

Positioning Medicaid and CHIP for the Future: Health IT Regulations, Initiatives, and Opportunities—April 2009

E-mail Stephanie Rizk if you want a copy of today's presentations. We are in the process of posting all of our webinars to the project website, which is at <http://healthit.ahrq.gov/Medicaid-SCHIP>. All of our slides from 2008 are available and this will be up as quickly as we can.

Would like to encourage you if you have not done so already to register for the listserv. This is how we get information out about webinars and other offerings this year. There's information on this slide about how to sign up for the listserv. We send out notices about the webinars and the other technical assistance offerings that we will be having and general news items every now and again. There is not a lot of traffic but will at least keep you informed so you can be sure to participate in whatever you are interested in.

I think that is the end of the intro remarks. We have two excellent speakers today, and we are excited to have both here. I'll give you a background and then we'll begin presentations.

Our first presenter is Anthony Rodgers. Tony has over 30 years of health care executive management experience in public hospital systems, health plans, and Medicaid Programs. He was appointed to the position of Director of the Arizona Medicaid Program, known as the Arizona Health Care Cost Containment System (AHCCCS) in 2003.

As Director, Mr. Rodgers reports to the Governor and is responsible for health coverage for over one million Arizonans. The agency administers multiple sources of governmental and private funds and is responsible for regulatory oversight and compliance of Medicaid managed care health plans and health care providers to assure quality of care, fiscal accountability, and cost containment. Mr. Rodgers is Chair of the Multi-State Collaboration on Medicaid Health System Transformation and was recently appointed as a member of the National Quality Forum. He has been recognized by the *Arizona Business Journal* for leadership in health insurance coverage, and by the Urban League for community service. Mr. Rodgers has a master of science degree in public health and BA degree in economics and political science from UCLA. He holds visiting professor appointments at Arizona State University, the W.P Carey School of Business, and at UCLA School of Public Health and is an expert on nonprofit organization governance.

Our second presenter today, Ms. Patricia MacTaggart, has been involved in Medicaid and other publicly funded health care issues her entire career. She has held executive positions in a national research and consulting firm, HMA; a global for-profit company, EDS; a statewide not-for-profit company, Delta Dental Plan of MN; a federal government agency, HCFA/CMS; a state government, MN Dept. of Human Services/Medicaid Director; and a county government in Minnesota doing Medicaid eligibility. She is currently at George Washington University (GW), where she instructs graduate students in health information technology (HIT) policy, quality, and state health policy. She was also Vice Chair of the National Association of State Medicaid Directors.

She is currently a member of several national committees devoted to health care, quality, and electronic health information, including HIMSS NCA, AHIMA's Foundation, Academy Health IT Interest Group, March of Dimes National Public Policy Council, NCHICA, National Academy of Social Insurance (NASI), and CAHMI.

Both Tony and Trish are familiar to many of you on the call today. We'll let Tony begin his presentation.

Good afternoon, great to be with you. I know there's a lot of interest in the American Recovery and Reinvestment Act (ARRA) especially the HITECH provision so I thought it would be helpful to give you a broad view about how to think about the Act and how that fits with Medicaid. The Act really has a number of areas where states have the opportunity to fund various projects. Certainly one of the puzzle pieces [in] health IT adoption is EHR adoption, but the Act also has significant dollars for broadband expansion and telecommunication expansion. So where you have rural areas, where there's not adequate broadband for a project, especially as it relates to video, you have enough dollars. One of the things you should know as a state is there is a priority given to broadband expansion. But also the expectation that along with EHRs the ability to have electronic clinical decision support integrated so there is funding to support CDS as well as the necessary clinical databases and registries. There is also money for telemedicine and telehealth and dollars for patient decision support. So there are plenty of areas where states are being given grant money and I hope you'll be able to take advantage of that.

