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OFFICE OF INSPECTOR GENERAL

STATE MEDICAID AGENCIES' INITIATIVES ON HEALTH INFORMATION TECHNOLOGY AND HEALTH INFORMATION EXCHANGE

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OBJECTIVE

To assess State Medicaid agencies' initiatives on health information technology (HIT) and health information exchange (HIE).

BACKGROUND

In recent years, both the President and the Secretary of the Department of Health and Human Services (the Secretary) have promoted the goal of developing HIT and HIE. In 2004, the President announced his plan to ensure that electronic health records are available to most Americans by 2014. Additionally, the Secretary has stated that he envisions that Medicare and Medicaid will be viewed as leaders in the collaborative development and use of HIT.

Medicaid is a jointly funded Federal and State health insurance program for certain low-income and medically needy persons. Medicaid has been one of the fastest-growing items in Federal and State budgets, with costs totaling more than $317 billion in fiscal year 2005. HIT and HIE have the potential to reduce health care costs resulting from inefficiency, medical errors, inappropriate care, and incomplete information. These potential benefits of HIT and HIE adoption could be particularly important for Medicaid and its beneficiaries.

We based this study on a survey of all State Medicaid directors and on structured telephone interviews with State Medicaid directors who reported that they have current or planned HIT and HIE initiatives. In addition, we reviewed documentation of State HIT and HIE initiatives and interviewed officials from the Centers for Medicare & Medicaid Services (CMS) who are involved in this area or in the implementation of Medicaid Information Technology Architecture (MITA), which is a framework developed by CMS to help States modernize their Medicaid information systems.

FINDINGS

Twelve State Medicaid agencies have implemented a total of 16 HIT initiatives. Twelve State Medicaid agencies have implemented a variety of HIT initiatives for Medicaid beneficiaries and participating providers. These include claims-based electronic health records initiatives, electronic prescribing initiatives, remote disease-monitoring initiatives, and personal health records initiatives. In addition, many State

Medicaid agencies are in the process of developing similar HIT initiatives.

Twenty-five State Medicaid agencies are involved in planning and developing statewide HIE networks. Twenty-five State Medicaid agencies are currently involved in planning and developing statewide HIE networks that will allow for the secure exchange of health care information. The main goal of these networks is to develop a statewide infrastructure to support the widespread use of HIT. These networks are intended to allow most, if not all, health care providers and payers in the State to securely exchange clinical information.

Thirteen State Medicaid agencies include MITA as part of their HIT and HIE planning. Thirteen State Medicaid agencies are incorporating MITA into their HIT and HIE planning. Directors report that MITA provides useful guidance from CMS that will increase the interoperability of Medicaid information systems, as well as increase the possibility of Medicaid participation in future HIT and HIE initiatives.

RECOMMENDATIONS

Based on the findings of this study, CMS should:

Continue to support the goals of MITA. To further accelerate the adoption of interoperable health information systems, CMS should continue to emphasize the goals of MITA. CMS should work with State Medicaid agencies to implement MITA to facilitate future State Medicaid HIT and HIE initiatives. CMS may also consider revising the criteria that States' MMISs must meet to receive CMS approval for Federal funding to ensure that the criteria reflect the goals of MITA.

Collaborate with other Federal agencies and offices to assist State Medicaid agencies in developing privacy and security policies. CMS should collaborate with other Federal agencies and offices, when appropriate, to assist State Medicaid agencies in developing policies regarding the use of Medicaid health care information. Areas to focus on should include standards governing the transmission of Medicaid data and policies to ensure that only authorized users have access to records, as well as safeguards for beneficiaries' privacy, including beneficiary notice and consent and policies for handling sensitive health care information.

Continue to work with the Office of the National Coordinator for HIT to ensure that State Medicaid initiatives are consistent with national goals. CMS should continue to work with the Office of the National Coordinator for HIT, which coordinates all Federal HIT and HIE initiatives. CMS should work with the office to ensure that State Medicaid agencies' initiatives are consistent with national goals and that Medicaid is viewed as a national partner in the development of HIT and HIE standards.

AGENCY COMMENTS

CMS concurred with all of our recommendations. CMS stated that it supports the goals of the recommendations and has already taken steps to implement them. CMS commented that it is continuing to expand the MITA framework through the support of collaborative activities involving the States and the industry and that it also plans to revise the MMIS funding criteria to reflect the goals of MITA. CMS further noted that it is working with the Agency for Healthcare Research and Quality on selecting a vendor to work with State Medicaid and State Children's Health Insurance Program agencies to expand their involvement with HIT and HIE and to assist States in the areas of privacy and security. Finally, CMS stated that it will continue to work with the Office of the National Coordinator for HIT to ensure that MITA and the State initiatives that CMS supports financially are consistent with national goals and objectives.

TABLE OF CONTENTS

INTRODUCTION

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Medicaid is a jointly funded Federal and State health insurance program for certain low-income and medically needy persons. Medicaid has been one of the fastest growing items in Federal and State budgets, with costs totaling more than $317 billion in fiscal year (FY) 2005. HIT and HIE have the potential to reduce health care costs resulting from inefficiency, medical errors, inappropriate care, and incomplete information.[3] These potential benefits of HIT and HIE adoption could be particularly important for Medicaid and its beneficiaries.

Health Information Technology

HIT is used to electronically collect, store, retrieve, and transfer clinical and administrative information. The most common types of HIT include electronic health records (EHR), electronic prescribing (e-prescribing), remote disease monitoring, and personal health records.

Electronic health records are electronically accessible records of patient health care information that can be viewed by health care providers.[4]

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[1] The White House. "A New Generation of American Innovation," available online at http://www.whitehouse.gov/infocus/technology/economic_policy200404/innovation.pdf. Accessed May 25, 2007.

[2] HHS Secretary Michael Leavitt. "Secretary Leavitt's 500-Day Plan." Available online at http://www.hhs.gov/500DayPlan/500dayplan.html. Accessed May 1, 2007.

[3] Exec. Order No. 13,335, 69 FR 24059 (April 30, 2004).

[4] The term "EHR" is sometimes used interchangeably with electronic medical record (EMR). EMRs are an electronic means of automating a paper-based record, whereas EHRs generally contain medical information from multiple providers that may be transferred electronically.

