Opportunities for Facilitating Electronic Health Information Exchange in Publicly Funded Programs:

Findings from Key Informant Interviews with State Employee Health Benefit Plans

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Introduction

Health information technologies (HIT) and electronic health information exchange (eHIE) have been identified as essential tools needed to improve health care quality, effectiveness, and value. To facilitate the policy development processes for States to support these health care tools, the State Alliance for e-Health has charged the Health Information Communication and Data Exchange (HICDE) Taskforce 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 its charge, the University of Massachusetts Medical School Center for Health Policy and Research, in collaboration with the NGA Center for Best Practices, is conducting a qualitative analysis of the opportunities and challenges for publicly funded healthcare programs to participate in and facilitate the use of HIT and eHIE.

This report, the third of three, presents an overview of the findings and recommendations from key informant interviews conducted with state employee health benefit plan (SEHP) officials and staff members. This report is meant to assist the HICDE Taskforce in developing actionable recommendations for facilitating eHIE to support and advance high quality, cost effective healthcare purchasing and promotion strategies by SEHPs.

Methods

The HICDE Taskforce, during its 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. Seven state employee health plans (SEHP) 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 state value-based purchasing initiatives reviewed by the Commonwealth Fund[1], and selected states identified as innovators in modernizing health insurance by the National Association of Insurance Commissioners[2]. These agencies were interviewed between November 2007 and January 2008 (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,

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[1] S. Silow-Carroll and T. Alteras, Value-Driven Health Care Purchasing: Four States that Are Ahead of the Curve, The Commonwealth Fund, August 2007.

[2] State Innovations in Modernizing Health Insurance and Extending Coverage to the Uninsured. The National Association of Insurance Commissioners, December 2006.

key challenges, and recommendations at the state and federal level. The success factors, challenges, and recommendations presented here represent the perspectives of the SEHP officials interviewed, including their perceptions of the role of HIT and eHIE and how their states have begun to implement HIT and eHIE initiatives.

HIT and eHIE Success Factors Identified by State Employee Health Benefit Plans

"We utilize HIT for purposes of controlling cost and improving quality... We think about what is in the best interests of our members so we can in fact provide the right programs to steer people into proper behaviors ..."

State Employee Health Benefit Plans (SEHP) are large scale employer based health plans providing health care benefits to an increasingly large share of state citizens. In some states SEHPs are the largest purchasers of health care. The California Public Employees' Retirement System (CalPERS), for example, is the third largest purchaser in the nation covering 3 million member and dependent lives. Eligible persons for SEHPs include active state employees, covered dependants, local government employees, public universities, state government retirees, and other quasi-state government related organizations. In some states the SEHPs also provide health insurance coverage for local employers.

SEHPs are financed through multiple mechanisms such as state and county revenues, legislative appropriations, pension investment funds, and premiums collected from employers, employees and dependants. The organizational reporting structure of SEHPs varies from state to state. In many states the SEHPs are not associated with other health and human service agencies and are considered special fund units. In these cases, SEHPs act much like third party payers, billing each employee unit based on negotiated rates. In other states the SEHP is part of the state health and human service umbrella agency, with employee benefits being integrated with public benefit plans. The commissioner/administrator of a SEHP may report either to the legislature or to a cabinet level position or he/she may serve at the cabinet level. In general, SEHP interviewees emphasized how their organization tended to operate more like a private business than a traditional government agency.

SEHP interviewees, like the Medicaid and Public Health agency interviewees, recognized that HIT and eHIE are tools used to achieve health care quality improvements and reductions in health care costs. In addition there was the recognition that eHIE is only successful if there is collaboration at all levels of the health care continuum, from delivery to purchasing and regulation. It was almost universally viewed by interviewees that addressing provider adoption issues was as an important role for all participating stakeholders, including the SEHP. However, directly purchasing hardware and software for providers was not viewed as a fiscal responsibility of the SEHP. Multiple interviewees suggested that indirect incentives and market-based support for provider investments in HIT were more appropriate and would likely yield the most effective and efficient system adoption.

