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# **Medicaid Electronic Health Information Exchange System**

## **Initial Report**

**As Required By  
H.B. 1218, 81<sup>st</sup> Legislature, Regular Session, 2009**

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**Health and Human Services Commission  
January 1, 2011**

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## **Executive Summary**

Pursuant to H.B. 1218, 81<sup>st</sup> Legislature, Regular Session, 2009, the Health and Human Services Commission (HHSC) submits this report regarding the Medicaid health information exchange (HIE)<sup>1</sup> system. The bill directs HHSC to report on the status of the HIE system implementation, including utilization rates and goals for each health information technology (IT) component implemented as part of the system. H.B. 1218 also directs HHSC—in conjunction with the HIE pilot participants—to assess the benefits of securely exchanging medication history information.

In accordance with H.B. 1218, HHSC has taken a number of key steps toward implementing an HIE system for Medicaid and CHIP clients. These activities include:

- Development of a consent process to ensure the privacy and security of HIE.
- Identification of HIE pilot participants and initial planning and implementation of Medicaid medication history data exchange.
- Procurement and early development of Stage 1 of the HIE system, referred to as the Medicaid Eligibility and Health Information Services (MEHIS) project.
- Procurement of electronic prescribing (e-prescribing) services for Medicaid providers.

Additionally, since the passage of H.B. 1218, the federal government signed into law the Health Information Technology for Economic and Clinical Health (HITECH) portion of the American Recovery and Reinvestment Act (ARRA) of 2009. HITECH authorizes and appropriates funds to the Department of Health and Human Services for the Office of the National Coordinator of Health Information Technology (ONC) and the Centers for Medicare and Medicaid Services (CMS). In particular, HITECH authorizes CMS to provide incentive payments to eligible Medicaid professionals and hospitals that adopt and successfully demonstrate the meaningful use of certified electronic health record (EHR) technology. HHSC is working to implement a statewide HIE infrastructure, as well as the Medicaid EHR Incentive Program for Texas providers, leveraging CMS funding to continue development of the HIE system.

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<sup>1</sup> In this report, the term “health information exchange” means a health information exchange system that moves health-related information among entities according to nationally recognized standards.

## **Background**

Pursuant to H.B. 1218, 81<sup>st</sup> Legislature, Regular Session, 2009, HHSC submits this report regarding the HIE<sup>2</sup> system for Medicaid and CHIP clients. The bill directs HHSC to report on the status of the HIE system implementation, including utilization rates and goals for each health IT component implemented as part of the system. H.B. 1218 also directs HHSC—in conjunction with the HIE pilot participants—to assess the benefits of securely exchanging medication history information.

H.B. 1218 directs HHSC to develop an electronic HIE system to improve the quality, safety, and efficiency of health-care services provided under Medicaid and CHIP. H.B. 1218 also directs HHSC to establish an HIE pilot to determine the feasibility, costs, and benefits of exchanging secure health information between HHSC and local or regional HIEs. The health information to be exchanged between HHSC and local or regional HIEs must include, at a minimum, a patient's medication history. In addition, H.B. 1218 directs HHSC to establish a HIE Advisory Committee, and adopt rules as needed.

Since the passage of H.B. 1218, the federal government signed into law the HITECH portion of ARRA. HITECH authorizes and appropriates funds to ONC and CMS. ONC is responsible for grants to states and other entities to pursue initiatives to encourage the adoption of EHR technology and to create the infrastructure for the secure exchange of health information, including technical support for primary care providers and development of workforce training to support EHR adoption. In March 2010, ONC awarded HHSC \$28.81 million through the State HIE Cooperative Agreement Program. The purpose of this program is to continuously improve and expand HIE services to reach all health-care providers in an effort to improve the quality and efficiency of health care. HHSC used \$1 million of the award for the development of the *State of Texas Strategic and Operational Plans for Statewide Health Information Exchange* to guide the establishment and operation of these electronic health information networks. ONC approved these plans on November 3, 2010, releasing the remaining \$27.8 million for statewide HIE initiatives.

HITECH authorizes CMS to provide incentive payments to eligible Medicaid professionals and hospitals that adopt and successfully demonstrate the meaningful use of certified EHR technology. CMS will provide 100 percent funding for the incentive payment to Medicaid providers and covers 90 percent of the administrative cost of the state. The final rule specifies:

- Initial criteria eligible professionals and hospitals must meet in order to qualify for an incentive payment.
- Calculation of the incentive payment amounts.
- Other program participation requirements.

