

STRUCTURE

HHS at a Crossroads

As new federal laws change the healthcare paradigm, states and localities face tough decisions about human services interoperability. Which way will they turn, and what will serve their clients best?

By Rick Friedman.

OVER THE PAST 24 MONTHS, TWO NEW and important federal laws are changing the face of healthcare in the United States.

On February 17, 2009, President Obama signed the American Recovery and Reinvestment Act of 2009 (ARRA) into law. A portion of the law, the Health Information Technology for Economic and Clinical Health Act (HITECH) underscored the federal government's support of electronic health records to improve quality and contain costs by sharing electronic medical records in secure and confidential ways among providers.

A little more than one year later, on March 23, 2010, the Patient Protection and Affordable Care Act (also known as the Affordable Care Act, or ACA) was signed into law. ACA includes a number of health-related provisions that will take effect over a four-year period through 2014. Among other features of the law, Medicaid eligibility rules have been simplified and standardized across the country. Rather than requiring individuals or families to be found eligible under a number of narrowly defined, and frequently complex, eligibility categories, as was the case in the past, ACA levels the playing field by establishing a common national standard (133 percent of the Federal Poverty Level for Medicaid eligibility).

What does this have to do with human services interoperability?

Impact of HITECH and ACA on Human Services

For the past 20 years, Medicaid and a wide range of human services programs, principally those

administered through the U.S. Department of Agriculture (USDA) Food and Nutrition Service (FNS), such as the Supplemental Nutrition Assistance Program (SNAP, aka food stamps), and the U.S. Department of Health and Human Services' Administration for Children and Families (ACF) Children's Bureau and Office of Child Support Enforcement, have worked together closely to determine eligibility for their respective programs. Large, integrated eligibility determination systems, built and run by a state's department of human services and frequently administered at the county level, have most often served as the workhorses of the eligibility determination process.

With the new laws, however, there is an opportunity for state Medicaid agencies to shift their focus away from human services interoperability toward a much tighter coupling with healthcare insurers and other stakeholders focused on delivery of high-quality healthcare and improved outcomes.

For a number of years, Medicaid agencies having been shifting away from being passive payers of healthcare services, albeit with a sharp eye on reducing fraud and abuse, to being prudent managers of the care in which they are investing. They do this in a variety of ways, but a primary focus has been by paying much closer attention to not only what they are paying for, but whether the care has been effective.

The Office of the National Coordinator of Health Information Technology has been working very closely over the past two years with the Medicaid program to support technical as-



sistance to potential users of electronic health records, ranging from small community hospitals to large university-based institutions, and from solo private healthcare practitioners to large group practices, nurses, certified nurse practitioners and others. As the federal and state agencies engaged in EHR promotion and adoption continue to make strides in this area, oversight and regular tracking of where and how effectively tax dollars are being spent become increasingly important. Moreover, the need for a more complete and comprehensive view of an individual's medical history, consisting of records from many different healthcare providers, becomes both paramount and easier with increased EHR adoption.

The Affordable Care Act's likely impact will be equally far-reaching.

The national Medicaid income standard is considerably higher than the current income test in some states, and the elimination of the categorical eligibility rules means that many people, including single adults, previously ineligible will now be eligible for Medicaid enrollment. Medicaid is already the largest or second-largest part of most states' budget after education, and the numbers and types of Medicaid enrollees newly covered under the ACA will have a profound effect on each state's Medicaid program. Increasingly, Medicaid is taking on the demographics of a large health insurer rather than a safety net program. How much the people enrolled in each state's Medicaid program will continue to be similar demographically to the beneficiaries of SNAP and Child Welfare services remains to be seen. But to the extent these two groups begin to grow apart, coupled with states having to create new business process models to identify and enroll them into Medicaid based on considerably higher performance standards than in the past, there will be increasing pressure within Medicaid programs to turn away from cumbersome legacy systems and align more closely with health insurance programs and suspend or

even delay developing closer ties with the human services programs.

Apart from the new Medicaid eligibility rules under the ACA, the creation of a new organization in every state (a state option) and at the federal level, known as a health insurance exchange (the "Exchange"), is also part of the ACA landscape. The Exchange is designed to serve as a virtual one-stop "marketplace" where people seeking health insurance can go to have their income, citizenship status and other threshold criteria confirmed in an online, real-time environment and enroll in programs ranging from Medicaid to private health insurance without having to respond to a myriad of eligibility questions because of the previous complexity of the Medicaid decision rules. Additionally, through interfaces built between a "federal hub" and other federal agencies with extensive databases, ranging from the Internal Revenue Service to the Department of Homeland Security, the determination of Medicaid eligibility will be a considerably faster and more efficient process than it has been in the past.

Critical Decisions

The extent to which this new paradigm compels states to rethink their eligibility business process model—and the extent to which they can, or cannot, successfully leverage their legacy integrated eligibility determination systems—remains a major question for most states. At a time of incredibly tight state budgets and resource constraints, few states will want to build new and/or separate Medicaid systems from scratch.

On the other hand, given the need to re-envision how Medicaid eligibility determinations must be made in the future, and the drive toward more comprehensive health/medical views of Medicaid clients, the jury is out on which way states will elect to go: Will they continue their long-standing ties between Medicaid and human services, or will they sever or suspend that historical nexus to align more



closely with programs, companies and agencies engaged in the delivery and payment of health-care services?

A number of thought leaders at the federal, state and local levels are concerned that the increasing pressure for health to proceed alone and build its own eligibility silo may result in human services missing a once-in-a-generation opportunity to leverage the truly outstanding work that has been done during the past decade to share data across organizational barriers on behalf of their common clients.

The challenge for each of us is to determine how best to create and reinforce an understanding that there is support and commitment for interoperability across health and human services—and that there are efforts under way to link and leverage the ACF, Centers for Medicare and Medicaid Services (CMS), FNS and others along with states and other jurisdictions/organizations.

There is no question there is real interest and there are real activities currently under way to drive interoperability at the federal level across many programs. Both the USDA and, especially, the ACF have engaged stakeholders across their diverse programs to think increasingly from an enterprise-wide perspective. But it will also require states and other jurisdictions to drive the effort to think and act from an enterprise perspective as well.

Human services must be sufficiently motivated to ensure its spokespeople are well represented in the architecture planning and discussions with their health agency/Medicaid counterparts so their programs will be integrated into the broader enterprise efforts now or at a time when resources become available.

Lastly, the greatest challenge will be to identify the key opportunities and barriers to enhanced health and human services interoperability, and then to articulate them so effectively, both strategically and graphically, that the rationale is as clear, thorough and comprehensive as is our vision of the benefits of interoperability.

Rick Friedman (Richard.Friedman@cms.hhs.gov) is director of the Division of State Systems at the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services. His division is responsible for developing federal funding policies for the IT systems state Medicaid agencies use to manage their programs and participate in statewide health information exchanges between Medicaid and public health and human services programs consistent with ARRA, ACA and other federal requirements.

[The views expressed in this article are those of the author and do not necessarily represent those of the agency for which he works.]