PAPER IV

INCENTIVES AND MANDATES STATES USE TO PROMOTE HEALTH INFORMATION EXCHANGE

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Networks for Health

Abstract

We interviewed informants in 52 states and territories to understand what policy levers and actions states have used to promote health information exchange (HIE) services within their jurisdictions. We found a wide variety of approaches, ranging from very engaged states to those that have largely left the solving of interoperability challenges to the marketplace. To varying degrees, states use policy levers to encourage or require health care providers and payers to participate in HIE. In this paper we characterize these methods and the extent of their use.

Background

HIEs among the states[1] show varying levels of connectedness, ranging from states in which connectivity is sporadic and fragmented to those in which participation in a state-based HIE is nearly ubiquitous within the delivery system. An important factor in these outcomes is the policy levers the state is using to promote participation in an HIE. States that take a free market approach to HIE (we deemed these "Private Sector Promoters" in our companion paper[2]) may be doing little to encourage or steer health care providers and payers toward exchange activity. States that designate a specific nonprofit organization or state agency to perform exchange duties for the community are more likely to take steps designed to motivate participation among health care providers and payers. The various approaches to doing so are characterized below.

Ranges of Participation

It is important to recognize that participation in an HIE can include a wide range of information exchange, which is not well described by the Boolean "connected" or "not connected." For instance, one ambulatory practice may sign an HIE participation agreement and receive credentials to query an HIE via a stand-alone portal, which they might use infrequently. This ambulatory practice would not be making records available to be exchanged by the HIE, but it may still be counted as a "participant" in statistics shown on the HIE website. A second ambulatory practice may make records from every patient encounter available to other participants of an HIE, integrate its electronic health record (EHR) to automatically pull data from an HIE to be used in all patient visits, and routinely review notifications sent by an HIE about its patients for care management purposes. Both practices might be described as "connected," but their participation is clearly quite different. When states encourage health information exchange, their methods typically specify activity beyond simple participation.

[1] For readability, we use the generic "states" to include Puerto Rico and the District of Columbia in this paper.

[2] See Horrocks D, Young L, Bari L, **Methods States Use to Promote HIEs**, Civitas Resource Site, May 2022.

Policy Levers

Six categories of incentives or mandates are described with examples of states using each method:

Medicaid Incentives Health care providers/payers receive increased reimbursement for participation in an HIE	**Conditions of Participation** Health care providers/payers must participate in an HIE to be allowed to join Medicaid or a Shared Savings program
Connection Grants Hospitals and medical practices receive money for the initial integration to an HIE	**Public Health Authority** Public health agencies collect data under state authority and share it with an HIE for specific purposes
Legislated Mandate State law requires health care providers/payers to join and contribute data to one or more HIEs	**Mandated Use** State law or regulation requires health care providers to check records when providing certain treatment

Table 1: Categories of incentives or mandates

Medicaid Incentives

States use increased Medicaid reimbursement and contracts with managed care organizations (MCOs) to incentivize HIE utilization. In our interviews, 16 states described some version of a Medicaid incentive. For instance, Wisconsin encourages HIE participation by making it one of the measures against which organizations are scored in its Medicaid pay for performance programs. Hospitals can maximize their performance score and thus their incentive by sharing five identified data types with the state's designated HIE.

Florida Medicaid operates the Florida HIE, which is largely designed to support the Medicaid program itself and is primarily focused on exchanging encounter notifications. To encourage broad hospital participation in the Florida HIE, policy makers declared that hospitals must be sending admission/discharge/transfer (ADT) messages to be eligible for reimbursement under the state's low-income pool. These ADTs form the basis of hospitalization notifications to payers and primary care providers. The agency also scores a section of the competitive application to become an MCO in Florida, based on the organization's described plans for using encounter notifications. Thus, Florida is incentivizing both the supply of encounter notifications and the demand for their use as a care management tool.

Nevada requires its Medicaid MCOs to participate in the state's designated HIE. The agency also sets the fee MCOs must pay, thus creating a consistent revenue stream for its HIE. Arizona includes HIE participation in its MCO contracts and directs MCOs to hit certain targets for their high-volume providers to also connect to the state's designated HIE. Thus, the Medicaid agency directly requires MCOs to join the HIE and indirectly incentivizes health care providers to participate by making it necessary for the MCOs to themselves encourage connectivity in their provider contracts.