States need a CMS-approved Medicaid Health IT Plan and accompanying Advanced Planning Documents (APD) to receive funding for the Medicaid EHR Incentive Program. In December 2009, HHSC received \$3,856,551 in federal funds for Medicaid health IT planning activities. Texas submitted the Medicaid Health IT Plan and associated documents on October 29, 2010,

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<sup>2</sup> Ibid

for CMS approval. These documents, which will be updated at least annually, will provide policy direction for Medicaid health IT initiatives.

## **HIE Activities and Accomplishments**

### **Health Information Exchange Advisory Committee**

H.B. 1218 requires HHSC to establish an HIE Advisory Committee of 12 to 16 members to advise HHSC on issues regarding the development and implementation of the electronic HIE system, including the following specific issues:

- Data to be included in an EHR.
- Presentation of data.
- Useful measures for quality of service and patient health outcomes.
- Federal and state laws regarding privacy and management of private patient information.
- Incentives for increasing health-care provider adoption and usage of an EHR and the HIE system.
- Data exchange with HIE organizations to enhance: (1) the comprehensive nature of the information contained in EHRs; and (2) health-care provider efficiency by supporting integration of the information into the EHR used by health-care providers.

Advisory committee members represent the geographic and cultural diversity of the state. They also have an interest in health IT and experience in serving persons receiving health care through Medicaid and CHIP. The HIE Advisory Committee is expected to collaborate with the Texas Health Services Authority to ensure that the HIE system is interoperable with the statewide electronic health information infrastructure being developed with HITECH funding from ONC.

The HIE Advisory Committee has been meeting every other month since February 2010. Six meetings were held in 2010. At these meetings, HHSC staff reports on the status of HIE initiatives and seeks the input of committee members regarding HIE activities that continue to evolve. Table 1 lists the current membership of the HIE Advisory Committee and the areas they represent.

**Table 1: HIE Advisory Committee Members**

<b>Name</b>	<b>Region</b>	<b>Representation</b>
Joseph Schneider, MD, MBA, Chair	Dallas	Major provider association Pediatric medical informatics
Pamela McNutt, Vice Chair	Dallas	Health-care facility
Christina Dooley, MD	Denton	Medicaid and CHIP provider
Wendy Faldet	San Antonio	Pharmaceutical industry
Victor Gonzalez	Austin	Medicaid and CHIP enrollees
Ann Kitchen, JD	Austin	HIE organization
Susan McBride, RN, PhD	Fort Worth	Health-care facility
Sloane Cody	Austin	Managed care organization
Tony Gilman	Austin	Texas Health Services Authority
Robert Warren, MD	Houston	Health-care facility Pediatric medical informatics
Troy Alexander*	Austin	Department of State Health Services
Debra Wanser*	Austin	Department of Assistive and Rehabilitative Services
Terri Ware*	Austin	Department of Family and Protective Services
Ron Luke, JD, PhD*	Austin	HHSC Council
Teresa Richard*	Austin	Department of Aging and Disability Services

\* nonvoting members

Note: There is one vacant position

### **Medicaid Health Information Exchange Consent Policy**

In February 2010, HHSC created an internal workgroup to: (1) identify any legal, policy or procedural barriers to implementing Medicaid and CHIP HIE initiatives; and (2) develop privacy and security elements needed to implement HIE initiatives. The workgroup researched privacy and security policies and practices in use in other states and at the national level to identify any legal, policy, or procedural barriers to implementing planned HIE initiatives. A number of sources were consulted, including the Health Information Security and Privacy Collaboration studies commissioned by the federal Department of Health and Human Services.

The workgroup found that the following consent options are permissible under state and federal law:

- No Consent: Clients’ consent to release Medicaid claims data is not sought nor obtained.
- Opt-In: Clients’ affirmative signed consent must be obtained before Medicaid data can be exchanged via HIE.
- Opt-In with Restrictions: Same as Opt-In except that restrictions on which health information may be disclosed, the purpose for the disclosure, or specified health information to be disclosed are also allowed under this option.

- Opt-Out: Clients' consent for their Medicaid data to be exchanged via HIE is obtained during application process, with opportunity provided to opt-out.
- Opt-Out with Exceptions: Same as Opt-Out except that clients have the right to specify information to be removed from the electronic exchange.