There were some similarities between the success factors identified by the SEHP officials interviewed and those identified by Medicaid and Public Health interviewees. These similarities present opportunities for the HICDE Taskforce to develop integrated strategies to support the successful involvement of all publicly funded health care programs in eHIE/HIT initiatives. The success factors presented by SEHP officials are presented below:

- <u>Executive-level leadership is an important factor for SEHP quality improvement initiatives involving HIT/eHIE.</u> Support from the Governor and leadership at the senior health official level was important to prioritizing SEHP involvement in HIT/eHIE initiatives. In some cases Governors convened multiple stakeholder groups to begin

quality improvement initiatives, in others, executive orders and state-wide roadmaps/strategic plans were mechanisms by which the SEHP became involved in HIT/eHIE related initiatives. In one state, the Governor supported a mandate for the use of electronic medical records (EMRs) by 2015, resulting in a large-scale multi-stakeholder project involving the SEHP.

  - SEHPs stated the need for legislative support for their involvement in eHIE and HIT initiatives. An example of an important area for legislative action for SEHPs was a mandate for uniform administrative coding across all state plans and providers. In one state, legislative mandating of uniform administrative coding has resulted in the inclusion of Medicare claims data into the HIE efforts (another important data need identified by SEHPs).

- A multi-stakeholder collaborative ehealth governing body was highlighted as an important mechanism for convening and coordinating state-level eHIE. As with Medicaid and Public Health interviewees, SEHP officials emphasized the need for a multi-stakeholder collaborative ehealth leadership/governing body that is able to engage multiple health care stakeholders from the delivery to the regulatory and purchasing arenas. A governing body would:
  - help mitigate competitive barriers between private vendors, providers, and purchasers;
  - support community-wide strategies that promote provider adoption and use of HIT;
  - promote intrastate agency partnerships; and,
  - allow for the development of state-wide interoperable systems and collaborative quality improvement and transparency initiatives.

- Physician involvement in the development and leadership of HIT/eHIE initiatives was viewed as necessary for building trust in the provider community. The specific involvement of physicians as chairs and co-chairs of committees within these projects helped to generate greater community buy-in.
  - Involving physicians has been an important success factor in the implementation of provider tiering and quality measurement/benchmarking programs in SEHPs. By positioning the programs as “physician driven”, the negative perceptions related to government and private interests dictating clinical care guidelines are diminished.

- SEHP involvement with HIT and eHIE was often associated with broad health care quality and cost containment initiatives. SEHP interviewees identified their interest in HIT and eHIE as a necessary part of their quality improvement and cost containment activities. SEHPs were more often participating in and driving initiatives that employ the use of HIT/eHIE for clinical performance measurement, quality improvement programs (e.g., pay for performance), transparency initiatives (e.g. cost and quality websites), and consumer wellness tools (e.g., personal health records (PHR)). Many of these initiatives use claims based data with the intent to build in capacity for clinical data when it becomes available.
  - One SEHP official described the implementation of a state-wide provider practice support program that includes training and assistance tools for providers not meeting minimum performance standards. This “carrot only” approach, where providers are not penalized but supported, has resulted in significant buy-in and support for the program.

    - Multiple interviewees were participating in Bridges to Excellence[3] and Leapfrog Group's[4] practice and clinical performance programs.

- SEHPs, due to their large size, have significant purchasing power to support HIT and eHIE related projects. For SEHPs that contract with vendors, health plans, and provider groups, the contracting mechanism was viewed as a successful and necessary tool to promote HIT/eHIE use. The vendor contracting mechanism was seen as a successful means for encouraging vendor plans to report performance related data and drive the use of HIT tools such as EHRs and electronic prescribing (eRx). For vendors who currently use EHRs, the contracting process was viewed as a means to promote interoperability and eHIE between plans. This process was also viewed as an important means to address consumer movements among plans and providers.
    - To anticipate future HIT/eHIE needs the SEHPs interviewed have developed limited time-frame vendor contracts to allow for expedited contract changes when necessary. In addition placeholders have been included within the contracts for specific parameters such as standards, vendor relationships, etc, that can then be easily incorporated into contractual requirements at a later date.
- Aligning the purchasing strategies and joint purchasing strategies between the SEHP, other state agencies (including Medicaid), and outside stakeholders was identified as a successful mechanism to drive state-wide HIT/HIE adoption and use.
    - Although state and federal procurement rules have prevented some SEHP and other state agencies from entering into joint procurement contracts, aligning the use of requirements around quality, performance, and HIT/eHIE was viewed as an important means of standardizing processes and data across state agencies and other private stakeholders.

