



**Opportunities for Facilitating Electronic Health
Information Exchange in Publicly Funded
Programs:
Findings from Key Informant Interviews with Medicaid
and SCHIP Leadership and Staff**

Prepared by:

The Center for Health Policy and Research (CHPR) in collaboration with the University of Southern Maine Muskie School of Public Service Institute for Health Policy and the National Governors Association Center for Best Practices

Project Team:

Shaun T. Alfreds, MBA, CPHIT *
Eric T. Masters, MPH **
Jay Himmelstein, MD, MPH **

* University of Southern Maine, Muskie School of Public Service Institute for Health Policy

** University of Massachusetts Medical School, Commonwealth Medicine Center for Health Policy and Research

Introduction

Recent advances in health information technologies (HIT) and electronic health information exchange (eHIE) hold great promise for improving health care quality, effectiveness, and efficiency for all Americans. Yet concerns have been raised that the specific eHIE and HIT challenges for Medicaid and SCHIP programs and the vulnerable persons supported by these programs are not being addressed in a timely manner.

The Health Information Communication and Data Exchange (HICDE) Taskforce of the National Governors Association (NGA) State Alliance for eHealth has been charged to:

“Support the State Alliance on issues regarding the appropriate roles for publicly funded health programs in interoperable eHIE. Develop and advance actionable policy statements, resolutions, and recommendations for referral to the State Alliance to inform 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.”

To support the HICDE Taskforce in their charge, the University of Massachusetts Medical School Center for Health Policy and Research, in collaboration with the NGA Center for Best Practices, is conducting an analysis of the opportunities and challenges for publicly funded healthcare programs to participate in and facilitate the use of eHIE to improve healthcare quality, efficiency, and effectiveness.

This report, the first of three, presents an overview of the findings and recommendations from key informant interviews conducted with Medicaid/SCHIP leadership and staff members. This report is meant to assist the HICDE Taskforce in developing actionable recommendations for facilitating eHIE in Medicaid/SCHIP agencies.

Methods

The HICDE taskforce, during their deliberations in May of 2007, agreed that the eHIE and HIT challenges and opportunities for Medicaid/SCHIP, public health, and state employee health plans would be assessed using the following key principles:

- Leadership
- Interoperability
- Consumer Involvement and Information Sharing
- Financial and Contributory Responsibility
- Structure of the HIT/HIE Initiative (including alignment with other publicly funded programs)

To support this assessment, a semi-structured interview protocol was developed that incorporated these five principles and feedback from the HICDE Taskforce. Thirteen state Medicaid agencies that had implemented or had begun the implementation of eHIE and HIT related projects were identified. The agencies chosen represent states of varying size, demographic characteristics, and unique strategies in supporting HIT initiatives, including selected Medicaid Transformation Grantees and Medicaid initiatives funded through other mechanisms. Ten states were interviewed in July and August of 2007 (see Appendix 1 for a complete list of states and staff interviewed). Emergent themes from interview responses were then grouped into three categories: key success factors, key challenges, and recommendations at the state and federal level.

HIT and eHIE Success Factors Identified by Medicaid/SCHIP Agencies

All of the Medicaid/SCHIP interviewees expressed support for the advancement of eHIE and HIT. After coding and grouping interview responses, common themes emerged that are best labeled 'success factors'. These success factors were viewed as being integral to the success of Medicaid/SCHIP HIT/eHIE projects.

- The governor provided visible leadership in regard to eHIE/HIT efforts for Medicaid and SCHIP. Executive leadership recognized the value of eHIE/HIT in providing better quality outcomes and openly advocated for its use. Leadership exhibited commitment by providing funding, fostering multi-stakeholder collaborations, coordinating initiatives, and removing barriers to eHIE. State roadmaps were viewed as a successful tool for setting state-wide priorities involving Medicaid/SCHIP and other publicly funded health programs.
- Multi-stakeholder collaborations between state agencies, payers, providers and consumers were viewed as important. These partnerships fostered trust among public and private stakeholders. Key functions of multi-stakeholder collaborations included building consensus, aligning priorities, and developing recommendations for states' eHIE/HIT initiatives. These groups also helped to advance agreements and protocols for statewide interoperability structures, standards, and data and technology stewardship.
- Flexible funding models as demonstrated by the DRA Medicaid Transformation Grants were viewed as necessary to the expansion eHIE/HIT efforts in many Medicaid/SCHIP agencies. Traditional mechanisms, such as the "Medicaid only" rule expressed through the MITA framework, are not viewed by interviewees as being a good fit with the complexity and scope of eHIE/HIT projects. 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.