Based on the workgroup's recommendations, HHSC adopted the opt-out model for Medicaid HIE in August 2010. Advantages of the opt-out model include:

- Improved coordination of care due to higher client participation rates.
- Less costly to administer since only opt-out decisions are recorded (expected to be less than 1 percent of clients).
- Protects clients' privacy rights by providing some patient choice regarding participation, addressing concerns of patient rights advocacy groups.
- Provides HHSC with a mechanism to inform clients about the release of health information, including sensitive health information that is protected by various federal and state laws.
- Adaptable to future Medicaid and CHIP HIE initiatives as they are implemented.

#### *Client Communications*

Prior to the implementation of HIE initiatives, HHSC began informing existing Medicaid clients and new applicants about the electronic sharing of their health information with authorized Medicaid providers. An informational leaflet was sent with the December 2010 Medicaid ID letters mailed to all current clients, announcing that Medicaid will begin sharing clients' health information unless a client notifies HHSC to not share his/her health information. The leaflets will continue to be sent monthly to all newly enrolled clients for several months, until the consent process transitions to the MEHIS project. Clients and applicants will be informed that if they want their health-care providers to have access to their health information, they do not need to take any action. Clients who wish to opt-out of participation in the Medicaid HIE system will be directed to a client website or interactive voice response (IVR) system to record their decision. Clients may revoke their initial decision at any time. As part of ongoing provider and client outreach activities for health IT initiatives, Medicaid will be educating clients about the benefits of HIE, including:

- More complete health information resulting in better quality of care.
- Safer transfer of health information achieved via secure network.
- Faster transfer of health records resulting in more prompt treatment.
- Single source of access, allowing providers to view medical history easily and quickly.
- Avoids unnecessary duplicate tests by multiple providers.

#### **Medicaid Health Information Exchange Pilot Project**

In July 2009, HHSC sent an e-mail to HIE stakeholders across the state inviting health information exchange organizations interested in the Medicaid HIE pilot who met the definition in the legislation to participate.<sup>3</sup> Organizations listed in Appendix A all expressed interest and met the basic criteria. Medicaid staff has met with these organizations on several occasions to

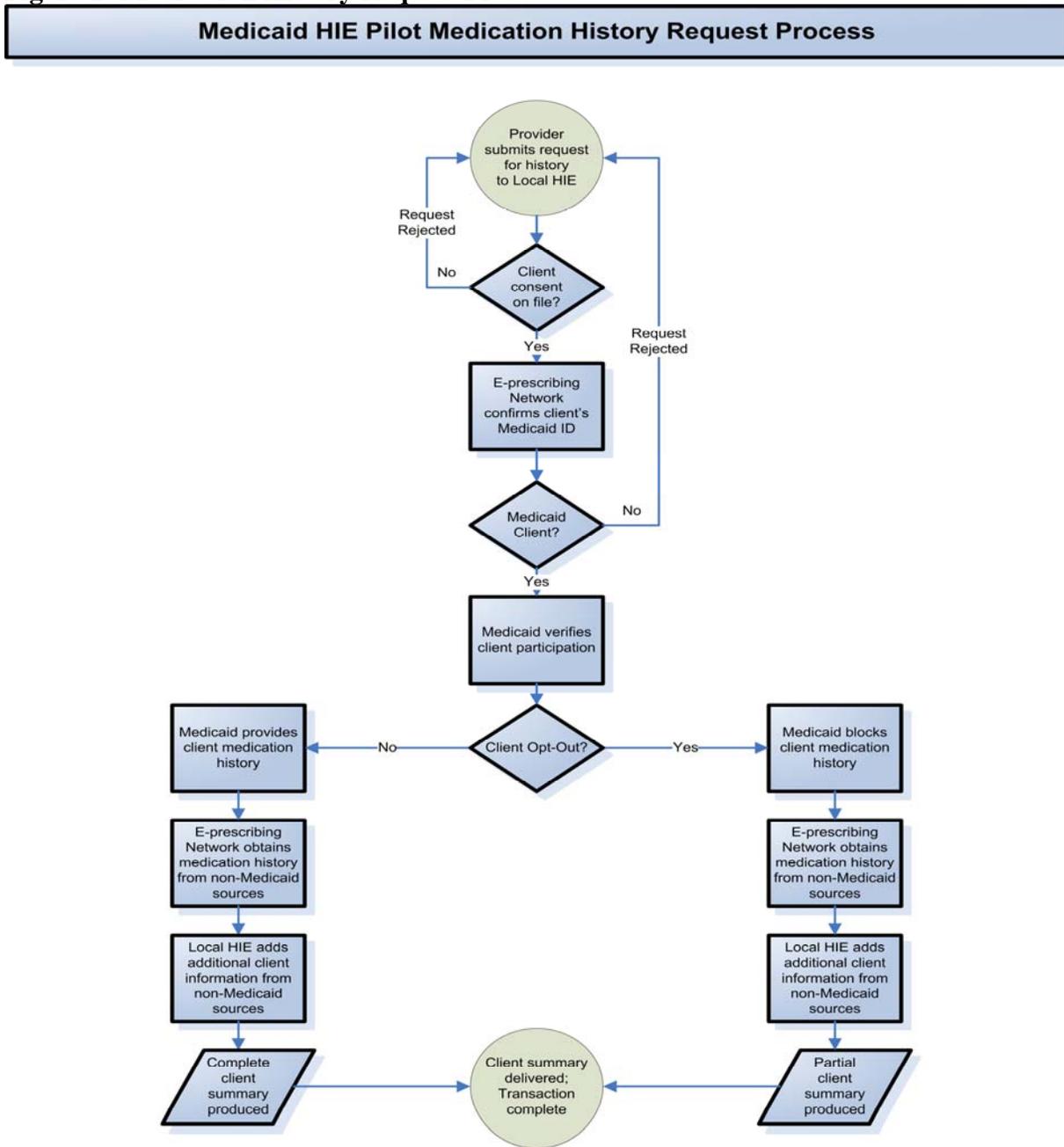
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<sup>3</sup> A local or regional HIE selected for the pilot project must possess a functioning HIE database that exchanges secure electronic health information among hospitals, clinics, physicians' offices, and other health care providers that are not each owned by a single entity or included in a single operational unit or network.