Challenges Encountered by State Employee Health Benefit Plans

The SEHPs interviewed recounted the challenges and obstacles related to their respective HIT/eHIE initiatives. Despite the number of challenges, there was consensus on the positive impact of their states' involvement with eHIE. The challenges presented by interviewees are presented below.

- States are struggling with how to participate in EHR, eRx, hospital HIT, and eHIE initiatives and they are unsure of the national direction. Is the federal government pushing for universal EHRs, eRx, eHIE, or all of the above?
- Quality measurement and reporting functionalities need to be embedded into EHRs and other clinical systems. Currently, clinical quality measures and clinical auditing are primarily conducted via expensive chart pulls. Even if a provider does have an EHR system, many such systems lack the functionality to produce aggregated quality reports.
- Lack of Medicare participation in HIT/eHIE quality initiatives. With Medicare covering most acute services provided to the disabled and the elderly, a comprehensively designed quality measurement program must include information on these encounters. Currently few states have access to accurate and current Medicare claims data. With Medicare being the largest purchaser of healthcare in the nation, it could also have

[3] http://www.bridgestoexcellence.org
[4] http://www.leapfroggroup.org

significant leverage in driving HIT/eHIE adoption in clinical settings if it were to participate with state partners.

- Educating employees (consumers) on the benefits (and realities) of HIT and eHIE. It is challenging to communicate the value of eHIE to consumers. Many consumers assume that physicians already use EHRs and other HIT tools. In addition there are significant consumer concerns over the privacy and security of their personal health information.
    - A challenge for many SEHPs is getting employees (consumers) to understand that quality improvement requires efforts (which often rely upon the use of HIT/eHIE) also need to come through individual behavioral change (e.g. diet, smoking cessation, exercise, disease management).
- Writing RFPs and contracts that address the health informatics needs of state agencies in the future. SEHPs recognized the significant leverage they have over their vendors but are challenged and requested assistance in writing RFPs and contracts that address their current, and more importantly, future informatics needs.
- In many states there is a lack of high-speed internet connectivity for rural health care providers. Interviewees viewed this lack of connectivity as a significant obstacle to promoting state-wide use of HIT/eHIE tools. The varying connectivity between urban and rural settings presented challenges related to developing fair practices to hold vendors accountable for acquiring clinical performance data.
- SEHPs recognize and are prepared to pay more for fully "wired" providers, but are challenged as to how to support the upfront investments in HIT systems. SEHP officials accept their broader responsibility to pay for their appropriate share of quality improvement. However, HIT and eHIE direct investments were not viewed as the role of SEHPs. Many officials interviewed expressed the need for market-based mechanisms to support HIT adoption by providers themselves rather than expecting the state agencies to purchase the systems. There was also consensus that SEHPs should not be subsidizing other state program investments in HIT and eHIE.
- Many SEHP legacy systems are outdated and will require significant upgrades and/or replacement as they participate in eHIE. Many officials pointed to the need for upgrading of their claims processing systems and the incorporation of data warehouses to support decision making. The mechanisms by which SEHPs can pay for these upgrades along with more broad based initiatives are not clear. Some interviewees suggested that state agencies are competing over limited funding streams, thereby impeding collaboration.
- Return on investment (ROI) and sustainability models are either limited or do not address the unique needs and requirements of state agencies. ROI for HIT and eHIE is poorly understood by most state agencies including SEHPs.
- Limited funding opportunities present a challenge when considering scalability. SEHPs that are investing in these technologies are challenged to get the most "value" due to the limited funding currently available through grants, contracts, and appropriations.

