

**STATE OF OREGON**

**OREGON HEALTH AUTHORITY**

**OREGON STATE MEDICAID**

**HEALTH INFORMATION TECHNOLOGY PLAN (SMHP)**

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**Health**  
Oregon  
Authority

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## Executive Summary

### Introduction

Oregon has a history of innovation in health care delivery, access, and technology, dating back to its groundbreaking Medicaid waiver with the implementation of the Oregon Health Plan in 1994, and continuing through 2009, when the state Legislature approved an ambitious health reform law (House Bill 2009). These ongoing innovations and changes are focused on improving the health care system in our state, and ultimately the health of our citizens. The important role of health information technology (HIT) in improving the quality and efficiency of health care delivery is considered key to accelerating Oregon's health reform efforts.

Recent changes include the restructuring of the governance of health care programs within state government, including the establishment of the Oregon Health Authority (OHA) as a separate but connected agency from the Department of Human Services. OHA operates with oversight from the newly created Oregon Health Policy Board allowing Oregon to respond quickly to new health policy challenges. Specific to health information technology, House Bill 2009 also created a Governor-appointed Health Information Technology Oversight Council (HITOC), and OHA most recently created of an Office of Health Information Technology (OHIT). These structures allow Oregon to coordinate statewide HIT efforts and accelerate the use of health information technology within Oregon.

Oregon is well prepared to advance the goals in the HITECH Act and the Patient Protection and Affordable Care Act (ACA), including, the focus of this document, the Medicaid Electronic Health Record (EHR) Incentive Program. Oregon's Strategic and Operational Plans for Health Information Exchange have been approved by the Office of the National Coordinator for Health Information Technology (ONC). Implementation of those plans is currently occurring, and stakeholder engagement efforts have involved more than 120 people from 80 organizations. Oregon's hospitals and providers are ahead of national averages on rate of EHR adoption and Oregon has a strong educational environment supporting health IT, with Oregon Health and Sciences University serving as the National Training and Dissemination Center for curriculum development for the ONC Health IT Workforce grant program.

Oregon has developed a comprehensive strategy for expanding the adoption and meaningful use of certified EHRs among Medicaid providers and hospitals. Some approaches described in this plan include efforts to maximize participation in the Medicaid EHR Incentive Program, analysis and proactive outreach to "pre-qualify" potentially eligible professionals and hospitals, direct provider communications and coordination with key stakeholders to help educate providers and hospitals about their eligibility for incentives, and the development of strategies beyond incentives to facilitate adoption and meaningful use of certified EHRs for all Medicaid providers.

### Environmental scan highlights

- Oregon's health care providers rank well above the national average for EHR adoption. 65.5% of office-based physicians are in a practice where an EHR is present. As of 2009, 47 of Oregon's 58 acute care hospitals had an EHR or had anticipated implementing one in 2010.
- All but nine Oregon hospitals are expected to meet eligibility requirements for Medicaid incentive payments. For eligible professionals (EPs) in Oregon, preliminary estimates show that more than half of pediatricians are expected to meet requirements, as are nearly all physicians in federally qualified health centers (FQHCs) and rural health clinics, and between 5% and 10% of other physicians (non-pediatricians, not in FQHCs).

- Oregon is actively building broadband networks around the state with the assistance of federal funds. Despite its large rural areas, Oregon ranks eighth among states on household access to a broadband connection.
- Oregon's health information exchange strategic and operational plans were approved by ONC in December 2010. The state has a number of health information exchange organizations (HIOs) in the operational or soon-to-be operational stage, and eight health systems offer some stage of health information exchange (HIE) services.
- Oregon's planning is well integrated with other health reform initiatives such as health information exchange, the planning for an Oregon health insurance exchange, medical home initiatives, Oregon's CHIPRA grant and other key efforts being conducted to improve the health of Oregonians.
- Oregon has updated its Medicaid Management Information System (MMIS), processing claims faster and more efficiently. The MMIS will play an important role, along with the 24-hour access Provider Web Portal, for the Medicaid EHR Incentive Program. Oregon's MMIS is currently undergoing certification.

### **Vision highlights**

- The Medicaid Health Information Technology Project's main goals are to increase Medicaid providers' ability to achieve meaningful use of certified EHRs through a robust incentive program and a coordinated network of Department of Human Services/OHA systems that is connected to the statewide health information exchange.
- This work will contribute to Oregon's overarching goal of a healthier population through:
  - Quality, efficient coordinated care through electronic access to clinical information
  - Optimized patient experience through effective investment and management of infrastructure, operations and administration of the health information technology and technical assistance needed to support meaningful use of certified EHRs and health information exchange
  - Achievement of the best results through secure electronic data reporting and bidirectional exchange of health information for increased population health.

### **Medicaid HIT initiatives and strategies highlights**

- Oregon Medicaid has a key role in health information exchange implementation.
- Oregon proposes a coordinated network of Department of Human Services/Oregon Health Authority information systems known as the Medicaid Health Information Network.
- Oregon is planning specific strategies to improve EHR adoption within the long-term care and behavioral health communities, and to ensure technical assistance is available to all eligible professionals in Oregon.