discuss business needs and options for establishing the medication history data exchange. The organizations also agreed to assist HHSC in preparing a report assessing the benefit to the state, patients, and health-care providers of exchanging secure health information. The medication history data exchange will be implemented in two phases. In Phase 1, Medicaid will share a non-standardized batch file with HIE pilot participants. In Phase 2, Medicaid will implement an interoperable exchange through the e-prescribing network provider as soon as practicable after the Pharmacy Claims and Drug Rebate Administration contract has fully transitioned to Affiliated Computer Services.

The Medicaid opt-out consent policy and the HIE organizations' opt-in consent model will work in tandem during the HIE pilot to provide a secure information exchange process that adheres to all applicable federal and state privacy and security rules. The HIE organizations will maintain a record of the clients' consent in order to request and receive medication history information from the Medicaid Pharmacy Claims and Rebate Administrator. This indicator is checked for permission and shared as appropriate with the entities involved in routing the data exchange. Unless a Medicaid client opts out of participation in the Medicaid HIE, their medication history will be electronically shared with Medicaid providers via the HIE organization. The HIE may receive additional medication history available through the e-prescribing network, as well as health information from other sources such as hospitals or labs. The HIE aggregates the information received from all sources and shares the client summary with the requesting provider. Figure 1 illustrates the medication history request process.

**Figure 1: Medication History Request Process**



Data exchange under Phase 1 of the HIE pilot will begin in early 2011, with Phase 2 expected to begin later in 2011. Participating HIE organizations have agreed to develop and design an evaluation methodology. The methodology will identify data to be collected as part of the HIE pilot to assess the benefit of HIE to Medicaid, patients, and health-care providers. Because actual data exchange has just begun, insufficient data has been obtained to perform the return-on-investment analysis required by H.B. 1218; however, the analysis will be conducted and reported in the next HIE report due January 1, 2013.

The cost for the HIE pilot is estimated at \$1,145,000, which includes implementation of the consent process, development of the batch files data exchange (Phase 1), and the interoperable

data exchange between the HIE pilot participants and the e-prescribing network provider network (Phase 2). All HHSC costs associated with the pilot will be paid for with federal grant funds from the Medicaid Transformation Grant.