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

The SEHP agencies interviewed were given the opportunity to make specific state and federal level recommendations to the HICDE Taskforce in order to address the challenges cited above and to promote eHIE in public sector programs. The recommendations that follow represent a summary of the responses received.

State Level Recommendations

- Governors should support the creation of a collaborative ehealth governing body to convene, facilitate, and direct state-wide eHIE efforts that include the needs of SEHP. This group, supported by the governor, should serve as a convener, facilitator, and consumer advocate.
  - One state recommended the following: Due to the challenges related to the myriad issues related to HIT, states will have greater success if they focus their efforts on specific collaborative, scalable projects that have a clear benefit to all stakeholders involved. Then, from that successful implementation, build buy-in for larger-scale initiatives.
- State ehealth governing bodies need to develop return on investment studies that demonstrate the value and sustainability of eHIE.
  - Determine the value proposition for all stakeholders (providers, consumers, pharmacies, labs, communities, state agencies, and the health care system).
- Governors should work with border states to align state data collection and sharing policies to support interstate data exchange.
- Executive leadership should make eHIE and HIT a priority across all levers of purchasing power for states. SEHP officials suggested that states use all the levers of purchasing power, including state employee benefit plans, to support eHIE.
  - Improve bargaining/regulatory power with HIT vendors and influence the inclusion of quality metrics within EHR and other clinical software packages.
  - Use the contracting process to align state agency procurement (e.g. Medicaid and SEHP) as well as require health plans to systematically use standardized HIT systems.
  - Use language that gives payment preference to providers who have an EMR/EHR system that is connected to an eHIE.
  - Remove barriers to interstate data exchange by promoting joint contracting where possible and joint requirements where regulations act as barriers.
  - Consider the promotion of “Centers of Excellence.” Only pay for certain high cost treatments at specific centers that use technology.
  - Consider an EHR mandate.
- Governors and legislatures should support funding mechanisms to address the software, hardware, and connectivity issues common among rural health care practices.

Federal Level Recommendations

- The Department of Health and Human Services (DHHS), the Institute of Medicine, and/or the Surgeon General should review existing performance and quality metrics and promote a standard “minimum set” of quality metrics and evidenced based practice guidelines to be incorporated into nationally supported HIT/eHIE efforts.
- The Department of Health and Human Services should align quality improvement and purchasing strategies involving HIT and eHIE among all federal agencies.
  - There needs to be a clear statement and/or plan from the federal government as to the direction they wish to head in regard to HIT/eHIE. What technologies are

supported? What standards are to be used? Where is the funding coming from? These questions need to be answered in order to promote interoperability across state lines.

    - The Healthy People 2010 was an example of a successful, federally driven initiative that can be used as a model planning process for DHHS and the Office of the National Coordinator for HIT.

  - Medicare must be a full participant in eHIE at the state level in order to achieve a successful national health information infrastructure both from a data and a purchasing perspective.
  - Secretary Leavitt's 'Four Cornerstones' are a good starting point for aligning purchasing priorities across federal and state agencies.

- <u>CMS, ONC, and other federal agencies should provide guidance to states and/or a framework for creating master patient indices that promote interoperability between states.</u>

Appendix 1: State Employee Health Benefit Plan Interviews

State employee health benefit plans from 8 states were selected for interviews:

- Seven interviews were conducted
- One state declined to be interviewed because it felt that it was not far enough along with its HIT/eHIE efforts