When it's all said and done, it's about creating component parts of a system that can manage chronic care. Taking the chronic care model, I wanted to show where EHRs and systems fit within the Wagner chronic care model. As you know the Wagner model shows an integrated system that takes advantage of a delivery network as well as decision support tools available to create an informed clinical practice team and on the other side are the tools that create an informed patient. Also the fact that the dollars are there for health information exchange and expansion into the community. There's opportunities to take advantage, to use EHRs that can help other community support programs as well.

Some of those opportunities include grants for health information exchange: there's \$300M for existing exchange expansion as well as planning new exchanges. There's also money for electronic health records and decision support. The money for EHRs can come from loans, or grants, or the incentive program. What's unique about the Act is that some of these grants can be 100% federally offset so they do not necessarily need to have matching dollars. There's also money for EHR adoption support and training, as well as broadband and telemedicine—all with the expectation that you are going to integrate this into your EHRs. There's also money for loan programs for those providers who may not have the money to start.

As for Medicaid, [it] has some other additional opportunities, including 90/10 funding for the administration of the incentive program and the administration of HIT support. Can qualify for 90/10 funding. Also competitive grants but there are still the MITA dollars

and you can apply for that provided you use the MITA infrastructure of the state whether it is clinical data database or developing interfaces, etc. and that is 90/10 for planning and 75/25 for implementation. The final thing to consider [is] how are we going to help medical education programs at hospitals to get access to dollars that are allotted to them. Sometimes states are subsidizing those programs.

The HITECH Act also funded activities for community health centers, Indian Health Center, there's money for public health centers either through CDC or other funding sources. Money for education on informatics for universities. As I mentioned there's funding for clinical decision support application development and for comparative effectiveness research as well as for repository, databases, and registries. The thing about the Act is that the funding is in different agencies and each will be establishing their priorities and purposes for funding.

So what should states be doing? I'm providing you a readiness checklist. The first [thing] is that states should really be doing an environmental scan. Where are you now? What is your situation? Do you have developed health information exchanges? Is there a lot of EHR adoption? That will then tell you what your gap is and where you need to invest priorities and time.

Then develop your Medicaid state strategic plan. You have a number of providers that need to be incorporated, like training programs and hospitals, qualified health centers, but there are also some nontraditional collaborators like public health and behavior health centers. These programs need to be incorporated as well.

The other thing on your checklist is that you are collaborating with both the public and the private [sector] and these stakeholders need to be involved. It is important that this is not just state Medicaid but involving private-sector counterparts.

The governor and legislature need to demonstrate political will. These are the type of programs that once you get started, they are going to need funding and if they are going to be subject to immediate budget cuts or reductions that will be a problem in maintaining and sustaining projects.

The governor needs to appoint an accountable entity. They can appoint two entities, a private entity and the Medicaid agency as the public entity as well. Or [they] can choose to establish a position within the state to be the accountable party.

What is the role of the Medicaid [agency]? Needs to be clarified and accepted. This is important because governors get re-elected every 4 years. You want to make sure you have continuity in authority and responsibility. And where it needs to be clarified is in legislation as well, but advance the idea of codifying the role of Medicaid in the effort. Then address the long-term view in the plan; this is a 3-5 year process, not something that is done in 1 year. In fact, incentive programs go as far out as 6 years so the strategic horizon needs to be that far out.

You need both public and private capital to ensure you get widespread adoption of electronic health records and the HIE infrastructure.

The other area that is important is the technical support for electronic health record adoption. Just having an incentive program is not going to be enough. Providers have to reengineer their processes and that's going to take on-the-ground assistance available to providers to help them through that burden period. That is so important to reduce the risk of failure.

So what should environmental scan and gap analysis have in it? You need to evaluate the capacity and gaps in your statewide exchange structure. If you have exchange going on now, what is its capacity to expand and to scale up?

What are the gaps in terms of the types of documents that are available to the exchange? Does it have your medication history, your lab information; can it exchange documents like the discharge summary; or is it currently only an administrative exchange? You need to look at that because you're going to need to put priority on upgrading your exchange capability.