Challenges Encountered by Medicaid/SCHIP Agencies

Medicaid/SCHIP interviewees described the many challenges and barriers they face as they plan, implement, and operate their respective eHIE/HIT projects. A summary of the key challenges expressed by Medicaid/SCHIP interviewees are highlighted below:

- Lack of communication and data sharing between state agencies ('agency silos'). State Medicaid and SCHIP agencies often do not communicate freely with other state agencies, due in part to their individual missions and different priorities. A primary challenge cited was the difficulty in developing consensus between state agencies on realistic expectations of the role, use, and implementation of eHIE. Another related challenge identified by interviewees is getting state agencies to share data with each other – a cultural shift is needed to get staff to understand that sharing data is a necessity if the benefits of improved health care quality and effectiveness are to be achieved. Sharing knowledge and keeping current about all the various eHIE and HIT initiatives at the state and federal level were also viewed as challenges.
- Lack of data systems interoperability between state agencies, other payers, and health providers ('data silos'). In addition to the cultural shift needed to get agencies to communicate more closely with one another, interviewees expressed concerns regarding the technical aspects of sharing data among state agencies and with other stakeholders (e.g., payers, providers, consumers). Agreements are needed to decide what qualifies as exchangeable data and how data is to be identified and pulled from the

various agencies/stakeholders involved. The costs of making data systems interoperable with each other, as well as the costs of replacing legacy systems, are viewed as barriers. In some states there remains the challenge of providing high speed access to interconnect state agencies with providers.

- Actual and perceived legal and regulatory issues in regard to data sharing and ownership. Most laws and regulations regarding health information were enacted before the advent of eHIE, an issue requiring states to review their privacy and security laws and regulations, especially regarding “high risk” populations. Medicaid/SCHIP agencies struggle to answer questions around data ownership; what types of data can be shared; how this information can be shared across state lines; and what responsibility Medicaid/SCHIP agencies have regarding data for persons no longer eligible for Medicaid/SCHIP coverage. Equally difficult for Medicaid/SCHIP agencies is the lack of understanding of how federal Medicaid/SCHIP regulations apply to states’ HIT/eHIE initiatives.
- Limited provider adoption of HIT tools such as EHR. Providers face many challenges with respect to purchasing and operating HIT tools, not the least of which is having access to high speed connectivity and being able to afford the technologies. Computer literacy, IT maintenance, and loss of productivity related to the adoption and use of HIT by providers were highlighted as challenges to Medicaid/SCHIP initiatives. Particular providers that may need assistance include those in small practices, those practicing in rural areas, and settings that provide services to the uninsured.
- Medicaid agencies are often understaffed for large scale eHIE/HIT projects. Finding staff, consultants, or vendors with the appropriate expertise was cited as a particular concern. Limited state agency expertise with eHIE/HIT has caused some states to contract out the staffing/ management of their eHIE/HIT initiatives. Related issues have to do with addressing expectations of staff, developing realistic project goals and objectives, as well as managing time and material resources.
- Medicaid staff need education and training on the appropriate uses of data made available through eHIE/HIT for quality measurement and improvement purposes. Developing the technical expertise and core competencies necessary to implement and operate new data applications made possible through eHIE/HIT is critical. Cultivating new leadership competencies was identified as equally important. Other staffing needs identified include staff education on standard definitions for HIT and eHIE and on MITA guidelines/maturity modeling, and how they relate to the current data systems in Medicaid/SCHIP agencies.

Recommendations from Interviewees for the Health Information Communication and Data Exchange (HICDE) Taskforce

Medicaid/SCHIP agencies interviewed for this project were given the opportunity to make state and federal level recommendations regarding eHIE and HIT. These recommendations are for the HICDE Taskforce’s consideration and have been labeled according to the five principles discussed above.

State Level Recommendations

- Encourage governors to champion the use of eHIE/HIT to improve health care quality and reduce costs. Leadership/Structure
 - Strong leadership from governors helps to foster collaboration and trust among healthcare stakeholders, including Medicaid/SCHIP.