### **Incentive program highlights**

- Oregon has assessed all areas of state discretion, and has opted for approaches that maximize incentive payments to Oregon professionals and hospitals, where possible. For example, Oregon has chosen a three-year payment structure to maximize hospital incentive payments early in their participation in the program.
- Most Oregon eligible professionals will use patient encounter methodology for calculating patient volume. Eligible professionals in Oregon will also have the option to use the patient panel methodology to calculate patient volume if it is applicable for the provider's circumstances.
- Regarding meaningful use, Oregon is requesting approval to move the immunization registry reporting menu-set objective to the list of core objectives for Oregon's incentive program.
- Applicants will access the incentive program application via the Provider Web Portal, and will use Oregon's software application (called Medical Assistance Provider Incentive Repository, or MAPIR) to

attest to their eligibility for incentives. MAPIR is being built under contract with Hewlett Packard (HP) through a collaborative of 13 states whose MMIS systems were built by HP.

- File exchange testing between the CMS National Level Repository (NLR) and MAPIR will take place as part of the CMS Group 2 states testing in winter/spring of 2011. Oregon has completed its connectivity testing with the NLR.
- Oregon plans to develop a strong pre-qualification strategy to reach out to potential eligible professionals prior to application to the program.
- The Medicaid EHR Incentive Program is being developed by Oregon's Medicaid HIT Project Team. Incentive program operations will be administered by Oregon's Medicaid agency operations section in conjunction with the Medicaid HIT Project Team.

### **Outreach communications plan highlights**

- Oregon's communication plan targets providers who may be eligible for both the Medicare and Medicaid incentive programs to provide assistance to the widest range of providers possible.
- The three core messages will be the announcement of the incentive program, connecting providers to O-HITEC for assistance and providing updates on the incentive program.
- Regular email announcements will be sent to the e-subscribe list for the Medicaid HIT Project website. However, to reach all providers directly, Oregon will send three direct mail pieces in the first half of 2011, augmented by messaging through existing organizational channels such as Medicaid contractors, provider associations, and others.

### **Verification and audit highlights**

- Oregon will conduct pre-payment verification and post-payment audits of applicants and incentive payments made to ensure compliance with federal and state rules.
- Pre-payment verification processes will be conducted by incentive program staff at the time of application.
- Medicaid patient volume for eligible professionals will be verified using MMIS data and, eventually, using Oregon's All Payer All Claims database.
- Hospital patient volume will be verified using Medicare cost reports. Oregon expects to amend its verification processes upon further guidance from CMS about the Medicare plan for auditing incentive payments.
- Oregon will use the DHS Office of Payment Accuracy and Recovery for audit oversight of the program. Selection of incentive payments subject to audit will be based on a risk-based sampling strategy.

### **Public health highlights**

- The Medicaid HIT Project Team includes a public health initiative that will promote and enhance Medicaid provider use of EHRs by fostering information exchange between providers/hospitals and Oregon Public Health Division (OPHD) data systems.
- The initiative will work with providers and state partners to develop technical assistance documentation and guidance for the three Stage 1 public health meaningful use objectives: submission of electronic laboratory reports, immunization data and syndromic surveillance data.
- The initiative will evaluate the capacity of public health systems that are first to receive and validate meaningful use data.
- Public Health will evaluate the readiness of the current public health infrastructure to participate in statewide health information exchange and participate in state planning around state-system participation in HIE.

## **I. Introduction**

### **Oregon's history of innovation and the role of HIT within health care reform**

Oregon has a history of innovation in health care delivery, access, and technology, dating back to its groundbreaking Medicaid waiver with the implementation of the Oregon Health Plan in 1994, and continuing through 2009, when the state Legislature approved an ambitious health reform law. Oregon's new law anticipated and complements many of the reforms of the federal recovery law (America Recovery and Reinvestment Act, ARRA) and in national health reform (Patient Protection and Affordable Care Act, ACA).

The central role of health information technology in improving access, quality and value in the health care system has been a thread running through Oregon's health reform efforts. Oregon's House Bill 2009 created the Oregon Health Authority (OHA), tasked with reforming the state's health care delivery system, with the vision of improving the health of all Oregonians. Oregon's Medicaid program is a key part of this planning. Health reform initiatives in Oregon thrive on the broad involvement of stakeholders including the general public, medical providers, health care organizations, insurers, consumer organizations and many other interested parties.

HB 2009 changed the structure of Oregon's state Department of Human Services (DHS) when it created the OHA. The OHA is the state agency at the forefront of lowering and containing costs, improving quality, and increasing access to health care in order to improve the lifelong health of Oregonians. The OHA brings most of the health-related programs in the state into a single agency to align the state's health care purchasing and reform efforts. The OHA is also the single state Medicaid agency. The OHA is overseen by the nine-member citizen Oregon Health Policy Board, whose purview includes comprehensive health and health care reform in our state.

DHS continues to house both child welfare services and the state's senior and disability services and programs. DHS also operates most of the Medicaid eligibility functions, so the agencies continue to coordinate as two closely aligned sister agencies with appropriate service agreements in place.

DHS/OHA share some services, including the newly formed Office of Health Information Technology (OHIT) that will be a resource for state health information technology efforts. Just as the OHA was conceived in part to maximize the State's purchasing power for health insurance, OHIT was conceived in part to maximize the State's strategy for shared services information technology (IT) architecture for health information technology applications. OHIT enables Oregon to leverage resources and institutional knowledge across agencies, ensuring that the adoption and implementation of health IT will be as cost effective as possible.

