative and clinical processes.

Modernizing Medicaid and SCHIP is not a simple feat for states. The Taskforce recognizes that while there are opportunities for states to leverage Medicaid and SCHIP programs to further eHIE initiatives, these programs also face significant challenges and have essential needs that must be addressed in order for these programs to effectively participate in such efforts.

The UMASS interviews of 13 state Medicaid/SCHIP agencies identified the following challenges:

- There is a lack of communication and data sharing between state agencies ("agency silos").
- There is a lack of data systems interoperability between state agencies, other payers, and health providers ("data silos").
- There is uncertainty among state Medicaid/SCHIP agencies about legal and regulatory issues pertaining to data sharing and ownership, which deter them from sharing any data particularly information on "high risk" populations.
- Provider adoption of HIT systems, such as electronic health records, is limited.
- State Medicaid agencies are often understaffed for large-scale eHIE/HIT projects.
- Medicaid staff need education and training on the appropriate uses of data made available through eHIE/HIT for quality measurement and improvement purposes.

These challenges are discussed in greater detail in the UMASS report to the Taskforce, which is appended to this report.

The Taskforce's deliberations also highlighted two themes:

- **Focus on patient-centered healthcare.**

The taskforce finds it critical to engage consumers in eHIE efforts, especially in the beginning when efforts are being organized. Establishing the public's trust is integral. The taskforce recognizes that in order for it to effectively promote eHIE initiatives, it is necessary to develop recommendations that encompass consumer engagement in ways that guarantee privacy protection and encourage the participation of consumers and consumer organizations.

Approximately half of the 58 million Medicaid/SCHIP beneficiaries are members of racial and ethnic minority groups.[8] Due to language or cultural barriers, racially and ethnically diverse Medicaid beneficiaries may be faced with increased barriers to health care. Therefore, the taskforce believes any efforts to engage Medicaid and SCHIP populations must consider the unique cultural and socioeconomic characteristics of those consumers.

- **Importance of continued federal and state financial assistance.**

Medicaid and SCHIP are jointly funded by federal and state governments. In order to ensure the success of eHIE initiatives by publicly funded health programs, continued federal and state financial assistance are necessary. An opportunity for SCHIP and state Medicaid programs participating in eHIE that was highlighted in several presentations to the taskforce was the availability of federal funding through Medicaid Transformation Grants and federal matching funds for investments in Medicaid Management Information Systems (MMIS) and the Medicaid Information Technology Architecture (MITA). Stemming from this testimony, the taskforce recognized that it is critical for state Medicaid programs to receive significant financial support for planning HIT/eHIE initiatives. The taskforce believes that even though federal and state funds have been available to state Medicaid through the programs noted, it is critical that funding continues, and at least, at the same levels.

MITA, an initiative from the Centers for Medicare and Medicaid Services (CMS), changes the way states design and implement their MMIS to improve the administration of the Medicaid program.[9] Historically, MMIS was used primarily as a financial and accounting system for processing claims. Even as states added other functions, it was difficult to exchange information across systems. MITA includes an architecture framework, processes, and planning guidelines for state Medicaid programs for advancing common objectives for eHIE. Currently, states can obtain Federal Financial Participation (FFP) for Medicaid administrative activities, including MMIS investments. State Medicaid agencies receive a 90 percent match for MMIS design, development, and installation and 75 percent match for ongoing maintenance. In the future, state MMIS funding will be based on how they meet the MITA objectives.

The Deficit Reduction Act of 2005 authorized the creation of the Medicaid Transformation Grant program to provide $150 million to state Medicaid agencies to implement HIT/eHIE initiatives. Two thirds of the money was awarded by CMS in January 2007. From a pool of 130 proposals, CMS selected 27 states to receive grants. States had a second opportunity in summer 2007 to apply for grants from the remaining funds. Medicaid Transformation Grants have bolstered funding and interest in state Medicaid activities in eHIE development. At the May meeting of the taskforce, representatives from state eHIE initiatives in Alabama, Arizona, New Mexico, and Utah delivered presentations about how their state Medicaid agencies are facilitating eHIE through the Medicaid Transformation Grants, and what their plans going forward are to expand their networks to other payers, providers, and state agencies. The taskforce believes that state Medicaid agencies need continued federal support for Medicaid

Transformation Grant projects and other HIT/eHIE efforts in order to modernize their Medicaid programs. The MITA framework encourages the integration of new system components, like an eligibility system, in state MMIS. FFP rules have not yet been revised to reflect the goals of MITA. The taskforce believes that state Medicaid agencies should continue to receive federal funding for MMIS and also in the future, opportunities for federal matching should be expanded.