- Visible leadership is required to help coordinate eHIE/HIT initiatives and break down silos. **Interoperability/Structure/Leadership**
 - Between states – More effort is needed to address issues concerning the interoperability of eHIE across state lines (e.g., licensing across state lines, data ownership, legal and regulatory issues, etc.).
 - Within state agencies – A cultural shift is needed within all state agencies to improve collaboration. Agencies need to align their individual priorities with respect to eHIE in order to facilitate interoperability.
 - Between state agencies and other payers, providers, and eHIE organizations (e.g., RHIOs) – Building a unified interoperable structure is essential to allowing all stakeholders to participate in eHIE.
- Promote the provision of more state funding for eHIE/HIT initiatives. **Financial Responsibility/Structure**
 - Funding is critical for seeding efforts to build statewide eHIE networks. Initial technology expenditures can be prohibitive without governmental assistance. Technology is best viewed as an investment not an expense.
 - Funding is necessary to advance the competency of the workforce to manage the eHIE/HIT initiatives and effectively utilize the data for quality measurement and improvement efforts. Staff training is often not budgeted. New technologies require new workforce skills. Agencies struggle to find and/or train appropriate staff who have the right skills to manage and operate these new technologies. Knowledge transfer and management skills are vital as eHIE/HIT both demands and allows users to manage data in ever more sophisticated ways.
- Examine and clarify state agency business regulations and procurement rules that may impede public/private partnerships. **Structure**
 - Public-private partnerships may or may not be bound by usual state business regulations. One state described how they created a public-private partnership to form a RHIO that did not have to adhere to state procurement regulations. This was viewed positively as state vendor procurement rules are often perceived as cumbersome. In contrast, another state explained how the public/private partnership between their Medicaid agency and the local primary care association (PCA) encountered difficulties with its vendor when it wanted to purchase eHIE/HIT tools already developed for a state health department from a different state. Since the PCA was the contracting entity, the vendor would not deliver the same tools without additional associated development costs as the PCA “was not a public entity”.
- Address state laws and regulations that need updating. **Structure/Interoperability**
 - State laws and regulations regarding health information were enacted before eHIE/HIT tools were available and therefore need to be updated. Sharing of behavioral health data, the exchange of data across state lines, and the licensing of providers across state lines are areas where particular attention is needed.
- Promote consumer involvement in eHIE initiatives. **Consumer Involvement**
 - Consumer involvement with state eHIE initiatives varies (e.g., holding focus groups, giving consumers a voting seat, conducting surveys). However, there is

consensus that consumers need to be involved with eHIE efforts from the beginning.

Federal Level Recommendations

- **The Department of Health and Human Services (DHHS) needs to develop a broader funding model to foster cross DHHS agency collaborations.** Funding initiatives that take into account the data needs of more than one agency will foster the electronic sharing of data across agencies and other healthcare related stakeholders. **Structure/Leadership/Financial Responsibility**
 - DHHS should take a holistic approach to funding initiatives and break down the ‘siloed’ funding approaches of CMS, HRSA, SAMHSA, AHRQ, and CDC.
 - Funding models should be created to follow the person not the payer.
- **The Centers for Medicare and Medicaid Services (CMS) should develop a unified message and support integrated eHIE and quality improvement projects between Medicare and Medicaid.** Providers lose visibility (and put members at risk) when 65+ member data is not available in the eHIE network. **Interoperability/Structure/Leadership**
 - Promote interoperability and data sharing between agencies.
 - Support a unified approach to quality improvement across all initiatives.
- **CMS should update and clarify federal financial participation and MMIS/ MITA regulations.** State Medicaid agencies need guidance in understanding the MITA framework, e.g., how MITA relates to eHIE outside the Medicaid agency and how MITA affects eHIE between Medicaid, other state agencies, and other healthcare stakeholders. **Structure/Interoperability/Financial Responsibility**
 - Promote more cross agency collaborations between state agencies.
 - Provide clarity on how MITA supports eHIE.
 - Provide enhanced matching funding and support for HIT/eHIE that go beyond “Medicaid Control”.
 - Provide a 90/10 match for eligibility systems. When redesigning MMIS using a service oriented architecture platform, eligibility becomes an integral part of the technological design. The lack of a 90/10 match for eligibility systems is a barrier to states that want to transform their IT systems.
- **CMS should encourage joint eHIE ventures between states.** **Interoperability/Structure/Leadership**
 - Although CMS does allow states to collaborate, it could be doing more to encourage states to develop the functionality of eHIE across state lines.