Both the Medicaid HIT Project and Oregon's HITOC, the Health Information Technology Oversight Council, are within OHIT. HITOC is a Governor-appointed, Senate-confirmed council established by HB2009 as part of Oregon health reform to provide coordination between public-private partnerships around HIT efforts and to oversee all HIT efforts in Oregon. In addition, HITOC acts as an advisory group to OHA on HIT issues.

### **Oregon's readiness to advance HITECH goals**

Because of Oregon's commitment to improving the health care system and its recognition of HIT as an essential tool, Oregon is poised to move steadily ahead with the goals of the HITECH Act and the ACA.

- Oregon is committed to facilitating the adoption of electronic health records (EHRs) so that its health care providers can meet meaningful use requirements and qualify for incentive payments through both the federally run Medicare EHR Incentive Program and the Medicaid EHR Incentive Program, outlined in this document.
- Oregon providers are ahead of the nation with strong EHR adoption, as described in the environmental scan section below.

- Oregon's health information exchange (HIE) strategic and operational plans, developed by HITOC, were approved by the Office of the National Coordinator for HIT (ONC) in December, 2010. The electronic health information exchange (HIE) that results from this work will be essential for health system and Medicaid reforms envisioned as part of the ongoing transformation of the health care system in Oregon.
- Oregon boasts a strong research community of national leaders in HIT and bioinformatics. Oregon Health & Science University is nationally recognized as a lead educator of the next, vitally needed wave of HIT specialists and its workforce training programs are models for many other states.
- Oregon's Regional Extension Center, O-HITEC is advancing strategies and deploying technical assistance to help providers adopt, implement and upgrade EHRs, and bring providers to meaningful use standards. Clayton Gillett, Executive Director of O-HITEC, is co-chair of the ONC's community of practice for meaningful use. O-HITEC's focus is not only on EHR adoption, but on using HIT to transform the delivery of primary care. This tracks closely with state and national health reform efforts.

Ultimately, through the combined efforts of these initiatives, Oregon envisions strong, integrated HIT and HIE to support meaningful use of EHRs within the provider community, thereby improving quality and health care outcomes and reducing overall health care costs.

### **Strategy for meeting meaningful use and expanding EHR adoption**

In approaching the Medicaid EHR Incentive Program, Oregon has a number of advantages, including higher rates of EHR adoption. However, the program's timeline is aggressive and EHR adoption continues to be a challenge for some providers, particularly those in rural areas or smaller practices sizes. Oregon is determined to maximize the amount of incentive payments going to providers and hospitals and will support them throughout the process with robust technical support and assistance. This will be done in concert with stakeholders, which include Medicaid program operations, health information exchange planning, O-HITEC, provider associations and others.

Oregon has developed a comprehensive strategy for expanding the adoption and meaningful use of certified EHRs among Medicaid providers and hospitals. This strategy has three prongs.

- Maximizing participation in the Medicaid EHR Incentive Program by developing state-specific program requirements, as allowable by federal rule, that expand the pool of eligible professionals.
- Direct provider communications and coordination with key stakeholder groups to educate providers and hospitals about their eligibility for incentives. Oregon is coordinating closely with several key stakeholders (Medicaid operations, statewide HIE efforts and stakeholders, O-HITEC, provider associations, and others), and is working to communicate clearly to providers about EHR adoption, meaningful use, and incentives.
- The development of strategies beyond incentives to facilitate adoption and meaningful use of certified EHRs for all Medicaid providers.

### **Oregon's State Medicaid HIT Plan and HIT Implementation Advance Planning Document**

To be eligible for implementation funding, and to launch the state Medicaid EHR Incentive Program, CMS requires states to submit a State Medicaid HIT Plan (SMHP) and HIT Implementation Advance Planning Document (IAPD). CMS expects that states will submit annual SMHP and IAPD updates, and permits states to submit other updates as needed. Oregon's HIT IAPD is being submitted to CMS at the same time as this SMHP. Further, Oregon anticipates providing SMHP and IAPD updates to CMS before the end of 2011.

To guide states in developing their SMHPs, CMS provided a SMHP template, outlining questions to be addressed, and indicating which questions may be deferred to later SMHP updates. Appendix A provides a crosswalk or index between this document and the questions in the CMS SMHP template.

This SMHP represents Oregon's work under its HIT Planning Advance Planning Document (PAPD) approved by CMS in February 2010, and PAPD Update, approved by CMS in December 2010. The focus of this SMHP is to describe the HIT environment, vision, and strategies associated primarily with Oregon's Medicaid EHR Incentive program, and to carry over other initiatives and strategies outlined in the PAPD Update. The companion HIT IAPD describes the scope, tasks, schedule, staffing, resources, and budget requested to implement the strategies described in this SMHP.

**Medicaid Health Information Technology Project**

The Medicaid HIT Project, within OHIT, reports to Oregon's Medicaid director and the Chief Information Officer for DHS/OHA. The Medicaid HIT Project is tasked with performing or coordinating work under Oregon's HIT PAPD, SMHP, and ultimately Oregon's HIT IAPD.