III. Recommendations

<u>Recommendation 1.0</u>: The State Alliance should direct NGA to provide states guidance for the development of executive orders and direct NCSL to provide guidance related to legislation. Relative to public programs, components should, at a minimum, include:

- **A set of specific objectives for Medicaid/SCHIP participation in eHIE, particularly as it relates to quality, transparency, and cost containment;**
- **Procedures for designing an eHIE roadmap;**
- **Indemnity;**
- **Requirement that all state agencies adopt and utilize interoperable HIT;**
- **Consumer protections to ensure appropriate access to health data;**
- **Commitment to inclusiveness and diversity in eHIE activities amongst health care providers, payers, and consumers; and**
- **State procurement rules that enable fair and flexible innovations, require the adoption of interoperable HIT applications, and align with any state-wide eHIE/HIT policies.**

The taskforce believes that legislation and executive orders are two mechanisms that state government leaders can leverage to promote HIT adoption and eHIE. At least 15 executive orders were issued by governors in 2006, and approximately 100 bills were introduced in the 2007 legislative session supportive for HIT and eHIE.[10] The taskforce recognizes that states have differing needs and are likely to draft policy with different components. It heard testimony from experts involved in state eHIE activities about the importance of having state leaders set priorities to guide eHIE development. Therefore, taskforce members decided to outline some of the components of state HIT/eHIE policies that they believe are essential to successful efforts.

A state roadmap is necessary for laying out the state's objectives and plans for eHIE. It is a critical step towards implementation. Some states, such as Arizona, Kansas, Kentucky, Minnesota, and Vermont, have completed their statewide eHIE plans and have moved to implementation. The taskforce believes that best practices have emerged from these states' planning activities. Representatives of state eHIE efforts highlighted two key goals for state eHIE roadmaps: (1) to reach consensus on HIT/eHIE priorities and (2) to develop models for participation.

One challenge that emerged from taskforce deliberations was the lack of common technical standards among state agencies. As a result, systems at different agencies can

not communicate directly and exchange information with difficulty, if at all. This fragmentation also makes it difficult to see how program information (e.g. Medicaid, public health) could fit together and limits the opportunity on the individual person level to coordinate care. The taskforce heard from UMASS that state Medicaid leaders also voiced concerns about communication, data sharing, and data systems interoperability between state agencies.

Another issue that resonated with the taskforce was consumer protection. At the May meeting of the taskforce, taskforce members heard from state experts who felt that the public will only give states one chance to gain its trust. To that end, the taskforce believes state leaders should set expectations related to privacy and security of consumer health information. One example is The Clinical Health Record™ from SharedHealth in Tennessee, which is a patient centered system that configures role-based access controls.

Procurement rules in many states are interfering with timely implementation of eHIE initiatives. Procurement rules can be counter intuitive to the real needs of an initiative. For example, HIT procurements are often completed before all requirements are known, resulting in a contract with an incorrect scope.[11] Therefore, the taskforce believes state procurement rules should enable fair and flexible innovations. Furthermore, state leaders can leverage state procurement rules to advance standards-based products, and align procurement rules with other state HIT/eHIE policies.

<u>Recommendation 2.0</u>: Each state should develop or adopt a vision for state eHIE that leverages existing and planned public and private eHIE efforts and outline an eHIE roadmap by the end of 2008 that must be implemented by 2014. Components of the roadmap should, at the least, include how the state plans to (1) organize the implementation of eHIE in the state; (2) engage diverse stakeholders, including consumers, providers and payers; (3) develop and test exchange architectures incorporating existing and approved standards; (4) build financial, political support, and legislative authority for eHIE development; (5) ensure consumer protections are in place; (6) train and sustain an eHIE-capable workforce; and (7) enable intrastate collaboration and data exchange.

<u>Recommendation 2.1</u>: In close coordination with ONC and other federal agencies (e.g. CMS), NGA should play a leadership role on behalf of all governors to facilitate the coordination of individual state roadmaps in the context of a national interstate eHIE strategy.

The taskforce was very interested in discussing the ways in which a vision for state eHIE sets up a state for health care transformation. The use of HIT improves the coordination of care; and also may contribute to reducing health care costs by reducing medical errors and increasing the efficiency of administrative and clinical processes. Since President Bush proclaimed the goal of having electronic health records (EHRs) for most Americans by 2014, a surge of public interest has led the federal and state governments to address ways to promote the adoption of HIT and development of eHIE. To this end, the

taskforce believes each state should immediately begin outlining an eHIE roadmap, if they have not already done so, and implementing eHIE in the state.