Appendix 1: State Medicaid/SCHIP Interviews

Thirteen states were selected for interviews:

- Ten interviews were conducted
- Alaska declined to be interviewed because the Medicaid agency felt it was not far enough along with its HIT/eHIE efforts
- Delaware referred us to staff at the Delaware Health Information Network, with whom only a partial interview was conducted
- One state canceled their interview and did not reschedule

States Interviewed

State/Agency	Interview Date	Participants
Kentucky	July 10, 2007	<ul style="list-style-type: none"> ▪ Trudi Matthews, Senior Policy Advisor for e-Health, Cabinet for Health and Family Services ▪ April Smith, e-Health project manager, Office of IT ▪ Laura Cole, e-Health project manager, Office of IT
District of Columbia	July 16, 2007	<ul style="list-style-type: none"> ▪ Robert Maruca, Senior Deputy Director of the Department of Health Medical Assistance Administration ▪ John McCarthy ▪ Sam Walker ▪ LaRah Payne
Alabama	July 18, 2007	<ul style="list-style-type: none"> ▪ Mary Hayes Finch, Chief of Staff, Alabama Medicaid Agency ▪ Carol Hernan Steckel, Commissioner ▪ Kim Allen, Director Medical Services ▪ Kathy Hall, Co-Chair Policy Workgroup ▪ Kim Bath, Co-Chair Finance Workgroup ▪ Dr. Mary McIntyner, Medical Director, Co-Chair Clinical Workgroup ▪ Lee Maddox, Co-Chair Technical Workgroup
Wisconsin	July 18, 2007	<ul style="list-style-type: none"> ▪ Denise Webb, Policy Initiatives Advisor, eHealth, Department of Health and Family Services ▪ Kathleen Farnsworth, Chief of Staff, eHealth Initiatives, Department of Health and Family Services ▪ Micca Hutchins, eHealth Initiatives Project Manager ▪ Cheryl McIlquham, Director Office of Policy Initiatives and Budget

Missouri	July 20, 2007	<ul style="list-style-type: none"> ▪ George Oestreich, Director of Clinical Services, Division of Medical Services, Department of Social Services Medicaid Program ▪ Rhonda Driver, Department of Social Services, Division of Medical Services ▪ Amy Wood, Deputy Director of Pharmacy and Clinical Services, Division of Medical Services, Department of Social Services
West Virginia	July 23, 2007	<ul style="list-style-type: none"> ▪ Leonard Kelley, Deputy Commissioner, Bureau for Medical Services ▪ Jerry Roueche, Assistant to the Secretary of the Department of Health and Human Resources ▪ Michael Morris, Health Information Systems Coordinator for Bureau of Public Health
Vermont	July 25, 2007	<ul style="list-style-type: none"> ▪ Judy Higgins, Chief Information Officer, Office of Vermont Health Access (Medicaid)
Tennessee	July 26, 2007	<ul style="list-style-type: none"> ▪ Brent Antony, TennCare Chief Information Officer ▪ Antoine Agassi, Director and Chairman of the State's eHealth Advisory Council ▪ Laurie Lee – Deputy Executive Director for the Department of Finance & Administration (SCHIP)
Indiana	July 27, 2007	<ul style="list-style-type: none"> ▪ Jeffrey Wells, Indiana Medicaid Director ▪ Mike Sharp, Director of Pharmacy ▪ Randy Miller ▪ Natalie Angel, Office of Federal Grants and Procurement, Indiana Family and Social Services Administration ▪ Emily Hancock, Health Policy Advisor, Indiana Office of Medicaid Policy and Planning
Arizona	August 3, 2007	<ul style="list-style-type: none"> ▪ Anthony Rogers, Director of the Arizona Health Care Cost Containment System
Delaware*	August 8, 2007	<ul style="list-style-type: none"> ▪ Robert White, Board Chair, Delaware Health Information Network / Chief Executive Officer, Delaware Physicians Care, Inc. ▪ Gina Perez, Project Manager, Delaware Health Information Network

* Partial interview only and no Medicaid staff involved.