**Table 2: HIE Pilot Costs**

<b>Opt-out Consent</b>	<b>Phase 1: Flat File Interface</b>	<b>Phase 2: e-Prescribing Network Provider</b>	<b>Total</b>
\$500,000	\$100,000	\$545,000	\$1,145,000

### **Medicaid Health Information Exchange System**

H.B. 1218 directs HHSC to develop an electronic HIE system to improve the quality, safety, and efficiency of health-care services provided under Medicaid and CHIP. In developing the HIE system, HHSC must:

1. Ensure that the confidentiality of patients' health information is protected and that patient privacy is maintained in accordance with applicable federal and state law.
2. Develop interoperable IT systems across the HHS Enterprise, including data warehousing initiatives.
3. Develop an interoperable HIE system that can receive and exchange electronic health information as necessary to enhance: (1) the comprehensive nature of the information contained in EHRs; and (2) health-care provider efficiency by supporting integration of the information into the EHRs used by health-care providers.
4. Include the following elements in the HIE system:
  - Authentication process that uses multiple forms of identity verification before allowing access to information systems and data.
  - Formal process for establishing data-sharing agreements within the community of participating providers in accordance with applicable federal laws.
  - Method by which HHSC may open or restrict access to the system during a declared state emergency.
  - Capability of appropriately and securely sharing health information with state and federal emergency responders.
  - Compatibility with national health IT initiatives coordinated by ONC.
  - Technology that allows for patient identification across multiple systems.
  - Capability of allowing a health-care provider to access the system if the provider has technology that meets current national standards.

HHSC is currently assessing some of the mandated elements in H.B. 1218 to determine how and when to implement these provisions in MEHIS. These provisions include: (1) an authentication process that uses multiple forms of identity verification before allowing access to the system; (2) technology that allows for patient identification across multiple systems; (3) a method by which to open access to the system during a declared state emergency; and (4) the capability of appropriately and securely sharing health information with state and federal emergency responders.

H.B. 1218 further requires that HHSC implement the HIE system in three stages. In accordance with the legislation, HHSC is developing the Medicaid Eligibility and Health Information Services (MEHIS) as the HIE system in three stages.

*MEHIS Implementation – Stage 1*

H.B. 1218 requires that in Stage 1 of HIE system implementation, HHSC must develop and establish an EHR for each Medicaid client, and make it available to each client through the Internet. HHSC is expected to consult and collaborate with physicians and other stakeholders to ensure that the EHRs support HIE with EHR systems in use by physicians in the public and private sectors.

On September 1, 2010, HHSC executed a contract to implement and operate MEHIS.. Stage 1 is expected to be operational in 2011 with first-year costs estimated at \$15.2 million, which are further detailed in Table 3.

**Table 3: MEHIS Costs**

	<b>FY 2011</b>	<b>FY 2012</b>	<b>FY 2013</b>	<b>FY 2014</b>	<b>Total</b>
MEHIS Implementation and Operations	\$11,940,233	\$8,612,223	\$8,229,888	\$7,281,739	<b>\$36,064,083</b>
Claims Administrator & Vendor Drug Interface	\$2,505,133	\$1,191,154	\$1,191,154	\$1,191,154	<b>\$6,078,595</b>
Contracted Project Support (IV&V)	\$786,849	\$615,745	\$615,745	\$615,745	<b>\$2,634,084</b>
	<b>\$15,232,215</b>	<b>\$10,419,122</b>	<b>\$10,036,787</b>	<b>\$9,088,638</b>	<b>\$44,776,762</b>

MEHIS Stage 1 is designed to replace Medicaid’s current paper format of identification with permanent plastic cards that allow health-care providers secure access to Medicaid eligibility and adjudicated claims history information. MEHIS will enable providers to use a card reader to access an HHSC database through a portal to verify client eligibility at the point of care. It will also enable Medicaid providers to access a claims-based EHR. The new system will support eligibility verification, aggregation of medical service encounter data, medication history for filled prescriptions, immunization history from the state’s immunization registry, and program information, such as Texas Health Steps (THSteps) notifications. MEHIS will have automated program notification, provider and client portal capabilities, and call center access. While the MEHIS design supports secure and confidential access to claims data, MEHIS as currently planned does not provide certified EHR functionality, such as access to clinical data maintained in a provider’s electronic medical record. Specifically, MEHIS will include:

- Plastic Medicaid ID card,
- Client opt-out capability through an IVR or website,
- Medicaid claims-based health and medication information,
- Immunization information,
- Automated program notifications for THSteps pending and past due medical and dental checkups,

- Web-based provider and client portals for access to the EHR,
- Client and provider help desks,
- Infrastructure for HIE capabilities, and
- Access to e-prescribing functions.

Consistent with H.B. 1218, the following industry standards will be utilized by the MEHIS project.