This work includes developing the Medicaid EHR Incentive Program, encouraging eligible Medicaid providers to adopt and use EHRs in a meaningful way, and working with providers and state systems to ensure that providers can meet meaningful use objectives in Oregon. In addition, the Medicaid HIT Project will develop the state Medicaid vision of integrating the DHS and OHA information technology systems to better serve Medicaid clients and providers. This involves sharing data as appropriate within and outside DHS and OHA and supporting the Medicaid share of the development of Oregon's statewide health information exchange. The integration of these systems will manage costs for the state, improve health care and human services delivery, and improve the health of Oregonians served by Medicaid through better coordination and information sharing across all other programs accessed by Medicaid clients.

## II. Environmental Scan

### Section Overview

- Oregon's health care providers rank well above the national average for EHR adoption. 65.5% of office-based physicians are in a practice where an EHR is present. As of 2009, 47 of Oregon's 58 acute care hospitals had an EHR or had anticipated implementing one in 2010.
- All but nine Oregon hospitals are expected to meet eligibility requirements for Medicaid incentive payments. For eligible professionals (EPs) in Oregon, preliminary estimates show that more than half of pediatricians are expected to meet requirements, as are nearly all physicians in federally qualified health centers (FQHCs) and rural health clinics, and between 5% and 10% of other physicians (non-pediatricians, not in FQHCs).
- Oregon is actively building broadband networks around the state with the assistance of federal funds. Despite its large rural areas, Oregon ranks eighth among states on household access to a broadband connection.
- Oregon's health information exchange strategic and operational plans were approved by ONC in December 2010. The state has a number of health information exchange organizations (HIOs) in the operational or soon-to-be operational stage, and eight health systems offer some stage of health information exchange (HIE) services.
- Oregon's planning is well integrated with other health reform initiatives such as health information exchange, the planning for an Oregon health insurance exchange, medical home initiatives, Oregon's CHIPRA grant and other key efforts being conducted to improve the health of Oregonians.
- Oregon has updated its Medicaid Management Information System (MMIS), processing claims faster and more efficiently. The MMIS will play an important role, along with the 24-hour access Provider Web Portal, for the Medicaid EHR Incentive Program. Oregon's MMIS is currently undergoing certification.

### 1. Overview of EHR adoption

Oregon has invested in ongoing research on health information technology adoption and implementation rates among providers and hospitals. Oregon's Office for Oregon Health Policy and Research conducted a health information technology inventory in February 2010.<sup>1</sup> The inventory included results from various sources, including four surveys:

- Oregon 2009 Ambulatory EHR Survey, which was sent in February 2009 to 2,273 ambulatory clinics and physician practices (respondents included 1,168 practices and clinics and 7,845 clinicians, representing a 57.7% overall response rate from practices);<sup>2</sup>
- Oregon HIT Assessment, 2009: Hospital and Health System Survey;
- Oregon HIT Assessment, 2009: Independent Physician Association Survey; and
- Oregon HIT Assessment, 2009: Health Plan Survey.

<sup>1</sup>Office for Oregon Health Policy and Research, Oregon's HIT Environmental Assessment, February, 2010. Prepared by David M. Witter, Jr., Witter & Associates. Available at:

[http://www.oregon.gov/OHPPR/HITOC/docs/Oregon\\_HIT\\_EnvironmentAssessment20100209.pdf](http://www.oregon.gov/OHPPR/HITOC/docs/Oregon_HIT_EnvironmentAssessment20100209.pdf).

<sup>2</sup>Office for Oregon Health Policy and Research, Oregon Electronic Health Record Survey Report: Ambulatory Practices and Clinics, 2009, p. 8. Prepared by David M. Witter, Jr., Witter & Associates. Available at: <http://www.oregon.gov/OHPPR/HITOC/docs/OR2009EHRSurvey.pdf>

The 2009 Ambulatory EHR Survey was intended to measure adoption rates across practices (regardless of payer type) to provide a picture of how access to health IT was progressing for all Oregonians, and so did not focus specifically on Medicaid providers.

## 2. Provider adoption of EHRs

Oregon health care providers rank well above the national average for electronic health record adoption. According to 2009 Ambulatory EHR Survey, 65.5% of Oregon office-based physicians are in a practice where an EHR is present, compared with 43.9% nationally; 32.2% of Oregon physicians use a fully functional EHR, compared with 6.3% nationally.

### **Reasons for providers' EHR adoption**

2009 Ambulatory EHR Survey respondents identified the perceived benefits of EHR adoption as improving access and tracking of patient information, eliminating the potential for lost patient charts, efficiency/reduce costs for transcription and filing/records management, record legibility, e-prescribing and medication lists, and better patient care/safety and coordination of care.<sup>3</sup>

The most cited implementation concerns include the expense, loss of productivity, ongoing costs and expense of purchase. Additional concerns include inadequate return on investment, need to customize EHRs, staff training, interfacing data with other systems and physician resistance to change.

### **Factors associated with high and low rates of adoption**

Factors associated with high EHR adoption rates include the size of the health system or practice. Large health systems and practices tend to have higher adoption rates. Kaiser and Oregon Health & Science University have 100% adoption, health system-operated/affiliated practices or clinics have 70%, federally qualified health centers have 60% and community hospitals have 57%.