Taskforce members felt that states could not successfully implement eHIE initiatives without developing thorough plans. Developing a state roadmap is an opportunity for state government leaders to engage and solicit input from various stakeholders (e.g. payers, providers, consumers) and begin the process of establishing trust among different participants of an eHIE. A state eHIE roadmap is an opportunity for all stakeholders to articulate a shared vision for eHIE development and set statewide priorities, as well as timeframe expectations, for action. The roadmap should define the statewide goals and measurable objectives for HIT adoption and eHIE development and outline specific plans for implementation

Critical components to include in a roadmap are financing and technical interoperability strategies; as well as methods to ensure consumer protections are in place and are enforced. The taskforce also noted in its deliberations the importance of having a strategy for building workforce competency on eHIE matters. Finally, the taskforce believes that states also should consider the impact of the statewide roadmap on interstate exchange and devise strategies that ensure flexibility in their approaches to accommodate for cross-state exchange.

State eHIE roadmaps are valuable tools to leverage in developing a nationwide strategy for eHIE development. Several members of the Taskforce have been actively involved in their respective states' roadmap development process and believe that states should have a forum for discussing best practices and challenges.

Recommendation 3.0: Governors should designate a single authority for the state to coordinate state government based eHIE implementation activities and work, in collaboration, with public/private eHIE efforts.

Many states have HIT/eHIE efforts occurring simultaneously in various state agencies and communities. The taskforce believes that uncoordinated state government HIT/eHIE initiatives fail to leverage the promise of HIT/eHIE to improve the quality of care and reduce state health expenditures. UMASS heard from state Medicaid leaders that one of their primary challenges was the difficulty in developing consensus with other state agencies on realistic expectations of the role, use, and implementation of eHIE.[12] The taskforce also believes that the public and private sectors should collaborate to develop eHIE. One method to ensure coordination of eHIE efforts is to designate a single state authority for HIT. The taskforce chose the word "authority" without specifying whether it referred to an individual or group because taskforce members recognized that states would need to assess their own organizational structures to make that decision. The goals of a state HIT authority would be the same in every state—to improve communication and data sharing between state agencies and to oversee and collaborate with all HIT/eHIE efforts.

<u>Recommendation 4.0</u>: Governors and state legislatures should align to establish flexible financial mechanisms to support and ensure sustainable eHIE.

State agencies are currently prohibited from distributing resources across programs or sharing with other agencies. Unfortunately, this is often conflicting with the needs of state HIT/eHIE initiatives. The taskforce felt strongly that the structure of state budgets should be more flexible to support and ensure sustainable eHIE. The State Alliance has a specific objective to advance interoperable, eHIE within and among states. The taskforce believes that state leaders should make it easier for state agencies and programs to plan and implement joint efforts because its improves communication and data exchange between publicly funded health programs.

In May, the taskforce heard from a representative from CMS about the guidelines expressed through the MITA framework and related to MMIS FFP. These guidelines permit MMIS funds to only be spent on Medicaid enrollees, and other federal programs have similar procedures. In September, the taskforce heard from UMASS that state Medicaid leaders identify traditional mechanisms, such as the "Medicaid only" rule, as being inadequate to support the complexity and scope of HIT/eHIE efforts. The taskforce believes the concept of eHIE is to link organizations together, thus funding that promotes collaboration between state agencies or amongst a larger stakeholder constituency is preferable to funding that is directed at a single state agency.

States' efforts to establish flexible financing mechanisms that enable different state agencies to collaborate on eHIE initiatives will be a greater success if they have the support and commitment of the U.S. Department of Health and Human Services (HHS). HHS is encouraged to establish similar mechanisms for creating broader funding approaches to foster collaboration across agencies that receive federal funding for the common purpose of working on HIT/eHIE initiatives. Finally, taskforce members support a unified approach to quality improvement across all initiatives.

<u>Recommendation 5.0</u>: To successfully implement HIT and eHIE initiatives and to adopt MITA, state Medicaid agencies will require new technology, project management, policy, legal, consumer protection and programmatic competency development. Therefore, states should fund greater development of technical assistance resources for state Medicaid/SCHIP and information technology agencies to build workforce competency for eHIE. Such resources could be aligned with the Health Resources and Services Administration technical assistance toolbox modules:

- **Introduction to HIT**
- **Getting Started**
- **Opportunities for Collaboration**
- **Project Management and Oversight**
- **Planning for Technology Implementation**
- **Organizational Change Management and Training**
- **System Implementation**

- **Evaluating, Optimizing, and Sustaining**
- **Advanced Topics**

Technology can either improve or interfere with the efficiency of administrative and clinical processes. The taskforce recognizes that successful HIT/eHIE initiatives depend as much on investment in staff training and education as the technology investment itself. Using new HIT systems requires that staff members develop new skills to manage and operate the technologies. The taskforce believes there are many skills that staff members must develop to be proficient in HIT/eHIE, and that these skills are not limited to technical competencies. Staff members also need training in project management, policies of the organization, legal restrictions, consumer protections, and programmatic content to develop the necessary competency to manage and operate HIT/eHIE.