Appendix 2: Medicaid and SCHIP Interview Protocol

General:

1. Introduction of the team and purpose of the interview: To make actionable recommendations to Governors for the facilitation of health IT (HIT) and electronic health information exchange (HIE) use and adoption in state Medicaid and SCHIP programs.
2. What is your position and role in the Medicaid / SCHIP program?
3. Can you describe the organizational and reporting structure of the Health and Human Services agencies in your state?
4. Can you describe the HIT or electronic HIE efforts being planned or currently underway in your Medicaid and SCHIP programs? Please describe the goals of the project(s) (quality, cost, program improvement etc.) and expected outcomes.
5. Where are you in the implementation process? (Planning, Design & Development, Implementation, Fully Implemented)

Targeted Queries for Structure, Governance, Consumer Roles, Fiduciary Responsibility, and Interoperability:

1. Can you describe how your Medicaid and SCHIP programs became involved in this HIT/HIE initiative?
2. How is your project initially being funded? Are you taking advantage of federal match funding (FMAP) in this project? Using Medicaid Demonstration Waiver authority? State appropriation?
3. Have you conducted a needs assessment / return on investment (ROI) study? If so, please explain the methodology. (Are results available to be shared?)
4. In your opinion should Medicaid / SCHIP programs be fiscally responsible for supporting HIT adoption at provider sites?
5. How does the project address provider HIT adoption challenges? For practices serving a disproportionate share of Medicaid members or needing particular assistance (CHCs, RHC, small practices, LTC, etc.)? Are you providing, or planning to provide incentives or requirements for: Adoption? Implementation? Ongoing maintenance?
6. Are you collaborating with other publicly funded programs (Public Health, State Employee Benefits Plans, Others)? Public/Private partnerships? Private initiatives? HIE? States? Others? If so, How?
7. Who are the key stakeholders involved in the initiative? How are you building trust among the parties?
8. How have you incorporated stakeholder feedback in the planning and implementation phases? Have you solicited consumer feedback?
9. How are consumers involved in the project? Is there an opt-in or opt-out strategy developed? If so, why did you choose that model? Are you pursuing targeted efforts to reach diverse populations?
10. Is consumer education and outreach part of the project? If so, how is this being accomplished?
11. What is the governance model of the initiative?

- a. Transformational (i.e., traditional governance structures are being realigned significantly so as to bring about a new system that has the potential to greatly improve processes and outcomes through new structures, procedures, technologies)?
 - b. Collaborative (i.e., governance is distributed equally among all stakeholders)?
 - c. Coordinated (i.e., where one primary stakeholder has governing responsibility)?
12. Is Medicaid /SCHIP leading the initiative?
 13. How is the Governor / Governor's office involved?
 14. How does this project relate to your MMIS and the MITA initiative? Your current data systems?
 15. How is your project addressing interoperability and data exchange? Interdepartmental? Intrastate? Interstate? Public/Private (RHIO)? Others? How are members/beneficiaries being identified (Master Patient Index etc.)?
 16. What HIE technical standards are in use? Are there additional standards planned for the future?
 17. What is the governance structure of the electronic HIE if you are participating in one. How is your organization represented?
 18. How is your project addressing access control, audit protocols, and appropriate purposes of data use?
 19. Are there risk management strategies included in your project? Please describe.
 20. Have you built in an evaluation plan? How are you measuring results?
 21. What kind of sustainability plan do you have in place for this initiative? Financial? Programmatic (if a pilot project: future rollout)? Growth / Maturity? Maintenance of relationships and trust?
 22. What are your plans for future HIT / HIE initiatives?
 23. What are the primary challenges and barriers that you have encountered during the project to date? Cultural? Training/Workforce? Technological? Process or project management? Engagement with vendors? Engagement with Providers? Others?

Recommendations:

1. What changes in Federal Medicaid policies would be useful to support HIT / HIE in your Medicaid and SCHIP program? MMIS / MITA? Procurement? Medicare? Other?
2. What changes in State Medicaid / SCHIP policies would be useful to support HIT / HIE in your Medicaid program? Legal and Regulatory? Other?
3. What recommendations would you make to Governors to provide greater support and assistance for HIT / HIE initiatives in the Medicaid / SCHIP programs?
4. What other needs have you identified regarding HIE / HIT in Medicaid and SCHIP that would require action?

For more information, please contact:
Shaun Alfreds at (207) 228-8306



222 Maple Avenue, Higgins Building, Shrewsbury, MA 01545-2732
Tel. (508) 856-7857 Fax. (508) 856-4456
<http://www.umassmed.edu/healthpolicy/HIT/PolicyDevelopment.aspx>