Conditions of Participation

Some states have passed rules that only allow health care providers to participate in an optional program if the clinicians are connected to a designated HIE. Policy makers may be hesitant to place such requirements on participation in the basic Medicaid program for fear of losing providers and thus reducing health care access for needy populations. Yet such requirements may be deemed reasonable for participation in a value-based care program, particularly if performance under the program would likely be improved through use of an HIE. In Wyoming, participation in the state's designated HIE is a condition for health care providers to be in the patient center medical home program. Pennsylvania policy makers enforce a similar requirement for its patient-centered medical homes but allow health care providers to choose among the several state-certified HIEs.

The Maryland Primary Care Program (MDPCP) is a shared savings program with more than 500 engaged practices. Maryland's state designated HIE makes various reports, tools, and patient data available to the practices, and program administrators will not approve participation in the MDPCP program for primary care providers that are not connected. Maryland's Health Services Cost Review Commission (HSCRC) likewise mandates that, if hospitals wish to participate in the state's All-Payer Model, they must send ADTs to the HIE. HSCRC uses the HIE's patient matching capability and the ADTs to support a variety of quality measure calculations, and the HIE further uses the ADTs to support statewide encounter notifications for care management purposes.

North Carolina passed legislation in 2015 making connection to the state's designated HIE a condition of participation in Medicaid or other state-funded health care, a requirement that phases in between 2018 and 2023.[3] The state's HIE, the North Carolina Health Information Exchange Authority, an agency of state government, receives demographic and clinical data from participants and reports that while the mandate technically applies to services "paid for with Medicaid or other State-funded health care funds," more than 80% of HIE participants send records for all patients. The law was passed concurrent to the state's move toward a Medicaid Managed Care model and has resulted in broad connectivity; all North Carolina acute care hospitals are connected as are some across state borders, which frequently treat North Carolina residents. The requirement currently extends to hospitals, physician practices, Medicaid MCOs, and the state lab. Pharmacies, out-patient surgery centers, and dentists are due to connect in 2023. The breadth of the Medicaid program makes this model a strong HIE participation incentive for larger organizations such as hospitals. But policy makers are monitoring whether the approach could, at the margins, become a barrier to some smaller health care providers accepting Medicaid reimbursement.

Connection Grants

One incentive states may use when an HIE does not yet have broad connectivity to a class of participants is to issue grants or other payments to subsidize the cost a health care provider will incur during the initial connection. Such costs vary depending on which EHR vendor a health care provider uses. A version of this strategy was used extensively during the HITECH Act's Regional Extension Center (REC) program, in which practices generally received payments at

[3] The NC Statewide Health Information Exchange Act can be viewed here, retrieved June 2022: https://www.ncleg.gov/EnactedLegislation/Statutes/HTML/ByArticle/Chapter_90/Article_29B.html

each of three milestones for EHR adoption.[4] HITECH Act funding also allowed Centers for Medicare & Medicaid Services (CMS) to provide matching funds to state Medicaid agencies that implemented programs to support HIE connectivity. New York[5] and Alabama[6] are among the states that provided support for the initial connection to an HIE, leveraging matching funds from CMS. Ohio ran a similar program specifically for behavioral health providers. The CMS authority to support these initiatives expired in 2021.

During our interviews, a handful of other states described grants to incentivize connectivity as a strategy used in the past, but our informants did not provide any examples of such programs in place today. If connectivity grants continue to be used, our research failed to identify them. Some policy makers have articulated a need for connectivity grants for skilled nursing facilities or community-based organizations, since these groups were often overlooked during earlier incentive programs.

Public Health Authority

A method states use to increase the amount of health information being exchanged is to share with an HIE the data a public health agency has collected based on its own legislated authority. In our study, 36 states reported using an HIE as a conduit to communicate data collected under public health authority back to clinicians in the field. The COVID-19 pandemic seems to have been a catalyst for this activity, with many HIEs now sending positive COVID case alerts to primary care providers or communicating immunization status at the point of care. Other frequently mentioned examples of public health data available at the point of care include prescription drug monitoring program (PDMP) records, overdose events captured by emergency management services, and reportable lab results. Colorado's public health agencies, for example, make reportable lab data and Medicaid enrollment files available to the state's qualified HIEs for communication back to clinicians and care managers. Maine's Department of Health and Human Services sends immunization registry data, reportable labs, and COVID-19 test results to its designated HIE (HealthInfoNet). The HIE also receives all medical, non-medical, and medication data from Medicaid.