EHRs typically contain health care information from multiple providers and sources.

Electronic prescribing is the electronic transmission of prescription or prescription-related information between a prescriber and a dispenser, a pharmacy benefit manager, or a health plan.

Remote disease monitoring is the use of automated tools to electronically collect and transmit health care information to assist in patient monitoring. The patient typically collects information at home and then transmits the information electronically to the clinician.

Personal health records are electronically accessible records of patient health care information that can be maintained by the patient. These records may include medical histories, prescription histories, and lab results that patients can give to their providers.

Health Information Exchange

HIE is defined as the sharing of health care information electronically among disparate health care information systems.[5] HIE requires each participant in an HIE network to agree to certain information-sharing policies and procedures. HIE is needed to make HIT, such as EHRs and other technologies, become fully interoperable, meaning that health care providers not only can view or read data from another entity, but also can modify them and exchange them with other users.

Local or regional HIE networks are often called Regional Health Information Organizations (RHIOs). The goal of these networks is to allow most, if not all, health care providers and payers in a region or community to securely exchange clinical information. To achieve this goal, RHIOs develop and maintain standards for information sharing and manage a set of contractual conventions among participants. RHIOs also create agreements among HIE network participants to ensure that only authorized users are permitted access to protected information.

The Office of the National Coordinator for HIT

The Office of the National Coordinator for HIT works with public and private-sector partners to provide leadership for the development of a

[5] The American Health Quality Foundation. "Quality Improvement Organizations and Health Information Exchange." Available online at http://www.ahqa.org/pub/uploads/QIO_HIE_Final_Report_March_6_2006.pdf. Accessed May 25, 2007.

nationwide HIE network, called the Nationwide Health Information Network. The office, which is located within the Office of the Secretary of the Department of Health and Human Services, is involved in a variety of HIT and HIE activities, including developing certification criteria for EHRs, identifying HIT and HIE standards, addressing privacy and security concerns for HIE networks, and coordinating all Federal HIT and HIE programs.[6]

Medicaid Information Systems

HIT often relies on existing information systems as sources of patient data. Within certain Federal guidelines, each State Medicaid agency develops its own information systems to assist with the administration of its Medicaid program.

Medicaid Management Information System is the primary information system used to administer Medicaid programs.[7] States originally designed their Medicaid Management Information Systems (MMIS) as financial systems to pay Medicaid provider claims. As the Medicaid program grew more complex, States expanded their MMISs to support an increasing array of Medicaid program functions. Over time, States developed separate subsystems to handle new agency requirements. These subsystems frequently do not communicate with one another. For example, a State's MMIS might process its pharmacy claims under one system and its dental claims under another system.

Medicaid Information Technology Architecture is a framework that the Centers for Medicare & Medicaid Services (CMS) developed to help modernize States' MMISs. The Medicaid Information Technology Architecture (MITA) is intended to help MMISs become integrated information systems that support all the technical requirements associated with administering their Medicaid programs. In April 2007, CMS began asking States to complete a self-assessment.[8] In the assessment, States document their current business processes and set goals to improve those processes, using the MITA framework. States

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[6] Senate Testimony. "Accelerating the Adoption of Health Information Technology." Available online at http://www.hhs.gov/asl/testify/t060622a.html. Accessed April 17, 2007.

[7] Projected State and Federal expenditures for MMISs in FY 2006 were approximately $2 billion.

[8] CMS. "MITA: Frequently Asked Questions," available online at http://www.cms.hhs.gov/MedicaidInfoTechArch/Downloads/mitaseries01.pdf. Accessed May 25, 2007.

complete this assessment when they seek Federal funding for the design, development, or installation of new MMISs.

MITA also aims to enhance States' ability to manipulate and exchange data. One of the goals of MITA is to allow for interoperability among State and Federal health care agencies, RHIOs, and eventually the Nationwide Health Information Network. MITA encourages States to adopt common standards that will assist in HIE and improve States' MMISs. MITA suggests steps such as integrating clinical and administrative data within the MMIS and utilizing standards for transmitting data, which are preconditions for many HIT and HIE activities.

Medicaid Funding for HIT and HIE

State Medicaid agencies can receive funding for HIT and HIE initiatives from Medicaid matching funds for administrative expenditures, as well as from Federal grants.[9] The Federal match for administrative expenditures is generally 50 percent; however, it is higher for certain administrative functions. In the case of MMIS expenditures, the Federal match is 90 percent for design, development, and installation and 75 percent for ongoing operational maintenance.[10] To receive Federal funding, States' MMISs must meet certain criteria established by CMS, including Chapter 11 of the State Medicaid Manual (Pub. No. 45), as periodically amended.[11]

States may also receive Medicaid Transformation Grants to support their HIT and HIE initiatives. These grants were established by Congress for FYs 2007 and 2008 and may be used for HIT.[12] In January 2007, CMS awarded 33 grants, totaling $103 million. Eighteen of these grants were for HIT and HIE initiatives, totaling $64 million.

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[9] 42 U.S.C. § 1396b(a)(7).

[10] 42 U.S.C. § 1396b(a)(3).

[11] 42 CFR § 433.112.

[12] Deficit Reduction Act of 2005, Pub. L. no. 109-171, § 6081 (to be codified at 42 U.S.C. § 1396b(z)).

METHODOLOGY

We based this study on four sources of data: (1) a survey of all State Medicaid directors, (2) structured telephone interviews with all State Medicaid directors who reported that they have current or planned HIT and HIE initiatives, (3) a review of documentation of State HIT and HIE initiatives, and (4) interviews with officials from CMS who are involved in HIT and HIE initiatives in Medicaid. We collected these data between July 2006 and March 2007.

Survey of State Medicaid Directors

We electronically mailed a survey to all State Medicaid directors in the 50 States, Washington, DC, and Puerto Rico.[13] The survey was completed directly by either the State Medicaid director or by his or her designee. Our questions focused primarily on whether State Medicaid agencies have any current or planned HIT and HIE initiatives. We received a response from each of the 52 State Medicaid directors.