You need to analyze your current state of EHR adoption. Many of the FQHC and even private physician offices have already adopted electronic health records. Why is knowing the adoption rate important? The Medicaid agency will not get a return on investment that is reducing the cost of medical care because of the amount of inefficiency, etc. You will not be able to pull that out of the cost curve or the quality improvement unless you can add this information in.

There needs to be an analysis of what are the provider attitudes and challenges. No access to broadband, rural practices, no time to train staff. What are the challenges and how will you tackle them in your strategic plan?

You need to analyze the integration of public health information and what information is available now and behavioral health information. What are the rules and how are you going to provide that information? Do we want behavioral health to be transmitted to physicians? It goes the other way too...what information does the behavioral health provider need that comes from the personal health provider?

Your technical support requirements and the technical competencies you have internal to the organization as well as external technical assistance you need to provide. Assess what are your funding options and which agency of the federal government might provide resources and what opportunities are available for private financing. Many states are already moving forward to fund information exchange. You can use that and match federal dollars with that.

Also assess your legislative, policy, and regulatory authority to make exchange of information as well as HER to give Medicaid authority to do the incentives and provide the impetus.

In building a strategic plan, look at your strengths and weaknesses because you want to manage your resources and strengths and your opportunities and threats for failure of these endeavors.

You need to set specific measures for goals. There are many pie-in-the-sky strategic goals. These should be specific to adoption strategy, timelines you put into goals, as well as outcome data. Better immunizations? Improvement in quality measures? Incorporate what you learned to your “as is” state and use that to then describe your readiness and finally work that into the scope of your Medicaid efforts within your state.

By establishing key milestones in your strategic plan you are creating public accountability for achieving those milestones. This is helpful in describing requirements to [the] legislature and governor. So it is important they are clear and reflect the timeline the President has set for adoption of electronic health records.

Need to describe your resources and look at current resources and how you will leverage. Your public/private capital requirements and then describe your strategic action steps. So that is basically the framework of an HIT strategic plan.

One of the things you’ll realize is that there are a whole new set of business partner relationships. Those you are sending data to and those who are providing data to you. So when you think about this as you do your environmental scan, who are the partners you [tend] to bring to the table so that data can be exchanged? Whether that is laboratory data or pharmacy or medication data, case management information you want available. These are the new partners and you need to have the business associate agreement in place to make this work.

It also requires a new infrastructure, which is really just expanding on the MITA infrastructure. I know CMS has a very good set of guidelines in terms of the MITA infrastructure. What changes is the security. In some cases you have to add in tools for consent and in other places you’re going to add interfaces where you’re sending data and you want authentication. So this makes the MITA environment much more complex and what is important is—whether you contract to a vendor or you have your own environment—you’re going to have to look at how your environment is going to have to change to support health information exchange. Whether it is administrative claims data as well as the other functionality that you’re going to want to push out to the health record, whether that is eligibility information, etc.

This next slide shows the specification for a Medicaid HER with e-prescribing, clinical documentation. Your referral processes: if you want automated including documentation of the continuity of care document, if you want to export to a hospital or other. You also want to have bi-directional interfaces with public health and others and you also want to have clinical decision support. What’s unique about Medicaid is that there [are] some clinical decision support references that will help physicians. Pediatricians in particular will want EPSDT clinical decision support references so they know when to make

referrals. Also we have chronic disease models and processes that you'll want to have customized references for. There's eligibility verification, integrated with the HER. Essentially you'll want a patient portal so they can see their information and you'll want standard report delivery. In subsequent years regarding meaningful use, you'll want to be able to generate reports off physician systems and submit information electronically. It will be important that we integrate case management, dental, and long-term care and that's unique to Medicaid because these are very important programs that can be integrated and used with an EHR.