In our study 26 states reported sharing Medicaid claims, or partial claims, with their HIE. These data are used to derive clinically relevant information, combined with other records to enhance the resulting dataset, or used as part of analytics and reporting services. For instance, South Dakota provides its HIE with dental and prescription claims files. Washington, D.C.'s HIE uses Medicaid claims to append chronic conditions flags to the COVID immunization reports primary care practices receive. HIEs may also be a mechanism to inform a patient's new Medicaid MCO about claims history from the previous Medicaid MCO, allowing care managers to more quickly identify services that could be helpful (e.g., Maryland). Public health data and Medicaid claims are often provided to the HIE for specific purposes, with extra protection of patient privacy, and not necessarily contributed under the HIE's regular participation agreement.

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[4] The milestone payments were technically made to one of 62 REC organizations, which in turn decided how much to pass on to medical practices. The REC program is described at this site, retrieved May 2022: https://www.healthit.gov/topic/regional-extension-centers-recs

[5] New York's program was called Date Exchange Incentive Program (DEIP) and is described at this site, retrieved May 2022: https://www.nyehealth.org/nyec-news-vol-81-may-2017/

[6] Alabama provided CMS matching funds, leveraging the HITECH Act, in the form of HITECH grants, in accordance with CMS's State Medicaid Director's letter, SMD #16-003, as approved by CMS through the State's Implementation Advance Planning Document (IAPD).

Legislated Mandate

In some circumstances, states are going beyond incentives and conditions of participation and passing laws to require a class of organizations to participate in a state designated HIE and to send selected data. This top-down approach is likely to be paired with a regulatory authority to sort out the details, exceptions, and allowable uses of data. In our interviews a handful of states reported using this approach, which seems to be a more recently adopted strategy.

In 2016 New York State adopted regulations requiring all general hospitals and health care facilities using certified EHR technology, as defined under the federal HITECH Act, to connect to the statewide network called the SHIN-NY through one of the state's qualified regional HIEs.[7] Under the regulation, health care facilities must allow other participants in the SHIN-NY to access patient information, if by law and policy they are authorized to do so. The New York State Department of Health regulates certain particulars and further oversees programs to improve the consistency and quality of data within the SHIN-NY.[8]

After Connecticut made several attempts to promote statewide HIE capabilities, which fell short of policy makers' aims, the Connecticut General Assembly passed enabling legislation in 2018 for a newly constituted, state-designated HIE.[9] The legislation directs that all licensed health care providers will connect to the nonprofit HIE, with timing and particulars defined in regulation by the Connecticut Office of Health Strategy.[10] The approach allows policy makers to incrementally increase for whom and how participation is required. According to Jenn Searls, the CEO of the now-designated HIE called Connie, "The mandate goes a long way in helping people say, 'Well, we will eventually all need to connect, so let's figure out how to get it done now.'"

In 2022 the Maryland general assembly passed legislation to require retail pharmacies to send records of all dispensed medications to the state-designated HIE called CRISP.[11] Among the many public health uses for these data, working toward the equitable distribution of COVID antiviral therapies and promoting antibiotic stewardship were top priorities. But CRISP will also be able to deliver the medication records to clinicians at the point of care. The legislation includes oversight and regulation by the Maryland Health Care Commission and requires CRISP to establish a committee of patient advocates to advise on appropriate uses of data. According to Craig Behm, CRISP's Executive Director, "It was extremely important to demonstrate that the HIE would be judicious and transparent in how medication data is used.

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[7] The regulations are found in Section 300.6 of Title 10 (Health) of the Official Compilation of Codes, Rules and Regulations of the State of New York (10 NYCRR). New York State defines health care facilities in NYS Public Health Law section 18(1)(c). The regulations gave general hospitals about one year and health care facilities about two years to connect.