Structured Interviews With Selected Medicaid Directors

We conducted in-depth structured telephone interviews with all State Medicaid directors or their designees in the States with a current or planned HIT or HIE initiative. We considered an initiative to be current if it was being used by Medicaid beneficiaries or participating providers as of January 2007. We considered an initiative to be planned if it was in the process of being planned or developed but was not in use by Medicaid beneficiaries or participating providers as of January 2007. To distinguish between current and planned initiatives, we also conducted a number of follow-up interviews in early January to determine the status of the initiatives.

We asked respondents to provide detailed information about their HIT and HIE initiatives. Specifically, we asked about the technological capabilities of the initiatives, the types of providers and Medicaid beneficiaries who use these technologies, the entities that developed these initiatives, and any reported benefits and challenges of these initiatives. We received a response from each State Medicaid director with a current or planned initiative.

[13] We refer to these 52 entities as State Medicaid agencies.

Documentation Review

We requested and reviewed supplemental documentation provided by the State Medicaid directors or their designees. This information included State legislation, planning documents, grant proposals for the Medicaid Transformation Grants, project summaries, press releases, and Web sites. We used this information to further describe States' HIT and HIE initiatives.

Structured Interviews With CMS Officials

We conducted in-person, structured interviews with staff at CMS involved with Medicaid HIT and HIE initiatives. We questioned staff about State Medicaid agencies' implementation of HIT and HIE initiatives. We also asked them about MITA and Medicaid Transformation Grants.

Limitations

The information in this report is based primarily on data reported by State Medicaid directors or their designees. We did not independently verify their responses or the capabilities of their HIT and HIE initiatives.

Standards

Our review was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

Twelve State Medicaid Agencies Have Implemented a Total of 16 HIT Initiatives

Twelve State Medicaid agencies have implemented a total of 16 HIT initiatives for Medicaid beneficiaries and participating providers. These include electronic health records initiatives, electronic prescribing initiatives, remote disease-monitoring initiatives, and personal health records initiatives. (See Table 1.) In addition, 39 State Medicaid agencies are in the process of developing 64 similar types of HIT initiatives.[14] Appendix A provides a detailed description of the current initiatives. Appendix B provides a list of States with planned initiatives.

Table 1: Current State Medicaid HIT Initiatives

State	Electronic Health Records	Electronic Prescribing	Remote Disease Monitoring	Personal Health Records
Florida		✔		
Iowa	✔			
Kansas	✔	✔		
Louisiana	✔			
Mississippi		✔		
Missouri	✔	✔	✔	
Montana	✔			
Pennsylvania	✔			
Tennessee	✔	✔		
Vermont	✔			
Wisconsin	✔			
Wyoming			✔	
Total Initiatives	**9**	**5**	**2**	**0**

Source: Office of Inspector General analysis of State Medicaid directors' responses, 2007.

Nine States have implemented claims-based EHRs

Nine State Medicaid agencies have implemented claims-based EHR initiatives for Medicaid beneficiaries. These States are Iowa, Kansas, Louisiana, Missouri, Montana, Pennsylvania, Tennessee, Vermont, and Wisconsin. In addition, 27 State Medicaid agencies are in the process of developing EHR initiatives.

[14] Note that in a number of cases, States with current initiatives are also developing additional initiatives.

Technology. All nine current EHR initiatives rely on Medicaid claims data from the States' MMISs.[15] These EHRs contain clinical information about the patient, such as prior diagnoses, medical procedures performed, and prescription history. This information is derived from procedure and diagnosis codes contained in the Medicaid claims data.[16] In all but one case,[17] authorized health care providers access this information through a secure Web portal.[18] Four of the EHR initiatives have also begun to incorporate a limited amount of data from other sources, such as immunization records from public health departments.

Claims-based EHRs are distinct from other types of EHRs that rely on HIE networks. The nine current claims-based EHR initiatives are based primarily on one data source—Medicaid claims data—and have limited interoperability. Unlike interoperable EHRs, in which providers exchange clinical information with one another, these current EHR initiatives enable providers only to view information derived from prior Medicaid claims. Providers cannot directly enter information to the record or exchange their clinical records with other providers. State Medicaid directors report that developing claims-based EHRs is an inexpensive way of offering providers health care information about Medicaid beneficiaries.

Population served. The nine current EHR initiatives target different Medicaid populations and providers. Four have records available for the entire Medicaid population in the State, three have records available for Medicaid beneficiaries participating in the State's fee-for-service program, one is limited to Medicaid beneficiaries participating in a managed care program, and one is limited to certain beneficiaries who are chronically ill. The initiatives also target different

[15] The fee-for-service (FFS) claims represent the majority of the information used in these EHRs. For managed care services, encounter data are collected rather than claims. We use claims as a general term to refer to both claims and encounter data, unless otherwise noted.

[16] Medicaid claims include Current Procedural Terminology (CPT) codes, which identify specific health interventions taken by medical professionals, and International Classification of Disease (ICD-9) codes, which classify diseases.

[17] In Vermont, the EHR is accessed through the State Medicaid agency's internal computer network. See Appendix A for more details.

[18] A Web portal is an Internet-based site or system that creates a single point of access to information collected from different sources. Common portal features include user authentication (log-in and password) and personalized content views in which content is displayed to match specific user needs and roles.

types of providers. Four of the current initiatives allow all enrolled providers to access beneficiaries' EHRs, while the remaining five initiatives allow only specific types of providers, such as providers in emergency departments, to access this information.

Benefits and challenges. According to State Medicaid directors, the primary goal of their EHR initiatives is to improve quality of care by providing more information to clinicians about beneficiaries' medical histories. Directors explain that having access to a beneficiary's prior diagnoses and treatment history enables clinicians to provide better care.

Directors also report that their EHR initiatives may prevent Medicaid fraud, waste, and abuse. Six directors state that their EHRs will likely reduce duplication of services by enabling providers to see, for instance, that diagnostic tests have already been performed. They also note that their EHRs allow providers to identify drug-seeking behaviors of beneficiaries[19] and to verify beneficiary identity by checking whether certain demographic information, such as the age and sex of the patient, matches the information in the EHR.

When asked about challenges in implementing their EHR initiatives, directors report that developing security and privacy policies has been a major concern. As one director notes, "When you are breaking new ground, there is no cookbook for privacy and security issues. Our lesson learned is that everything is more complex than you think it will be." In particular, notifying beneficiaries about how their information will be used and developing procedures to handle sensitive data, such as mental health, substance abuse, and HIV/AIDS information, have been challenging.