So when it's all said and done, this is what it should look like. The electronic health record and health information exchange as the backbone of the point-of-care data. Whether physician has EMR or EHR it is important that they have a point of view on patient record that includes data from all points. This is the only way you can ensure [a] medical home, the only way you can ensure medical continuity. The only way you get full return on your investment. Thank you.

Reminder to folks, please use the chat mechanism and we'll have them in the queue ready to go when the next presenter is finished.

What I'm going to do is give a little context and one of the lessons I think is very important to learn is you thought the world of government had acronyms, welcome to the world of health information technology. We've got HIT, EHRs, EMRs, CPOE, e-prescribing, and just about every other "e" out there. People out there, because it's evolving, are using terms very differently. So it's very important to really [be] clear on what you mean and what you want others to hear when you use acronyms. It's going to be critical to lay things out and even when you say the words you find out people mean different things.

This is my illustration about where we came from. I've been around Medicaid for some time and in the beginning, the early 70s, we basically did Medicaid management systems that were claims processing. We went from the days of just paying claims to realizing we had information and maybe we should do something with it. Which is in the day of decision support, which was the late 80s. And then you came to the 90s, we decided we should not only retrospectively look at data but we should try to look at it prospectively and look at relational databases to look at multiple pieces of information. In the mid-90s we were doing data mining, what is the information out there. In 2006 we entered the world of web-based information, a move away from the old legacy systems, trying to get into the world of information that allows new technology and new opportunities. The world has changed.

Now we're in the next world, people have to transition both with the technology but quite frankly this is sociology. We all have a hard time with transition; what's important for us is not health information technology for the sake but what does it mean for health care reform, better delivery, better outcomes both in delivery and in health care. So the next three slides have to do with the way health care reform links to the opportunities from three different perspectives.

First is consumers. For them, it is access to insurance coverage, which is really the eligibility system and once you have access to insurance, access to the appropriate benefits at the right time from the right provider. That's what clinical decision support provides the provider in appropriate solutions. You then have to have an appropriate provider network to provide those services, which is the claims processing. If you don't pay the provider, they won't provide the services—but for the provider to be effective they need to have access to cultural and language needs of individuals, which is where we get the Web literacy issues for the providers but also from the consumer perspective. Also helps to eliminate medical errors and provide various tool to help do their job. What is intriguing is there was some concern about consumers that were homeless but in reality there is a high percentage of homeless with cell phones. It doesn't mean there aren't opportunities using modern technology. We just need to figure out the right technology for the right people. The last thing is allowing people to view their data.

In addition to the consumer, it is about what it means to providers to help deliver the health care that we the consumer hope to receive. For them it is basic ABCs, adequate reimbursement, funding for the infrastructure so they can maximize the use of health information technology, see the benefits to serving the population outweighing the negatives. Which means, are the tools there to help the provider be a part of this prospective delivery system and quality base? So the provider tools help build their competency, help them to defer to their clinical judgment and to expedite payment and decision making through e transfers and billing.

And then for the purchasers. The ABCs for the purchasers [is] really aligning the incentives: consumer, provider, taxpayer are able to improve the quality of health and health care delivery. It's all about balancing the three legs of quality, access, and affordability. For continuity of care, continuity of providers, and continuity of the system. This is all about states moving toward being an effective purchaser of health care for a very large consumer base and doing it based on evidence-based medicine.

There are few opportunities for health information technology. In order to do that you must address things in a very different way. We have talked about literacy for a long time but for the Medicaid program it is basically making sure everything is communicated at a 4th-grade reading level. You can have reading level but for actual literacy you need health literacy and computer literacy. In order to have effective communication, this is about trust between consumers, providers, and purchasers. This is about dealing with a fairly important policy and security issue about privacy. Security of consent both through tools like authentication and authorization in order to build complete communication. Complete communication goes back to what I said, that it is dependent on both interoperability and integration. Communication is really about data. In order to get evidence-based information, we need to deal with things we have not in the past, which is, what is appropriate retention of data, what is clean data and how do we get the data distributed? How do we do it effectively, efficiently, and in a way that is easy to use?