**Table 4: MEHIS Standards**

<b>Standard</b>	<b>Description</b>
Health Level 7 (HL7) Messaging	Defines a series of electronic messages called interactions to support all healthcare workflows.
Clinical Document Architecture (CDA)	Specifies the structure and semantics of clinical documents used for HIE.
Web Services for Remote Portlets (WSRP)	Defines a standard web service interface for interacting with web-based user interfaces.
JSR168 for Java Portlet Specifications	Portal development is a way to integrate different web-based applications for supporting deliveries of information and services; this standard specifies the grouping of different portlets into one portlet application.
Lightweight Directory Access Protocol (LDAP)	A protocol for querying and modifying data of directory services implemented in Internet Protocol (IP) networks.
JSR208 for Java Business Integration (JBI)	Specification developed for an approach to implementing a service-oriented architecture (SOA); built on a web services model and provides a pluggable architecture for a container that hosts service producer and consumer components.
X12 270/271 Eligibility Inquiry and Response	An electronic data interchange (EDI) standard for eligibility inquiry and response, designed so that inquiry submitters can determine (a) whether an information source organization (e.g., payer, employer, health maintenance organization) has a particular subscriber or dependent on file, and (b) the health care eligibility and/or benefit information about that subscriber or dependent(s).
Cross-Enterprise Document Sharing (XDS)	A profile created to facilitate the sharing of clinical documents between institutions that provides a centralized method of indexing documents.
Service-Oriented Architecture (SOA)	Flexible set of design principles used during the phases of systems development and integration in computing. A system based on SOA will package functionality as interoperable services that can be used within multiple separate systems from several business areas.
Extended Markup Language (XML)	A set of rules for encoding documents in machine-readable form.

H.B. 1218 requires that HHSC adopt rules specifying the information required to be included in the MEHIS. HHSC has proposed new Texas Administration Code §356.101, relating to Data for the Medicaid Eligibility and Health Information System. The proposed new rule was published as proposed in the *Texas Register* on October 1, 2010, and is expected to become effective February 3, 2011. It specifies that the following information will be included in the claims-based EHR:

- The name and address of each of the individual's health-care providers.
- A record of each visit to a health-care provider, including diagnoses, procedures performed, and laboratory test results.
- An immunization record.
- A prescription history.
- A list of due and overdue THSteps medical and dental checkups.
- Any other available health history that health-care providers who provide care for the individual determine is important.

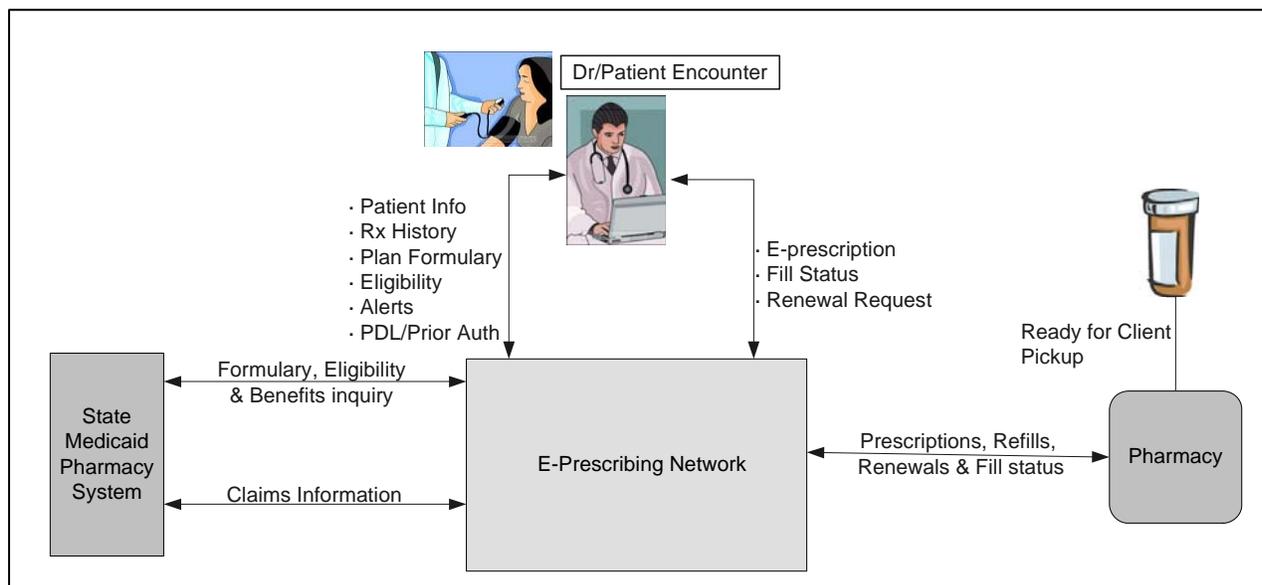
H.B. 1218 also specifies that in Stage 1 of HIE system implementation, HHSC must require Medicaid managed care organizations (MCOs) to submit complete and accurate encounter data no later than the 30<sup>th</sup> day after the last day of the month in which the MCO adjudicated the claim.