Practices with larger numbers of clinicians range from a 50% EHR adoption rate (for practices with five to nine clinicians) to 79% adoption rate (for practices with 50 or more clinicians). Practices with more than one location have a range of 40% (for five locations) to 69% (for five or more locations).<sup>4</sup>

Factors associated with low EHR adoption rates include being a solo clinician practice (26%) or a practice with two to four clinicians (40%). Freestanding ambulatory surgery centers tend to have lower adoption rates (22%), as do public/tribal/institution-based clinics (public health departments, school-based clinics, tribal clinics and college health centers) that are not federally qualified health centers (FQHCs) (23%).

#### *Survey definitions and methods*

The 2009 Ambulatory EHR survey defines an Electronic Practice Management (EPM) System as including patient scheduling, registration, eligibility, coverage contracts, billing, electronic claims submission, claims tracking, accounts receivable, workflow management tools and reports. The survey defines three categories of EHR system, "any EHR", "basic EHR", and "fully functioning EHR" based on definitions in a widely cited paper, *DesRoches et al* (2008).

The category of "any EHR" includes any type of EHR self-declared by a survey respondent, including self-developed systems. The category of "basic EHR" system includes all of the following functional components: patient demographics, patient problem lists, electronic medication lists, clinical notes, order entry management of prescriptions, and viewing capability of laboratory and imaging results (reports). The category of "fully functional EHR" system includes the basic system functionalities of clinical notes of the medical history and follow-up, ordering of laboratory and radiology tests, electronic transmission of prescriptions and orders, and electronic return of images. Fully functional also includes clinical decision support with warnings of drug interactions or contraindications, highlighting out-of-range test levels and reminders regarding guideline-based intervention screening.

The survey defines "clinicians" as physicians (MDs and DOs), physician assistants (PAs), and nurse practitioners (NPs). Although the current data do not support an analysis of the distinction between Medicaid providers and others, EHR adoption rates among different provider practice types are discussed in detail below.

<sup>3</sup>2009 Ambulatory EHR Survey, p. 3.

<sup>4</sup>2009 Ambulatory EHR Survey, p. 2.

**Adoption by setting/provider type**

The 2009 Ambulatory EHR Survey provided information about EHR systems; it measured responses from provider locations rather than providers themselves. This approach takes into account the possibility that providers work in multiple locations. The expected result of this approach is a greater survey response rate per system and reduced duplicity of reporting among providers. The data gathered through this approach does not reflect specific provider types.

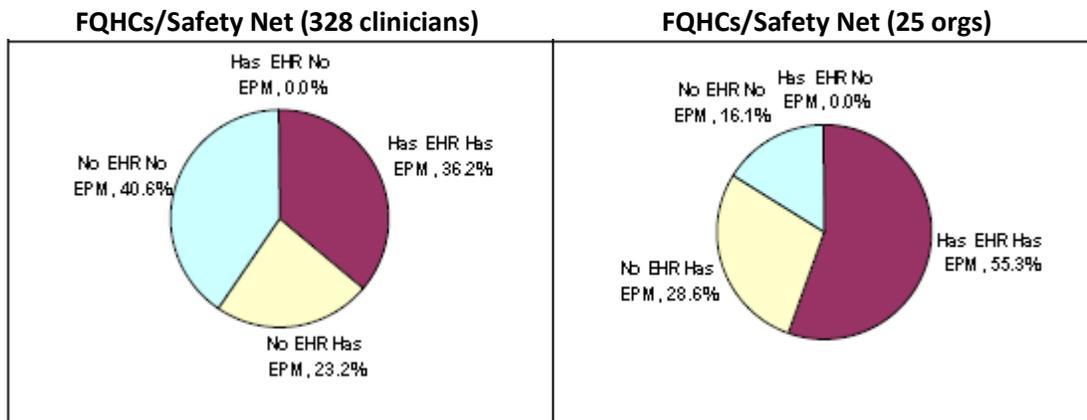
The highest rates of clinician adoption are for practices/clinics operated by health systems (95.8%) and Kaiser and OHSU (100%). The lowest clinician access to EHRs occurs in ambulatory care centers (8.6% of 535 ambulatory care center clinicians), clinician name practices (25.1% of 426 clinicians) and public/other clinics (37.6% of the 189 clinicians).<sup>5</sup>

The highest rate of adoption related to specialists is for multi-specialty practices (90.1%) and mixed primary care clinics (69.8%). Multi-specialty practices and mixed primary care practices represent 54.6% of the surveyed clinicians. The lowest adoption rates are for specialty categories of ophthalmology/optometry (29.0%) and surgery and surgical specialties (24.9%).<sup>6</sup>

**Adoption for safety net providers**

EHR adoption rates among Oregon’s safety net providers are bolstered by the work of a non-profit Health Center Controlled Network, OCHIN. OCHIN has also received the ONC award to become Oregon’s Regional Extension Center (REC), and has formed a division, O-HITEC, to provide REC services in Oregon. The function of O-HITEC is discussed in greater detail on page 21.

Among responding safety net organizations, including FQHCs and rural health centers (RHCs), 60% have both EHR and electronic practice management (EPM), 36% have no EHR but do have EPM, and 4% have no EHR and no EPM. Among responding clinicians, 65.5% have both EHR and EPM, 33.5% have no EHR but do have EPM, and 0.9% have no EHR and no EPM.<sup>7</sup> However, by 2011, safety net respondents forecasted that 88% of the clinics would use an EHR serving 94% of the clinicians in FQHCs.