This is not new, this is a slide of a survey done by NGA in 2007 looking ahead to where states identified their e-health priorities at that time. You can see that 25 states looked at eHIE adoption but if you look underneath it's really the categories that make that possible. The states were not looking at doing a pull. They were looking at either the policy issues, quality, privacy, or components, EHRs, EMRs, telehealth, registries. All states were looking to moving this direction. What they dealt with were the barriers involved. Obviously funding is the top. Money is not only funding but sustainability because dollars have to be around for the long term, not just the short term. In order to have sustainability we have issues with multiple standards, issues related to privacy, governance, and states have been working on those issues over the past 2 years. As we look at this slide and see multiple states that have addressed one or more than one component from e-prescribing to telehealth, decision support or basic things like replacement of the MMIS system.

What have states said as lessons learned from implementation? Well, proceed slowly. That doesn't mean that the enemy of the perfect is not looking forward at all but involving stakeholders early, often, and ongoing. Again, pilots start with a certain subset but when you build a pilot you have to think about how that's going to be sustained in the long term or a statewide system of systems.

The next one is my favorite: plan broadly, implement incrementally. One of the main things is don't bite off too much but make sure your pilots [don't] get in the way of implementation. This is core to making it work: strong project management and dedicated resources at [the] provider level, at the state level, and at the stakeholder [level]. And then sustainable collaboration: getting participants to the table, keeping them there, and listening to what is being said.

The first step in moving forward in health information transformation was really the Medicaid Transformation Grants. That was 100% federal funding and it crossed all the things we've talked about before: decision support, data warehouse, physician tools, disease management. Each state started from where they were at and moved themselves forward.

Take that forward to now, we have had two pieces of major legislation and I wanted to point out CHIPRA because it's very important. The Children's Health Insurance Program Reauthorization Act had a couple of important components. It talks about expanding eligibility; that is, how you get more children into the insurance program. In order to do that, there are health information technology tools, but most important is about improving quality. Two explicit items that have health information technology components were the development and implementation of evidence-based quality measures and if we can do that effectively that is using tools and the encouragement and development of a model children's health record.

The AARA for Medicaid, Tony talked about that a lot, but I want to emphasize there are three very specific responsibilities which are necessary in order to draw down the dollars. I think there is a lot of discussion around the first one, which is administering the

incentive payments to providers. But for states to do that you must identify the providers, users of Medicaid, all children's hospitals that serve Medicaid, but for physicians, 20% of their patients must be Medicaid. States need to figure out and identify those providers and in addition they have to track meaningful use. There's a lot of discussion clarification on meaningful use and I think one of the things there is, it is clear in the Medicare definition of meaningful use although further clarification will come, the states will be defining meaningful use although it will have to be reviewed and approved. Those are components of simply administering the incentive, which is why the incentive payments are talked about as a 2011 piece. The second is that states must provide meaningful oversight including tracking of meaningful use reporting mechanisms and this will require a look behind, as Tony said the more we have health [information] technology tools in place, that this is automated, the more efficient it will be in moving forward. The third component is what I really want to emphasize, is that states must pursue initiatives—and I think this is really the opportunity we don't want to miss—to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information. This is definitely looking beyond Medicaid, this is looking at the implementation of building on the Medicaid/MITA model. Clearly there will be requirements by CMS for regulation, but most of this guidance will come down in "Dear State Medicaid" letters. States will need clearly to pay out their incentives to build out their MMIS structure; that entire process is an APD planning document. I'm beginning to think through those processes in order to have that in place.

The second requires adequate oversight. Will indeed have a need for look behind which will require both human and IT resources. At a time when we have shortfalls and limited resources and states in recession it's important to make sure both the human and IT resources at the state. The states will need to amend state plans, look at state laws, and deal with state legislature to make sure the budget is there because there is a state match and an ability to make sure all state laws allow them to move forward using that mechanism.