Planned EHR initiatives. The majority of the 27 State Medicaid agencies with planned EHR initiatives will develop claims-based EHRs similar to the current initiatives. In a few cases, Medicaid agencies are attempting to develop more interoperable EHRs that will rely on HIE networks. In two cases, Medicaid agencies are planning to replace their claims-based initiative with more interoperable EHRs that will include data from other sources and allow providers to exchange a wider range of clinical information.

[19] Drug-seeking behavior is defined as a fraudulent presentation of disease to multiple doctors and pharmacies in an attempt to obtain prescription drugs for use, trade, or sale.

Five States Have Implemented E-Prescribing Initiatives

Five State Medicaid agencies have developed e-prescribing initiatives for Medicaid providers: Florida, Kansas, Mississippi, Missouri, and Tennessee. In addition, 21 State Medicaid agencies are in the process of developing e-prescribing initiatives.

Technology. All five current e-prescribing initiatives allow providers to electronically prescribe medication and to view beneficiaries' prescription histories that are derived from Medicaid claims data. The initiatives also provide clinicians with information about the State's Medicaid drug formulary[20] and potential drug interactions. Providers can access e-prescribing through Web portals or through the use of hand-held computers known as personal digital assistants. For three of the initiatives that use Web portals, e-prescribing is an additional function that can be accessed through the same Web portal as the States' EHR initiatives.

Population served. All five e-prescribing initiatives started with a limited number of providers. State Medicaid agencies have since expanded their initiatives or have plans to expand them in the near future. For example, Florida's State Medicaid agency first offered e-prescribing to Medicaid participating providers who had the highest volume of prescriptions. Now the initiative is available to all Medicaid participating providers in the State.

Benefits and challenges. The State Medicaid directors with current e-prescribing initiatives cite a number of goals of their initiatives. These goals include avoiding adverse events due to drug interactions or errors, limiting drug-seeking behavior by enabling physicians to view medication histories, increasing adherence to the Medicaid formulary by enabling providers to view formulary information, and monitoring physician prescribing behaviors.

State Medicaid directors cite privacy and security challenges similar to the ones they experienced in implementing EHR initiatives. Additionally, two directors report difficulty with expanding their initiatives because some pharmacies do not have the capability to receive prescriptions electronically.

[20] A drug formulary is a list of prescription medications approved for coverage.

Planned e-prescribing initiatives. The majority of the 21 State Medicaid agencies with planned initiatives will develop e-prescribing initiatives similar to the current initiatives. Two State Medicaid agencies with current e-prescribing initiatives, Florida and Tennessee, received Medicaid Transformation Grants to significantly expand upon their current initiatives. For example, Florida will expand its existing e-prescribing initiative to allow physicians to prescribe and dispense certain types of generic medications when beginning new treatment regimens for Medicaid beneficiaries.

Two States have implemented remote disease-monitoring initiatives

State Medicaid agencies in Missouri and Wyoming have implemented remote disease-monitoring initiatives for selected Medicaid beneficiaries. In addition, three State Medicaid agencies are in the process of developing remote disease-monitoring initiatives.

Technology. Both remote disease-monitoring initiatives provide beneficiaries with an electronic telemonitoring device for use in their homes. These devices collect health information and monitor the beneficiaries' vital signs, and other medical statistics, on a daily basis. In Missouri's initiative, the device is a central processing unit that can incorporate an array of technologies, such as an automated blood pressure cuff or a scale. In Wyoming's initiative, the device asks beneficiaries questions about their health status, such as weight changes or test results.

In both initiatives, the information collected from the beneficiary is transmitted through a telephone line to providers who are charged with monitoring the beneficiary's health status. If any problems are detected, the monitoring team follows up with the beneficiary. The monitoring information is also shared with the beneficiary's primary care provider.

Population served. Both initiatives are available primarily to chronically ill beneficiaries who might benefit from daily monitoring. These beneficiaries commonly have conditions such as diabetes, asthma, and chronic heart failure. In each case, the State Medicaid agency works with a vendor to enroll beneficiaries and train them to use the devices. The number of beneficiaries enrolled in these two initiatives ranges from about 60 to 225.

Benefits and challenges. According to the two State Medicaid directors, the overall goal of their initiatives is to improve patient outcomes and reduce emergency care and hospitalizations. They also note that their

initiatives may reduce the total cost of care for participating beneficiaries.

When asked about challenges, the two directors reported different types of issues. One director noted the difficulty in keeping up-to-date telephone numbers for participating beneficiaries, which is critical because the initiative relies on the telephone to connect the devices and to communicate with the individual. The other director cited challenges with measuring the impact of these types of initiatives.

Planned remote disease-monitoring initiatives. The three State Medicaid agencies with planned remote disease-monitoring initiatives are in the early stages of development. Each State Medicaid agency is in the process of assessing available technologies to select an appropriate vendor.

No State has implemented a personal health record initiative

No State Medicaid agency provides personal health records to Medicaid beneficiaries; however, 13 agencies are planning to develop such initiatives. Most of these planned initiatives are similar to EHR initiatives in that they are claims based. Unlike EHRs, however, personal health records are maintained by the beneficiary, most commonly through a portable computer drive or a Web portal. Medicaid agencies are most commonly developing these initiatives in conjunction with their EHR initiatives, often using similar technology. Two State Medicaid agencies have already developed a Web portal for their initiatives but have not yet released the records to Medicaid beneficiaries.

Twenty-five State Medicaid Agencies Are Involved in Planning and Developing Statewide HIE Networks

Twenty-five State Medicaid agencies are involved in planning and developing statewide HIE networks that will allow for the secure exchange of health care information. The main goal of these networks is to develop a statewide infrastructure to support the widespread use of interoperable EHRs and other HIT. These networks intend to allow most, if not all, health care providers and payers in the State to securely exchange clinical information. Box 1 on page 14 provides a description of different State approaches to HIE networks. Appendix C provides a list of the States involved in planning statewide HIE networks.