Source: Office for Oregon Health Policy and Research, Oregon Electronic Health Record Survey Report: Ambulatory Practices and Clinics, 2009

<sup>5</sup>2009 Ambulatory EHR Survey, p. 14.  
<sup>6</sup>2009 Ambulatory EHR Survey, p. 20.  
<sup>7</sup>2009 Ambulatory EHR Survey, p. 32.

*FQHCs, FQHC lookalikes and HIT grants*

Oregon's 27 FQHCs and 2 FQHC look-alikes provide services in 153 sites throughout the state. Fifteen of the FQHCs are OCHIN members. Recently, Oregon's FQHCs have received some federal government and non-profit HIT grant funding.

Seventeen FQHCs in Oregon were awarded Capital Improvement Program (CIP) grants by the federal Health Resources and Services Agency (HRSA). These grants were made available via the American Recovery and Reinvestment Act of 2009 and provided funds to support construction, repair, renovation, and equipment purchases. Equipment purchases permitted include HIT systems and EHR-related enhancements for Community Health Centers. Total CIP funding to Oregon FQHCs was \$14.3 million.<sup>8</sup>

In August 2009, United Way awarded the Coalition of Community Clinics a Project Innovation Grant in the amount of \$36,000. This coalition includes thirteen FQHC clinics in the Portland Metro area. The grant has three primary deliverables, one of which is the creation of an information technology plan for each of the eight community-sponsored clinics. Currently these clinics are working with OCHIN to develop a plan for adoption of an EPIC EHR system in most clinics. EPM adoption is expected in one to two years, while full EHR adoption may take three to five years.<sup>9</sup>

*Rural health clinics*

Oregon has 60 RHCs that operate throughout the state Oregon. Rural clinics have a broad range of capacity and demand for health IT. Of the 46 RHCs that responded to a 2007 survey, 63% report that they do not use or have electronic medical records.<sup>10</sup> Thirty of the 46 RHC respondents were without EHRs, 11 report planning to implement an EHR in the next year, 16 report being unable to implement an EHR due to the prohibitive monetary cost, and nine list both prohibitive cost and time required as reasons for being unable to implement an EHR.

*Safety net clinics supported by OCHIN and HRSA funding*

EHR adoption rates by FQHCs and Community Based Health Centers (CBHCs) have been accelerated by OCHIN. Fifteen of the 29 FQHCs/FQHC look-alikes are OCHIN members. OCHIN has 18 members in Oregon, and several in four other states; its members operate clinics in more than 200 locations. OCHIN provides a comprehensive suite of products including practice management and EHR (Epic) services, panel and population management tools to member organizations.

As an Organized Health Care Arrangement (OHCA) under HIPAA with a single record per patient, OCHIN functions as an HIO among its member organizations. The OCHIN master patient index contains information on more than 400,000 Oregonians and 600,000 lives across California, Oregon and Washington. OCHIN also operates SafetyNetWest, a practice-based research network that solicits proposals and coordinates research projects involving safety-net populations.<sup>11</sup>

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<sup>8</sup>HRSA websites, accessed Jan. 28, 2011, including: Capital Improvement Program Announcement Number: HRSA-09-244 Date: May 1, 2009 (<http://bphc.hrsa.gov/recovery/cip/capitalimprovementguidance.pdf>), Oregon FQHC grantees and awards amounts from: <http://granteefind.hrsa.gov/> and matched to two customizable data warehouse reports accessed via <http://datawarehouse.hrsa.gov/customizereports.aspx>.

<sup>9</sup>Conversation with Tracy Grotto, former executive director of the Coalition of Community Health Clinics, Jan. 4, 2011.

<sup>10</sup>Oregon Health & Science University Office of Rural Health, Oregon Federally Certified Rural Health Clinics, 2008 Report, p. 39. This office recently completed a new survey of RHCs, and results are expected by spring 2011.

<sup>11</sup> Oregon Health Authority and the Health Information Technology Oversight Council (HITOC), Health Information Exchange: A Strategic Plan for Oregon, August 23, 2010, p. 73. Available at: <http://www.oregon.gov/OHPPR/HITOC/Documents/SandOpPlans201008/HIEStrategicPlanOR.pdf>.

In 2007, OCHIN received three grants from the federal Health Resources and Services Administration (HRSA) totaling nearly \$3 million to support implementation of EHRs at health centers and in networks that link multiple health center grantees, and to help health center networks implement HIT other than electronic health records, such as electronic prescribing, physician order entry, personal health records, community health records, health information exchanges, and creating interoperability.<sup>12</sup>

#### *County and local health clinics*

Oregon has 34 local public health departments (LHDs) that serve Oregon's 36 counties. A May 2010 survey found that, of 32 responding health departments, only four reported having an EHR system in active use. Among the 32 respondents, 28 reported actively using an EHR, an EPM, or both. Conversely, only four of the 32 local health departments are not using either an EHR or EPM.<sup>13</sup>

Survey responses reveal that Oregon's LHDs provide a range of primary and preventive care services.