In September 1, 2009, HHSC amended existing managed care contracts to submit encounter data within 30 days, plus all new managed care contracts now include the 30-day requirement.

Finally, H.B. 1218 requires that HHSC support and coordinate e-prescribing tools used by Medicaid and CHIP providers in Stage 1 of HIE system implementation. HHSC is to consult and collaborate with physicians and other stakeholders to ensure that the e-prescribing tools: (1) are integrated with existing e-prescribing systems otherwise in use in the public and private sectors; and (2) to the extent feasible, provide current payer formulary information at the time a health-care provider writes a prescription and support the electronic transmission of a prescription.

E-prescribing not only replaces paper prescriptions with electronic prescriptions, but also includes the electronic transfer of prescription, drug formulary, client benefit, and patient information among prescribers, pharmacies, and payers. Implementation of e-prescribing in Medicaid will occur in 2011. Figure 2 depicts the interactions among physicians, patients, and payers during e-prescribing.

**Figure 2: E-Prescribing Data Exchange Process**



HHSC will implement e-prescribing in two stages. In Stage 1, the Medicaid pharmacy system will be connected to the network that facilitates the electronic interactions between payers, prescribers, and pharmacies. This connectivity will allow prescribers that currently use an EHR or other e-prescribing technology to prescribe medications through the network to e-prescribe for Medicaid clients. In Stage 2, HHSC will offer a web-based e-prescribing tool that can be used by any Medicaid and CHIP provider through a secure website. The web-based tool will be key offering in Stage 1 of the MEHIS implementation.

The operator of the e-prescribing network is responsible for ensuring that all e-prescribing systems, including payer, prescriber, and pharmacy systems, are certified prior to connection. Certification of e-prescribing capabilities requires compliance with nationally-adopted standards. Both stages of the e-prescribing implementation will include a certification step.

The success of e-prescribing is directly correlated to the adoption rate of Medicaid prescribers. In 2008, the e-prescribing rate for all Texas providers was 3 percent (excluding controlled substances). At the end of 2009, the rate had increased to 10 percent (excluding controlled substances). Additionally, the percentage of physicians prescribing electronically increased from 10 percent in 2008 to 15 percent in 2009.<sup>4</sup> Texas Medicaid anticipates continued increases in adoption of e-prescribing in the coming years. The projected targets are at least 10 percent in 2010 and 15 percent in 2011.

The total implementation cost of an e-prescribing program in Medicaid and CHIP in fiscal years 2010 through 2011 is \$935,342 all funds. These costs include contracted costs for both stages of implementation and estimated transaction costs at the targeted e-prescribing rates. After accounting for federal funds, the estimated general revenue cost over the two-year period is just under \$436,000. However, the estimated financial benefit to the state exceeds the estimated cost in the first year of implementation. The estimated return on investment to the state as a result of

<sup>4</sup> State Progress Reports on Electronic Prescribing, December 2009 and September 2010, Surescripts, [www.Surescripts.com](http://www.Surescripts.com)

e-prescribing for the first two years of operations is more than \$1.7 million. It should be noted that the cost and benefit estimates are based on certain assumptions. Once the program becomes fully operational, these assumptions will need to be monitored and adjusted to match actual program cost and benefit.

**Table 5: E-Prescribing Costs**

<b>E-Prescribing</b>	<b>FY 2010</b>	<b>FY 2011</b>
Total Estimated Cost	\$587,922	\$347,419
Federal e-Prescribing Costs	\$314,051	\$185,640
State e-Prescribing Costs	\$273,871	\$161,779

*MEHIS Implementation – Stages 2 and 3*

MEHIS will establish an infrastructure for future Medicaid HIE in Stage 1, although actual data exchange with Medicaid providers is not planned to start until Stage 2. This will occur in coordination with the Medicaid EHR Incentive Program and collection of meaningful use and clinical quality measures. However, the real value of MEHIS is that it will help to make claims data actionable. Claims and encounters serve as the basis for payment to providers and MCOs. With MEHIS, this data will be leveraged to enable targeted and purposeful communication between Medicaid, health-care providers, and clients for improved health outcomes. For example, MEHIS will offer automated reminders of periodic services through a variety of media, such as e-mail, text-messaging, or mail based on provider and consumer preferences. MEHIS also has the potential to continue to benefit clients and providers after a patient has transitioned from Medicaid via its ongoing participation in the planned statewide HIE.