In all 25 States, the Medicaid agencies are working with multiple public and private entities to plan and develop statewide HIE networks.[21] These entities typically form advisory boards or nonprofit organizations charged with overseeing the development of the HIE networks. These groups often include representatives from the medical community and insurance industry, officials from Governors' offices and public health departments, and large employers within the State.

State Medicaid agencies are involved in these statewide planning efforts to varying degrees. In some instances, the agencies have taken a lead in establishing advisory boards; in other States, the agencies are less involved, taking on roles such as serving on planning committees. Medicaid agencies are most commonly involved in planning that includes securing funding for the networks, developing privacy and security policies, establishing common data standards, and building technologies to support the networks.

State Medicaid directors commonly highlight the importance of Medicaid in the development of statewide HIE networks. As one director notes, "Given the number of people that the Medicaid program covers in our State, Medicaid is a major force in HIE activity." In other States, the directors note that their HIE networks are relying on Medicaid data as the first step in developing a statewide infrastructure.

[21] In some States, the Medicaid agencies are represented by the department in which the Medicaid agencies are housed.

BOX 1: STATE APPROACHES TO HIE NETWORKS

States have taken a variety of approaches to HIE. Below are several examples of statewide HIE networks.

- The Delaware Health Information Network (DHIN) is a nonprofit organization created by the State legislature in 1997. DHIN has piloted what it claims to be the first statewide HIE network. The network, which includes three hospital systems and a small group of providers, enables participants to exchange a variety of health care information, including lab results; radiology reports; and admission, discharge, and transfer reports. DHIN also plans to develop a record locator system, which would enable providers throughout the State to locate and exchange patients' medical records. The network will eventually be extended to other providers across the State.

- The Florida Health Information Network (FHIN) is a nonprofit organization created by a Governor-led advisory board in 2005. The network will eventually provide a statewide infrastructure that will enable health care professionals to access patients' medical records from any provider database connected to the network over a secure Internet connection. FHIN initially plans to start exchanging data between three existing RHIOs in Palm Beach, Tallahassee, and Tampa Bay in 2007 and intends to extend the program statewide at some point in the future. The FHIN will also work closely with the Office of the National Coordinator for HIT to model its network on the standards of the nationwide HIE network.

- Arizona Health-e Connection is a nonprofit organization formed in 2007 to facilitate HIE and HIT in the State. Arizona has developed a plan called the Health-e Connection Roadmap that aims to achieve 100-percent electronic health data exchange among payers, providers, consumers, researchers, and Government agencies, when appropriate. A stated goal of the plan is for the network to be consistent with the goals of the Office of the National Coordinator for HIT. As a first step, Arizona plans to develop a statewide Web portal that enables physicians to electronically order clinical services, generate and confirm referrals, and receive clinical results, while simultaneously supporting the development of regional HIE networks. Arizona then plans to develop a secure statewide network that will enable all authorized providers to exchange health care information.

Source: Office of Inspector General analysis of States' HIE network documentation, 2007.

Thirteen State Medicaid Agencies Include MITA as Part of Their HIT and HIE Planning

Thirteen State Medicaid agencies are incorporating MITA into their HIT and HIE planning. MITA is a framework developed by CMS to help States modernize their Medicaid information systems. Directors report that MITA provides useful guidance that will help modernize States' MMISs and result in the more efficient administration of their Medicaid programs.

Directors in these 13 States also report that implementing MITA will increase the interoperability of their MMISs, as well as increase the possibility of Medicaid participation in future HIT and HIE initiatives. Additionally, five of these directors note that the standardization of systems and data contained in the MMISs—a central goal of MITA—is also critical to Medicaid's participation in HIE.

According to the directors, the 13 State Medicaid agencies are currently evaluating how to incorporate MITA into their States' MMISs. Eleven of these State Medicaid agencies have either completed, or are in the process of completing, an in-depth self assessment that requires them to identify current weaknesses within their MMISs and potential solutions.[22] For example, Ohio's State Medicaid agency has used this self-assessment process to identify opportunities to integrate many of the States' disparate information systems. Currently, Ohio's MMIS, which is over 20 years old, houses Medicaid data in a number of separate systems that cannot be easily accessed or manipulated. As a result of the self-assessment process, the agency is now relying on MITA principles to guide the development of a new, more-integrated MMIS, in which data can be easily exchanged and the systems are interoperable.

The 13 directors also commonly highlight the need to move away from outdated, inflexible systems that have limited ability to move and exchange data. They state that MITA promotes improvements that go beyond the traditional MMIS functions to include clinical information and interoperability. According to one director, "MMISs in the past were just about paying claims. Now, we want to incorporate clinical information so we can see the quality of care provided and what we are getting for our dollars."

[22] In April 2007, CMS began asking States to complete and submit MITA self-assessments whenever they apply for Federal MMIS funding for new system design, development, and implementation. Each of these 11 States started the self-assessment process prior to the new CMS policy.

RECOMMENDATIONS

State Medicaid agencies have implemented, or are in the process of developing, a variety of HIT initiatives. About half are also involved in planning and developing statewide HIE networks, and some are beginning to implement MITA, which may facilitate future participation in HIT and HIE initiatives. State Medicaid agencies' efforts represent significant steps toward the President's goal of making EHRs available to most Americans by 2014 and the Secretary's vision of Medicaid leadership in the collaborative development and use of HIT. Despite this, much work remains to be done to facilitate further adoption of HIT and HIE in Medicaid.

Based on the findings of this study, CMS should:

Continue To Support the Goals of MITA

To further accelerate the adoption of interoperable health information systems, CMS should continue to emphasize the goals of MITA. CMS should work with State Medicaid agencies to implement MITA to facilitate future State Medicaid HIT and HIE initiatives. CMS may also consider revising the criteria that States' MMISs must meet to receive CMS approval for Federal funding to ensure that the criteria reflect the goals of MITA.

Collaborate With Other Federal Agencies and Offices To Assist State Medicaid Agencies in Developing Privacy and Security Policies

CMS should collaborate with other Federal agencies and offices, when appropriate, to assist State Medicaid agencies in developing policies regarding the use of Medicaid health care information. Areas to focus on should include standards governing the transmission of Medicaid data and policies to ensure that only authorized users have access to records, as well as safeguards for beneficiaries' privacy, including beneficiary notice and consent and policies for handling sensitive health care information.