State/City	***Interview Date***	***Participants***
California	January 14, 2008	▪ **Gregory Franklin**, Assistant Executive Officer, Health Benefit Services, California Public Employees' Retirement System
Georgia	January 7, 2008	▪ **Nancy Goldstein**, Division Chief, State Health Benefit Plan, Georgia Department of Community Health ▪ **Alicia McCord-Estes**, Project Management Office Director, Georgia Department of Community Health ▪ **Sonny Munter**, Chief Information Officer, Georgia Department of Community Health ▪ **Lisa Marie Shekell**, Director of Communications, Georgia Department of Community Health ▪ **Cheryl Williams**, Clinical Director, State Health Benefit Plan, Georgia Department of Community Health
Massachusetts	November 26, 2007	▪ **Dolores Mitchell**, Executive Director, Group Insurance Commission, Commonwealth of Massachusetts
Minnesota	October 30, 2007	▪ **Pat Anderson**, Commissioner, Minnesota Department of Employee Relations ▪ **Susan McDonald**, Director, State of Minnesota Governor's Health Cabinet ▪ **Nathan Moracco**, Manager, SEMA4 Benefits Services, Minnesota Department of Employee Relations
North Carolina	January 8, 2008	▪ **Dan Soper**, Chief Operating Officer and Deputy Executive Administrator, North Carolina State Health Plan
Washington	November 30, 2007	▪ **Steve Hill**, Administrator, Washington State Health Care Authority ▪ **Richard Onizuka**, Health Care Policy Director, Washington State Health Care Authority
Wisconsin	November 19, 2007	▪ **Thomas Korpady**, Administrator, Division of Insurance Services, Wisconsin Department of Employee Trust Funds ▪ **Bill Cox**, Director, Health Insurance Plans Bureau, Wisconsin Department of Employee Trust Funds ▪ **Sonya Sidky**, Project Manager, Division of Insurance Services, Wisconsin Department of Employee Trust Funds

Appendix 2: State Employee Health Benefit Plan 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 employee benefits programs.

2. What is your position and role in the program?

3. Can you describe the organizational and reporting structure of the agency overseeing your state employee benefits program and its relationship with the Health and Human Services agency in your state?

4. Can you describe the mission of the state employee benefits program, the coverage options and populations served?

5. Can you describe the HIT or electronic HIE efforts being planned or currently underway in the employee benefits program? Please describe the goals of the project(s) (quality, cost, program improvement etc.) and expected outcomes.

6. Where are you in the implementation process? (Planning, Design & Development, Implementation, Fully Implemented)

Targeted Queries to assess the Structure, Governance, Consumer Roles, Financial and Contributory Responsibility, and Interoperability strategies of the initiative:

1. Can you describe how your employee benefits program became involved in this HIT/HIE initiative?

2. How is your project initially being funded? Are you taking advantage of federal funding in this project? 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 the employee benefits program be fiscally responsible for supporting HIE/HIT adoption at provider sites? How does this project(s) address provider HIT adoption challenges?

5. Are you collaborating with other publicly funded programs (Medicaid/SCHIP, Public Health Programs, Others)? Public/Private partnerships? Private initiatives? HIE? States? Others? If so, How?

6. Who are the key stakeholders involved in the initiative? How are you building trust among the parties?

7. How have you incorporated stakeholder feedback in the planning and implementation phases?

8. Who are your consumers and how are they involved in the project? Are you pursuing targeted efforts to reach diverse populations including the uninsured? Is consumer education and outreach part of the project? If so, how is this being accomplished?

9. What is the governance model of the initiative?

10. Is the state employee benefits program leading the initiative?

11. How is the Governor / Governor's office involved?

12. How does this HIE/HIT project relate to your current data systems?

13. How is your project addressing interoperability and data exchange? Interdepartmental? Intrastate? Interstate? Public health laboratories? RHIO?

14. What HIE technical standards are in use? Are there additional standards planned for the future? Are you involved with other national initiatives?

15. What is the governance structure of the electronic HIE if you are participating in one? How is your organization represented?

16. How is your project addressing access control, audit protocols, and appropriate use of data?

17. Are there risk management strategies included in your project? Please describe.

18. Have you built in an evaluation plan? How are you measuring results?

19. 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?

20. What are your plans for future HIT / HIE initiatives?

21. 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 policies would be useful to support HIT / HIE in your state employee benefits plan?

2. What changes in State policies would be useful to support HIT / HIE in your program?

3. What recommendations would you make to Governors to provide greater support and assistance for HIT / HIE initiatives?

4. What other needs have you identified regarding HIE / HIT in state employee benefits programs that would require action?

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