Looking to how the states can actually encourage adoption. If you look at MITA, it really aligns with level 3-5. It's basically how states are going to work with other agencies within their states as well as other state agencies as well as the federal agencies like CMS and the national coordinator. As Tony said, this is really about establishing your baseline relative not only to Medicaid but to other activities both public and private. What the vision is in the state is whether it's 3, 5, or 8 years and I wanted to emphasize you can't forget about the Indian reservations and then the roadmap. That roadmap talks about timeframe, benchmarks, how providers are getting involved. In MITA we talk about swim lanes; it's the same things about education and technical assistance, communities of practice, etc. Those are all components of moving forward those three responsibilities of the state in the framework of MITA but also working with other stakeholders, providers, consumers, other players.

Great! Thank you both very much; you both covered a lot of information in a short time frame. As a reminder there are two ways to ask a question; type a question in the chat box

and address to all panelists or click [the] “raise hand” button and then Stephanie can unmute your phone.

I think we do have a question. The integration of Medicaid data with public health and private health data presents serious challenge from MMIS, which currently collects, processes, and maintains only Medicaid data. Is there a recommended approach to bringing it all together under HIT?

Tony: Well there are two options: one is to create a data mark type of arrangement where you're not pulling the data into a common location but you know where that data is and you have a server available. And to the recipient this federated model we use for our HIE, they receive the data and can see where the data resides whether Medicaid or public health or a physician office. The other option is to integrate into a common database and to do that you're going to have to see whether there are any restrictions to having a common database of information from public health as well as Medicaid. Some states do not have a problem with that, [and] they are integrating. In other states I would suggest the other option of keeping the data separate but you are able to publish the data.

Trish: One of the things to remember when you say MMIS, you tend to think of the old claims processing. Another example is sort of mixed model, which is a Medicaid hub, which allows for within state government for there to be a repository but it is the hub between the clinics and hospital and in that case it is the information hospital. It is the place with a master patient index so the commonality of the patient is there, but what it is sharing with the private it is the information highway, but within that framework you might be able to use the mixed model.

I would just say you first must look at your regulatory restrictions and then have your architecture solutions set [to] match those regulatory restrictions or change your restrictions.

Question: When will the state Medicaid director letters be sent to the states outlining the environmental scan or strategic plan guidelines?

Neither Tony nor I work for CMS so we don't know, but my guess is they are working very hard on it.

There has to be a mechanism for states to inform CMS on how they are using MITA dollars or others so the reality is that they shouldn't wait until they get a letter. This is just good to do. If you're going to do a major systems project you really have to do an environment scan first and develop a plan based on the gaps and resource requirements.

We have a question regarding comparative effectiveness research: can you say something about how this may be accomplished using some of the EHR repositories developed by Medicaid agencies around the country?

One of the opportunities of electronic health records and the ability to move that data around is the availability of clinical data—not just administrative data—that you can begin to look at. Whether it is medication management, medication compliance, how different therapies are administered, you'll have the clinical data to see longitudinally. We're very intrigued especially with our minority communities to look at that and see how treatments and compliance are affecting disparities. The opportunity will be to pull the data into a common database or registries because you can move that data or store it either centrally or through a data mark where the data reside with the provider or in [a] separate database, but you're able to match with a common ID so you can pull data into a common report. So this is the opportunity with the dollars we are getting not only to pull, create the databases but then to have the analytical skill set development to clinical informatics, etc. to get new insight from the data. So I think that should be part of your strategic thinking. Right now we're working with our universities because they see a real opportunity for them to participate in comparative effectiveness research and are partnering with us so they would have the opportunity to participate in those grants.

Would you send [a] copy of [the] presentations and was it recorded and will it be available to those that couldn't attend? All of these presentations are posted on the health IT website on the Medicaid-CHIP section; the link is <http://healthit.ahrq.gov/Medicaid-SCHIP>. So we need to do some work to make sure they are accessible and compliant with Section 508 so as soon as we go through that process the slides will be posted as well as a transcript.