Continue To Work With the Office of the National Coordinator for HIT To Ensure That State Medicaid Initiatives Are Consistent With National Goals

CMS should continue to work with the Office of the National Coordinator for HIT, which coordinates all Federal HIT and HIE initiatives. CMS should work with the Office to ensure that State Medicaid agencies' initiatives are consistent with national goals and that Medicaid is viewed as a national partner in the development of HIT and HIE standards.

AGENCY COMMENTS

CMS concurred with all of our recommendations. CMS stated that it supports the goals of the recommendations and has already taken steps to implement them. CMS commented that it is continuing to expand the MITA framework through the support of collaborative activities involving the States and the industry and that it also plans to revise the MMIS funding criteria to reflect the goals of MITA.

CMS further noted that it is currently working with the Office of the National Coordinator for HIT to ensure that MITA complies with Federal privacy and security policies. It is also working with the Agency for Healthcare Research and Quality on selecting a vendor to work with State Medicaid and State Children's Health Insurance Program agencies to expand their involvement with HIT and HIE and to assist States in the areas of privacy and security.

Finally, CMS stated that it will continue to work with the Office of the National Coordinator for HIT to ensure that MITA and the State initiatives that CMS supports financially are consistent with national goals and objectives. In FY 2008, CMS also plans to draft a white paper on how MITA supports the Federal Health Architecture Framework. Appendix D provides the full text of CMS's comments.

Table 1: Detailed Descriptions of Current Electronic Health Record Initiatives

State	Description
Iowa Iowa Medicaid Electronic Record System (I-MERS)	A claims-based electronic health record (EHR) that contains descriptions of diagnosis and procedure codes, as well as prescription histories. Certain health care data, such as information related to mental health records or HIV/AIDS, may be viewed only by emergency room physicians in emergency situations. The EHR is accessible through a secure Web portal. Developed internally by the Iowa Department of Human Services. It was launched in June 2006. Records are available for all Medicaid beneficiaries. Records are currently being accessed by providers in a few hospitals and clinics that focus on primary and indigent care. This technology may be accessible to providers statewide by the end of 2007.
Kansas The Community Health Record Pilot Project (CHRPP)	Primarily a claims-based EHR that contains descriptions of diagnosis and procedure codes, as well as prescription histories and information about managed care encounters. Also includes information from other sources, such as lab results from participating labs and immunization records and lead-screening results from the State public health department. In some cases, limited physician-entered data are included, such as patients' vital signs and allergies. The EHR is accessible through a secure Web portal. Developed in partnership with one of the State's managed care organizations. It was launched in February 2006. Records are available for about 14,000 Medicaid beneficiaries covered by the managed care organization in one county. Records are currently accessible to approximately 300 providers at 20 test sites. This technology may be accessible to providers statewide by 2008.
Louisiana Medicaid e-CDI (Electronic Clinical Data Inquiry)	A claims-based EHR that contains descriptions of diagnosis and procedure codes, as well as prescription histories. Also includes clinical alerts for disease management of certain conditions, such as diabetes and asthma. The EHR is accessible through a secure Web portal. Developed in partnership with the vendor operating the State's MMIS. It was launched in September 2003. Records are available for all Medicaid beneficiaries. Records are accessible to all enrolled Medicaid providers who prescribe medication in the State, including doctors, dentists, pharmacists, and certain nurses.
Missouri CyberAccess	Primarily a claims-based EHR that contains descriptions of diagnosis and procedure codes, as well as prescription histories and information about managed care encounters. In some cases, limited physician-entered data are included, such as patients' vital signs and allergies. For a subpopulation of chronically ill beneficiaries, providers may also view electronic Web-based plans of care for beneficiaries. The EHR is accessible through a secure Web portal. Developed in partnership with a clinical management services vendor operator. It was launched in July 2006. Records are available for all Medicaid fee-for-service beneficiaries and provide some encounter data for beneficiaries covered by managed care organizations. Records are accessible to all enrolled Medicaid providers and are currently being accessed by approximately 3,600 providers.
Montana Montana Access to Health Web Portal	A claims-based EHR that contains descriptions of diagnosis and procedure codes, as well as prescription histories. Certain health care data, such as information related to substance abuse or HIV/AIDS, are not displayed. The EHR is accessible through a secure Web portal. Developed in partnership with the vendor operating the State's MMIS. It was launched in December 2005. Records are available for all Medicaid beneficiaries. Records are accessible to all enrolled Medicaid providers and are currently being accessed by more than 8,000 providers.

Source: Office of Inspector General analysis of State Medicaid directors' responses, 2007.

Table 1: Detailed Descriptions of Current Electronic Health Record Initiatives (continued)

State	Description
Pennsylvania The Emergency Department Electronic Health Initiative	A claims-based EHR that contains descriptions of diagnosis and procedure codes, as well as prescription histories. The EHR is accessible through a secure Web portal. Developed in partnership with a chronic disease management vendor. It was launched in December 2006. Records are available for the entire Medicaid fee-for-service population. Records are currently being accessed by providers in three high-volume emergency departments in rural Pennsylvania. Depending upon the results of the initiative, the State may extend the initiative to all emergency departments in the State.
Tennessee The Shared Health Clinical Record	Primarily a claims-based EHR that contains descriptions of diagnosis and procedure codes, as well as prescription histories and information about managed care encounters. Also includes information from other sources, such as lab results from participating labs and immunization records provided by the State public health department. In some cases, limited physician-entered data are included, such as patients' vital signs, over-the-counter medications, and Early Periodic Screening and Diagnostic Testing information. Certain health care data, such as information related to mental health or substance abuse, are not displayed. The EHR is accessible through a secure Web portal. Developed in partnership with a company that is a subsidiary of a Medicaid managed care organization. It was launched in June 2005. Records are available for all Medicaid beneficiaries. Records are accessible to all enrolled Medicaid providers and are currently being accessed by approximately 11,000 providers and other authorized users.
Vermont Care Coordination Initiative	Primarily a claims-based EHR that enables caseworkers to track beneficiaries' care. The EHR contains descriptions of diagnosis and procedure codes, as well as prescription histories. Also includes some information entered directly by case workers such as patients' vital signs and lab results. The EHR is accessible through the State Medicaid agency's secure network. Developed internally by the State Medicaid agency. It was launched in December 2006. Records are available for several hundred chronically ill beneficiaries. Records can be accessed only by caseworkers who care for these beneficiaries.
Wisconsin Emergency Room Medicaid Health Information Exchange	A claims-based EHR that contains descriptions of diagnosis and procedure codes, as well as prescription histories. The EHR is accessible through a secure Web portal. Developed in partnership with the vendor operating the State's MMIS. It was launched in April 2006. Records are available for Medicaid fee-for-service beneficiaries who have had more than three emergency department visits in a rolling 12-month period. Records can be accessed only by providers at 10 emergency rooms in Milwaukee County hospitals.