- Nursing services and case management are both offered at 30 out of 32 responding LHDs.
- Nutrition services are offered at 12 LHDs.
- Mental health services are offered at 13 LHDs.
- Primary care/physician services are offered at 12 LHDs.
- Substance abuse treatment services are offered at 11 LHDs.
- Social work services are offered at 9 LHDs.
- Six LHDs indicate that they offer other services, including such services as: immunizations, STI screening and treatment, HIV testing, TB treatment, refugee screening, home visit/community nursing, school based health centers, school nursing, dental services, developmental disabilities services, corrections health, pharmacy, prenatal care, and family planning.

Although 12 health departments indicate providing primary care/physician services, three of these reported having no EHR or EPM.

In addition to providing clinical services, county health departments play a critical role in public health surveillance. Approximately 80% of communicable disease reporting occurs electronically to local health departments from 12 clinical laboratories and the Oregon State Public Health Laboratory. These reports flow into the recently upgraded Oregon Public Health Epi-User Systems (Orpheus) and are the basis of reporting to the Centers for Disease Control and Prevention (CDC).<sup>14</sup> See page 23-25 for more information about Oregon's public health surveillance systems.

#### ***EHR types and products***

Across all practice types, respondents identified the use of 83 different vendors/products, with 76 vendors/products identified for independent clinician organizations.<sup>15</sup> In addition, 11 organizations serving 23 clinicians indicated that they were using self-developed EHR systems.<sup>16</sup>

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<sup>12</sup>HRSA press release, "HRSA Awards \$31.4 Million to Expand Use of Health Information Technology at Health Centers, August 27, 2007.

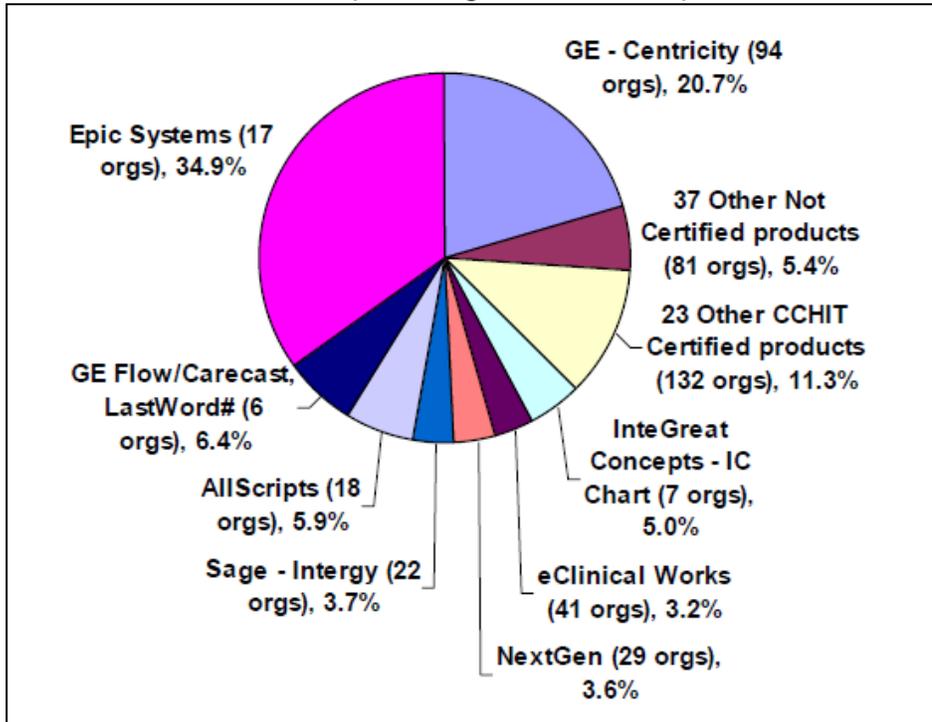
<sup>13</sup>Office for Oregon Health Policy and Research, Public Health and Health Information Exchange: A Survey of Oregon's Local Health Departments. September 2010. Available at [www.oregon.gov/OHPPR/HITOC/index.shtml](http://www.oregon.gov/OHPPR/HITOC/index.shtml), pg. 11.

<sup>14</sup> Oregon HIE Strategic Plan, p. 14.

<sup>15</sup> Clinician organizations are practices and clinics operated by independent physician practitioners or groups that are not under the ownership or auspices of hospitals or health systems nor operated by a FQHC, safety net or public clinic.

<sup>16</sup>2009 Ambulatory EHR Survey, p. 35.

**EHR Market Share of Clinicians – All Organizations  
(n=447 orgs, 5139 clinicians)**



Source: Office for Oregon Health Policy and Research, Oregon Electronic Health Record Survey Report: Ambulatory Practices and Clinics, 2009

Eight vendors/products account for 83.3% of the clinicians served by EHR products. The largest market share in terms of clinicians served are EpicCare (17 organizations with 34.9% of clinicians) and GE-Centricity (94 organizations with 20.7% of clinicians). Other GE EHR products (Flowcast, CareCast and LastWord) related to the acquisition of the IDX company several years ago involve 6.4% of clinicians at six organizations. These other GE EHR products are not certified by the Certification Commission for Health Information Technology (CCHIT) and several of the organizations are implementing replacement EHR systems that are CCHIT-certified.<sup>17</sup> Smaller market shares involve twenty-three vendors/products that are CCHIT-certified are serving 132 organization representing 11.3% of clinicians covered by the survey. Thirty-seven vendors/products that are **not** CCHIT-certified are serving 81 organizations representing 5.4% of clinicians covered by the survey. Many of these non-certified products are focused on specific medical specialties.<sup>18,19</sup>