Can you say something about the known timeline for the release for regulatory details before HHS will have to release before the states can take before moving forward on some of these opportunities?

That may be directed at me and I don't really have an answer on the timeline. I don't know Tony or Trish if you have any more insight.

There are some timelines for reporting standards. If you look at those timelines, standards are due this summer and some reports to Congress. I do know this, there is a real push to get this done quickly and you can bet on where it's going based on the NGA report. If you review some of the materials that have come out from the Markle Institute you're going to see a rapid effort to get grants to move the agenda forward quickly. Certainly by January but it may be sooner than that.

One of the things I would tell the audience, you really need to start planning now. 2011 is not far away. You can't wait until 2010 and expect to pull all of this together. You need to get a jump on the environmental assessment; even if you start out slow, there are opportunities to do Web surveys, licensing surveys, and opportunities to get grants. There is a general level of awareness so physicians are willing to engage. It is not as difficult to get information as it used to be, so don't wait too long waiting for the regulations or you'll be behind the curve.

Question: Now that we have an HHS secretary what should happen next?

As I gaze within my crystal ball, it's hard for HHS employees to speak about ARRA, which makes it hard to discuss this in a public form, but from a personal perspective, there's been a lot of hard work going on by groups of people working on the legislation at ONC and HHS. The fact that we have [a] Secretary is a good sign. We have Dr. Blumenthal in the Office of the National Coordinator so I'm hopeful that will help us make some movement forward but in terms of specifics I'm not sure that anybody really knows that.

Trish, did you say that states would be the ones that would assign meaningful use, can you explain that further?

Actually the legislation says for meaningful use that it will be state-approved and Secretary-released. So it's just like regular Medicaid in the states that approve the process. But it is going to be up to the states to work that through although there may be some guidance.

One of the things we have available is the multistate collaboration. We meet once a month, if you're interested in participating contact NASMD and get on our list because those are the very things we are talking about right now. We would like to be proactive to give feedback to CMS and also guidance to states.

Why should I care if my Medicaid agency participates in the incentive funds if I'm going to have to make a case to my legislature to make an investment of funds, even if the majority of the money is coming from the feds?

If you don't believe you're going to get a return from this effort, if you don't look at your data and see the opportunities that EHRs will help in terms of bending your cost curve and increasing your quality curve, then maybe you don't need to participate. But I would doubt that any Medicaid program can prove that electronic health records will not have a direct benefit on both cost and quality of care. In addition, you're not just depriving your Medicaid agency, you are depriving your providers of the dollars they need to participate. I think they will be very concerned if all the states around you are participating and you're the one-off state. So you have to think about the fact that this money is for providers. Additionally the President has set 2014 as the date for all Americans having electronic health records so you don't want to—you want to raise all boats. Medicaid has to be a leader in this. Medicaid is the fastest growing health care market today. The longer that you have an inefficient system you're going to see higher costs, inefficient care, and lower quality.

I would add to that most of your providers they're not going to get the Medicare money so their only avenue is the Medicaid money. The decision that you're not going to participate when that's the only way they are going to get access to this money is a hard political thing to do in any state. So if you don't participate you're not only failing the state, you're failing the providers within your state...how do you explain that to the providers?

From a more realistic point, this is an area—I'm stealing a quote—this is an area where there can be no program left behind. This doesn't work if everyone but one plays. This has to be a situation where all the purchasers, all the providers—the clinical and the administrative—and the purchasing leverage is all important. It is how we improve health care. From a realistic way, how can we do health care reform, how can we improve delivery, improve the health of an individual if we don't fully utilize federal funding and utilize all of the tools? That is what health information technology is about, it's about giving individuals tools to help them provide care better. It becomes an issue of why not instead of why.

Announcement of new Community of Practice for Sustainability and Funding. Contact skissam@rti.org by Friday May 15th if you are interested.