Source: Office of Inspector General analysis of State Medicaid directors' responses, 2007.

Table 2: Detailed Descriptions of Current Electronic Prescribing Initiatives

State	Description
Florida Wireless Handheld PDA Project	Provides electronic prescribing (e-prescribing) to providers through a secure Web portal and personal digital assistants. Includes claims-based prescription histories for fee-for-service beneficiaries, information about the State's Medicaid drug formulary, and a tool to alert providers about potential drug interactions. Developed in partnership with an e-prescribing vendor. It was launched in 2003. E-prescribing is currently available to 3,000 providers who write approximately 80 percent of all Medicaid prescriptions in the State. .
Kansas The Community Health Record Pilot Project	Provides e-prescribing to providers through a secure Web portal. This is the same Web portal used for the State's claims-based EHR initiative. Includes claims-based prescription histories, information about the State's Medicaid drug formulary, and a tool to alert providers about potential drug interactions. Developed in partnership with one of the State's managed care organizations and a vendor specializing in HIT. It was launched in February 2006. E-prescribing is currently available to approximately 76 providers at 20 test sites in Sedgwick County. This technology may be released to providers statewide by 2008.
Mississippi The Gold Standard eMPOWERx	Provides e-prescribing to providers through a secure Web portal and personal digital assistants. Includes claims-based prescription histories for fee-for-service beneficiaries, information about the State's Medicaid drug formulary, and a tool to alert providers about potential drug interactions. Developed in partnership with an e-prescribing vendor. It was launched in October 2005. E-prescribing is currently available to approximately 225 of Mississippi Medicaid's highest volume prescribers. This technology may be released to providers statewide by 2008.
Missouri CyberAccess	Provides e-prescribing to providers through a secure Web portal. This is the same Web portal used for the State's claims-based EHR initiative. Includes claims-based prescription histories, information about the State's Medicaid drug formulary, and a tool to alert providers of potential drug interactions. The initiative also allows providers to electronically request prior authorizations. Developed in partnership with a vendor operating the State's MMIS. It was launched in July 2006. E-prescribing is currently available to approximately 3,600 providers.
Tennessee Shared Health ePrescribe	Provides e-prescribing to providers through a secure Web portal. This is the same Web portal used for the State's claims-based EHR initiative. Includes claims-based prescription histories, information about the State's Medicaid drug formulary, dosing instructions, and side effects, as well as a tool to alert providers about potential drug interactions. Developed in partnership with a vendor specializing in HIT. It was launched in June 2005. E-prescribing is currently available to all prescribing providers with access to the State's EHR initiative.

Source: Office of Inspector General analysis of State Medicaid directors' responses, 2007.

Table 3: Detailed Descriptions of Current Remote Disease-Monitoring Initiatives

State	Description
Missouri Telemonitoring Initiative	Provides beneficiaries with an electronic telemonitoring device that enables the patients' vital signs, or other medical statistics, to be monitored daily. A central processing unit placed in the beneficiary's home can incorporate an array of devices, such as a scale or an automated blood pressure cuff. The results of the monitoring are transmitted to the participating beneficiary's provider. Developed in partnership with a vendor that specializes in chronic disease management. It was launched in July 2002. Available to beneficiaries who require medical monitoring and who have any of the following conditions: diabetes, asthma, hypertension, chronic obstructive pulmonary disease, chronic heart failure, acute respiratory failure, and pneumonia. Served approximately 226 beneficiaries between July 2005 and June 2006.
Wyoming Health Buddy Program	Provides beneficiaries with an electronic device which asks about their health status on a daily basis. The device is placed in the beneficiary's home and plugs into the telephone line and an electrical outlet. The results of the monitoring are transmitted to the participating beneficiary's provider. The device also provides beneficiaries with health care information and tips. Developed in partnership with a vendor that specializes in chronic disease management. It was launched in July 2004. Available to beneficiaries who require medical monitoring and who have any the following conditions: diabetes, asthma, chronic obstructive pulmonary disease, coronary artery disease, chronic heart failure, hypertension, and depression. Approximately 60 beneficiaries have participated.

Source: Office of Inspector General analysis of State Medicaid directors' responses, 2007.

Planned Medicaid HIT Initiatives

State	Electronic Health Record	Electronic Prescribing	Remote Disease Monitoring	Personal Health Record	State	Electronic Health Record	Electronic Prescribing	Remote Disease Monitoring	Personal Health Record
Alabama	✔				Montana	✔			
Alaska					Nebraska			✔	
Arizona	✔	✔		✔	Nevada		✔		
Arkansas					New Hampshire	✔			✔
California	✔				New Jersey	✔			
Colorado			✔		New Mexico	✔	✔		
Connecticut	✔	✔		✔	New York		✔		
Delaware		✔			North Carolina		✔		✔
District of Columbia	✔				North Dakota				
Florida	✔	✔		✔	Ohio	✔	✔		✔
Georgia	✔	✔			Oklahoma		✔		
Hawaii	✔				Oregon				
Idaho	✔	✔		✔	Pennsylvania		✔	✔	
Illinois					Puerto Rico				
Indiana					Rhode Island	✔	✔		
Iowa					South Carolina	✔			
Kansas					South Dakota				
Kentucky	✔			✔	Tennessee		✔		✔
Louisiana		✔			Texas	✔			✔
Maine					Utah				
Maryland	✔	✔		✔	Vermont		✔		
Massachusetts	✔	✔			Virginia	✔			
Michigan					Washington	✔			
Minnesota	✔	✔			West Virginia	✔			
Mississippi	✔				Wisconsin	✔			
Missouri				✔	Wyoming	✔	✔		✔

Source: Office of Inspector General analysis of State Medicaid directors' responses, 2007.