The taskforce also recognizes the lack of state funding is an obstacle for providing training to Medicaid staff. State Medicaid leaders reported that staff training resources are often not budgeted in Medicaid agencies.[13] Medicaid leaders also reported that in fact agencies struggle to find and/or train appropriate staff that have the right skills to manage and operate new technologies.[14] The taskforce believes Medicaid programs need state funding for technical assistance to build workforce competency in eHIE.

<u>Recommendation 6.0</u>: State Medicaid agencies implementing electronic health record systems in the Medicaid program, should implement a standards-based personal health record function that is portable and includes appropriate privacy and other consumer protections. When available, state Medicaid programs should require use of certified electronic health records and networks with standards-based information exchange capabilities.

<u>Recommendation 6.1</u>: State Medicaid agencies should ensure portable, private and secure access to personal health information to their enrollees through HIT systems such as personal health records. The State Alliance should encourage states to provide human and financial resources to develop cultural and linguistic competency required to engage diverse Medicaid/SCHIP enrollees.

The taskforce believes states should consider the impact of patient centered HIT systems like personal health records (PHRs) on consumer participation, awareness and safety. In May, the taskforce learned about the Clinical Health Record™ from SharedHealth in Tennessee which healthcare providers as well as patients can access through an internet-based server. All of the Medicaid beneficiaries in Tennessee are in the Clinical Health Record system.

State HIT/eHIE efforts should always be mindful of the cultural, linguistic, and socioeconomic diversity of Medicaid/SCHIP populations. States may need to provide Medicaid/SCHIP programs with additional funding to design multi-lingual PHRs, or human resources for computer training services. The taskforce believes that

Medicaid/SCHIP programs have an opportunity to use PHRs to engage and educate beneficiaries about their health.

Another opportunity for state Medicaid/SCHIP programs as they adopt HIT systems is to select certified products. The taskforce believes that certification ensures that a product meets a high standard for HIT systems and providers who have apprehensions about investing in HIT systems will get more reassurance from systems that are certified. The taskforce was not concerned with the packaging of the PHRs and EHRs. Some state Medicaid programs may include the PHR among the EHR system's functionalities, and others may develop a separate system.

Recommendation 7.0: State Medicaid agencies should implement incentive programs and/or reimbursement policies such as pay for participation, rate adjustment, case management, and pay for performance that will encourage provider adoption and use of HIT systems and participation in eHIE.

The taskforce supports states efforts to implement incentive or reimbursement programs to reward Medicaid providers who make investments in HIT and to speed up HIT adoption. The taskforce recognizes that the key objective of incentive and reimbursement programs should be improving the quality of health care. However, the high price of HIT systems creates a barrier for many healthcare providers who primarily serve Medicaid and SCHIP beneficiaries because they often lack the financial resources. Incentive and reimbursement programs may create the business case for providers to invest in HIT. Moreover, state Medicaid agencies also have a financial interest in working with providers who use HIT systems because HIT may contribute to reducing health care costs in Medicaid and SCHIP. Therefore, the taskforce believes state Medicaid agencies should implement incentive programs and/or reimbursement policies to encourage provider adoption and use of HIT and participation in eHIE.

Through the different incentive and reimbursement programs, providers are able to earn payments at different points in time – when they adopt HIT, as they use HIT, and once they achieve results related to improving quality of care and health outcomes. Incentive and reimbursement programs also can be leveraged to support better coordination of care for Medicaid beneficiaries with chronic illnesses. For instance, state Medicaid agencies can imbed pay for performance strategies in programs for care coordination and case management.

IV. Health Information Communication and Data Exchange Taskforce Next Steps

Working under its current charge, the taskforce plans to address issues related to two other publicly funded health programs – first, public health, and then state employee health benefits programs. The taskforce plans to further examine challenges and opportunities for these programs to facilitate eHIE. Current eHIE activities would likely

improve if the public sector was involved in decisions regarding leadership, interoperability, consumer involvement, funding, and group alignment to facilitate eHIE.

The Taskforce anticipates developing additional recommendations and/or policy statements on the issues discussed above and intend to provide the State Alliance with a report on additional recommendations at the next scheduled meeting.

ENDNOTES

[1] Medicaid Program Overview. The Centers for Medicare and Medicaid Services. Accessed 23 September 2007. Available online www.cms.hhs.gov/Medicaidgeninfo. Also see Medicaid Commission's Final Report and Recommendations presented to Secretary Michael Leavitt on December 29, 2006. Available online: http://aspe.hhs.gov/medicaid/122906rpt.pdf. Accessed 26 September 2007.
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