For Stage 2, MEHIS will:

- Incorporate CHIP clients into the MEHIS database.
- Integrate state laboratory test results to the EHR.
- Improve data gathering capabilities and system enhancements.
- Begin using evidence-based technology tools to create client profiles.

For Stage 3, MEHIS will:

- Expand the use of evidence-based benchmarking.
- Expand the HIE system to include other data exchange partners.

**Medicaid Health Information Exchange Initiatives: Consolidated Costs**

**Table 6: Consolidated HIE Costs**

<b>HIE Initiative</b>	<b>FY 2011</b>
HIE Pilot	\$1,145,000
MEHIS	\$15,232,215
e-Prescribing	\$347,419
<b>Total</b>	<b>\$16,724,634</b>

**Conclusion**

Since the passage of H.B. 1218, national health IT activities at the federal, state, and local levels have increased dramatically and continue to evolve rapidly. As such, HHSC has been working with the provider community and agency stakeholders to plan and put into place the HIE infrastructure and support mechanisms, as well as to develop the claims-based EHRs. HHSC has been working to ensure that all HIE initiatives are consistent across all the various HIE and EHR efforts. This includes pursuing federal funding to begin implementing the various components of the HIE system, and adhering to national standards and federal regulations as they become effective; however, more work remains. HHSC is committed to ensuring the development and implementation of a robust HIE system to fully support and service its clients.

## **Appendix A: HIE Pilot Participants**

**Integrated Care Collaborative (ICC)** based in Austin and serving Travis and Williamson counties is a nonprofit, regional collaborative of 24 hospital systems, nonprofit and federally qualified health clinics (FQHCs), emergency management services, jail health services, and other providers who arrange for or provide care for the uninsured or underinsured. Operating since 2002, the ICC uses a web-based system called ICare. ICC currently exchanges patient-specific demographic, encounter, and medication data for over 750,000 unique individuals with more than 4 million encounters at 70 locations throughout the region.

**Healthcare Access San Antonio (HASA)** based in San Antonio is a coalition of nine major Bexar County health-care providers, including four hospital systems, two FQHCs, two community health clinics, and the San Antonio Metropolitan Health District. Its mission is to improve the medical safety net in Bexar and surrounding counties. HASA currently maintains more than 300,000 unique patient records with approximately 2 million records. HASA's HIE system (SecureShare) is currently deployed at multiple clinic locations, receiving data from all stakeholders in a variety of formats. The system deploys an electronic signature authorization procedure to comply with patient privacy and Health Insurance Portability and Accountability Act (HIPAA) standards.

**Sandlot, LLC**, based in Fort Worth and serving the Dallas/Fort Worth area, is providing for the exchange of medical record information between disparate health care systems for more than 1.2 million patients. Sandlot's HIE system (SandlotConnect) is operational and used across multiple counties, providing real-time clinical data to health-care providers at the point of care. Currently, it connects seven area hospitals, two national labs, as well as two certified electronic health record (EHR) products that provide and collect clinical data. SandlotConnect users may also place electronic referrals, communicate with other physicians, and prescribe electronically.

**Texas Health Resources (THR)**, based in Arlington, is a non-profit health-care delivery system serving 16 counties in north central Texas with a population of more than 6.2 million people. THR has 28 health-care sites, including 13 acute-care hospitals, surgery centers, and 1 long-term care hospital. THR currently provides patient care data to a number of outside institutions including the Sandlot HIE.

**Health Information Network of South Texas** serving the Corpus Christi area is an adapting, open, self-sustaining HIE system that can demonstrate quantifiable social, clinical, and economic benefits for county patients and providers. In addition to preparing physicians to implement electronic medical records, the goal of the project is to implement an HIE focused on improving outcomes for high-prevalence, high-cost chronic diseases. The initiative includes three rural health-care providers, a children's health insurance plan, and Texas A&M – Kingsville.