Note: In certain cases, States with current initiatives may also be planning to develop additional HIT initiatives.

Planned Statewide HIE Networks Involving State Medicaid Agencies

State	Initiative Name
Arizona	Arizona Health-*e* Connection
California	California Regional Health Information Organization (CalRHIO)
Colorado	Colorado Regional Health Information Organization (CORHIO)
Connecticut	*e*Health Connecticut
Delaware	Delaware Health Information Network (DHIN)
Florida	Florida Health Information Network (FHIN)
Georgia	Health Information Technology and Transparency Advisory Board
Idaho	Idaho Health Quality Planning Commission
Indiana	Indiana Health Information Exchange
Kansas	Kansas HIT/HIE Policy Initiative
Kentucky	Kentucky *e*-Health Network (K*e*-HN)
Louisiana	Louisiana Health Information Exchange (LaHIE)
Massachusetts	MA-SHARE (Massachusetts—Simplifying Healthcare Among Regional Entities)
Michigan	Michigan Health Information Network (MiHIN)
Minnesota	Minnesota *e*-Health Initiative
New Jersey	Health Information Network Technology (HINT)
New York	Health *e*-Links Program
Ohio	Ohio Health Information Technology (OHHIT)
Rhode Island	Anytime, Anywhere Health Care Information
Tennessee	Tennessee *e*-Health Advisory Council
Utah	Utah Health Information Network Clinical (UHIN Clinical)
Vermont	Vermont Information Technology Leaders (VITL)
Washington	Washington Health Information Infrastructure Advisory Board
West Virginia	West Virginia Health Information Network (WVHIN)
Wisconsin	*e*Health Care Quality and Patient Safety Board

Source: Office of Inspector General analysis of State Medicaid directors' responses, 2007.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Office of the Administrator
Washington, DC 20201

DATE: AUG 07 2007

TO: Daniel R. Levinson
Inspector General

FROM: Herb B. Kuhn
Acting Deputy Administrator

SUBJECT: Office of Inspector General's (OIG) Draft Report: "State Medicaid Agencies Initiative on Health Information Technology and Health Information Exchange" (OEI-02-06-00270).

The Centers for Medicare & Medicaid Services (CMS) has reviewed the findings in the OIG draft report mentioned above regarding the extent to which State Medicaid agencies are implementing health information technology (HIT) and health information exchange (HIE) initiatives.

In recent years, both the President and the Secretary of the Department of Health and Human Services have promoted the goal of developing HIT and HIE. CMS shares that goal. We wish to thank the OIG for the opportunity to comment on this draft report. We agree with all of the recommendations and take very seriously the three tasks that OIG recommends to improve CMS' efforts. We support the goals of these tasks and have already taken steps to apply them.

OIG Recommendation

Continue to support the goals of Medicaid Information Technology Architecture (MITA). To further accelerate the adoption of interoperable health information systems, CMS should continue to emphasize the goals of MITA. CMS should work with State Medicaid agencies to implement MITA to facilitate future State Medicaid HIT and HIE initiatives. CMS may also consider revising the criteria governing Medicaid Management Information System (MMIS) funding to reflect the goals of MITA.

CMS Response

CMS is continuing to expand the MITA Framework 2.0 through the support of collaborative activities involving the States and the industry by expanding the definition of each of the 78 MITA business processes to include all five maturity level definitions. In addition, we will demonstrate the interoperability of the MITA Framework at our upcoming 2007 MMIS Conference in San Diego by building a provider enrollment module that can work with either *J2ee* or *.net* structures, as well as pieces from both software coding approaches. In fiscal year (FY) 2008, CMS will draft language in the State Medicaid Manual, Part 11, to revise the MMIS

funding criteria to reflect the goals of MITA. CMS will continue to work with States to facilitate new HIT and HIE initiatives.

OIG Recommendation

Collaborate with Other Federal Agencies and Offices to assist State Medicaid agencies with developing privacy and security policies. CMS should assist State Medicaid agencies with developing policies regarding the use of Medicaid health care information. Areas to focus on should include standards governing the transmission of Medicaid data and policies to ensure that only authorized users have access to records, as well as safeguards for beneficiaries' privacy including beneficiary notice and consent and policies for handling sensitive health care information.

CMS Response

CMS is currently working with the Office of the National Coordinator (ONC) to ensure that MITA meets the Federal privacy and security policies. In addition, we are working with the Agency for Health Research and Quality (AHRQ) on selecting a vendor to work with State Medicaid and State Children's Health Insurance program (SCHIP) agencies to expand their involvement with HIT and HIE. Part of the scope of that contractor's statement of work includes providing assistance to the States in the areas of privacy and security. CMS will work with both AHRQ and their technical assistance contractor to communicate our understanding of the privacy and security policies.

OIG Recommendation

Continue to work with the Office of the National Coordinator for HIT to ensure that State Medicaid initiatives are consistent with national goals. CMS should continue to work with the Office of the National Coordinator for HIT, which coordinates all Federal HIT and HIE initiatives. CMS should work with the office to ensure that State Medicaid agencies' initiatives are consistent with national goals and that Medicaid is viewed as a national partner in the development of HIT and HIE standards.

CMS Response

CMS is continuing to work with the ONC to ensure that MITA and the State initiatives that we support financially are consistent with national goals and objectives. In FY 2008, we will draft a white paper on the topic of how MITA meets and supports the Federal Health Architecture Framework with the goal of circulating this policy paper to all State Medicaid agencies and our respective Federal Regional Offices. CMS will work with ONC on the development of the paper to ensure it meets their needs and reflects that MITA and Medicaid Federal funding are tied to national HIT and HIE goals.

We appreciate the effort that went into this report and look forward to working with OIG on this and other pertinent issues.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Meridith Seife, Deputy Regional Inspector General.

Christine Moundas served as lead analyst for this study. Other principal Office of Evaluation and Inspections staff who contributed to this study includes Christi Macrina from the Dallas regional office. Other regional and central office staff who contributed include Elizabeth Jones and Mark Richardson.