[8] Certain data quality and other SHIN-NY programs are administered by the New York eHealth Collaborative, a nonprofit, which the state has designated to serve this purpose. Retrieved May 2022: https://www.nyehealth.org/who-we-are/about-us/

[9] The relevant Connecticut statute is Chapter 319o - Department of Social Services (ct.gov), retrieved May 2022.

[10] Connecticut Office of Health Strategy provides an overview of requirements here, retrieved May 2022: https://portal.ct.gov/OHS/HIT-Work-Groups/Health-Information-Alliance

[11] The legislation can be viewed here, retrieved June 2022: https://mgaleg.maryland.gov/2022RS/bills/hb/hb1127T.pdf

The support from patient advocates was predicated on striking a balance between privacy and enhanced clinical and public health decision-making."

Mandated Use

As noted earlier, connectivity to an HIE may be claimed despite limited use by a participating organization. A state mandate for clinicians or care managers to use the records delivered by an HIE is a strategy to promote utilization among clinicians. The aim is to make use of specific outside information part of the standard of care. In our interviews, the only such mandates we recorded were in relation to PDMP registries. Clinicians in many states are required by state law and regulation to check the PDMP before prescribing certain opioids to ascertain whether their patient might already have received similar drugs from another clinician. In some states, HIEs are one vehicle for clinicians to check these prior prescriptions, including in Washington, D.C., and North Dakota[12].

Federal Incentives

While our paper describes policies of states, it is worth noting that federal rule makers are also promoting HIE. The Office of the National Coordinator for Health IT (ONC) regulates against "information blocking" with authority from the 21st Century Cures Act. ONC also uses an EHR certification program to steer the market toward more interoperable solutions. CMS incentivizes making health records electronic and standards-based with its Meaningful Use rules, and it has gradually included HIE activities as requirements for health care providers to receive the highest Medicare bill rates. These approaches have largely been agnostic as to which exchange infrastructures are used, focusing instead on adherence to industry standards. However, in the same way many states have designated an organization to serve a special HIE role,[13] the federal government can be said to have recently endorsed (or "designated") a nationwide exchange network via the Trusted Exchange Framework and Common Agreement (TEFCA). The Sequoia Project serves as the Recognized Coordinating Entity (RCE) under TEFCA, working to form various health information networks into a common nationwide network. The breadth of services available under the TEFCA framework remains limited, but industry watchers are waiting to see if and how the federal government will promote participation in TEFCA.

Trends

Our research did not specifically seek to capture changes over time among the states, but our interviews left a strong impression that states are shifting away from grants to promote initial connectivity and toward incentives within the Medicaid program. Mandates in state law, while not widespread, do seem to be increasing, especially in instances where less stringent requirements previously failed to achieve the desired result. Public health agencies are sharing

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[12] For an example of regulation, see the North Dakota Board of Pharmacy's description: *Under 19-03.5-09 "Authority to adopt rules," each professional licensing board that is responsible for the licensing of individuals authorized to prescribe or dispense controlled substances for human consumption shall adopt rules under chapter 28-32 to require licensed individuals under that board's jurisdiction who prescribe or dispense controlled substances to humans to utilize the prescription drug monitoring program.* Retrieved June 2022: https://www.nodakpharmacy.com/PDMP-faq.asp

[13] Nearly one-half of states designate one or more nonprofit HIEs to serve a special role in their state. See Horrocks D, Young L, Bari L, **Methods States Use to Promote HIEs,** Civitas Resource Site, May 2022.

more and more data with HIEs that were collected under a state authority, a practice that in many states began with efforts to support the COVID-19 response.

Conclusions

While there is no consensus approach for states to incentivize or mandate health data interoperability, a variety of policy levers are available. For some policy makers, the money, time, and energy HIEs spend convincing participants to join or to contribute certain data could be better applied to enabling new capabilities for the state. Policies that make a state-based HIE's connectivity more complete tend to make that HIE more valuable for public and population health purposes. A state's judiciously crafted incentives or mandates can help achieve broad connectivity quickly and at lower overall cost. But matters of patient privacy, governance, and data use become even more important when state authority is leveraged. States should be looking to peers and evaluating outcomes to inform their own approaches.