The eight vendors/products account for 74.7% of the clinician organizations served by EHR products. The largest market share in terms of clinician organizations and clinicians use is GE Centricity (74 organizations and 21.3% of clinicians). The next largest vendors in terms of practice organizations served are eClinicalWorks (37 clinician organizations, 6.1% of clinicians), NextGen (28 clinician organizations, 7.6% of clinicians), Sage-Intergy (19

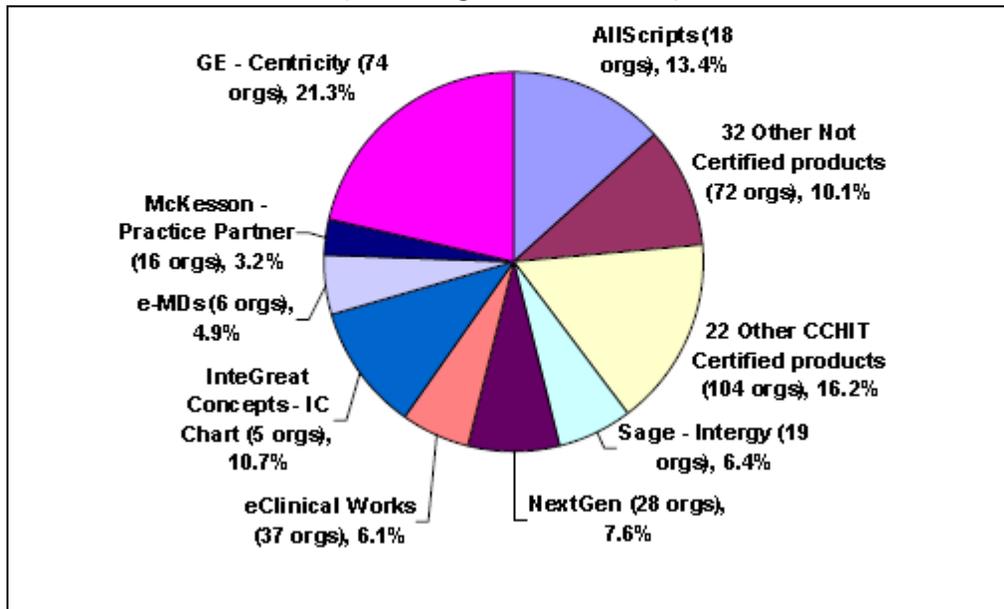
<sup>17</sup> This refers to the CCHIT certification process, which preceded the current federal effort to certify electronic medical records systems for compliance with meaningful use requirements.

<sup>18</sup> 2009 Ambulatory EHR Survey, p. 35-6.

<sup>19</sup> It should be noted that these market share indicators may be different from the real market share distributions due to variable response rates among practices with specific products. The survey process could not estimate response rates by vendor or product.

clinician organizations with 6.4% of clinicians) and Allscripts (18 clinician organizations, 13.4% of clinicians). Smaller market shares involve 22 vendors/products that are CCHIT-certified are serving 104 organization representing 16.2% of clinicians in clinician organizations covered by the survey. Thirty-two vendors/products that are **not** CCHIT-certified are serving 72 organizations representing 10.1% of clinicians in clinician organizations covered by the survey. Many of these non-certified products are focused on specific medical specialties.<sup>20</sup>

**EHR Market Share of Clinicians – Clinician Organizations  
(n=379 orgs, 2265 clinicians)**



Source: Office for Oregon Health Policy and Research, Oregon Electronic Health Record Survey Report: Ambulatory Practices and Clinics, 2009

Upgrading an EHR system from an older version (certified or not certified) to the current version in the same product line is generally much less of a challenge than changing products or vendors. While this level of accuracy regarding certification is clearly suboptimal, it nevertheless provides some insight into the magnitude of EHR system installation or upgrade efforts that will be required to meet the requirements to receive Medicare or Medicaid incentive payments for demonstrating the meaningful use of certified EHRs.<sup>21</sup>

In the 2009 survey, overall 87.6% of the 5,139 clinicians are in organizations using EHR products that are part of certified product lines. While health system practice/clinics have the lowest rate of certified products (58.5%) from the survey, EHR system replacement projects currently underway will substantially increase this rate. Of greatest concern are the 250 (11.1%) of the 2,265 clinicians at clinician organization practices that are not certified under the previous CCHIT process, and would likely need to change EHR systems to qualify for incentive payments.

<sup>20</sup>2009 Ambulatory EHR Survey, p. 36-7.

<sup>21</sup>2009 Ambulatory EHR Survey, p. 39.

### ***Adoption for other key provider types***

In addition to EHR adoption data from the 2009 Ambulatory EHR Survey, other sources have identified EHR adoption for tribal clinics, Veterans Administration health systems, and long-term care facilities. The State's HIE "system" is composed of a set of central services, rather than any kind of central infrastructure, network, or repository. These services include secure messaging services, provider directories, and trust services (to authenticate the identity of HIE trading partners, the security of their HIE technology, and the integrity of the data).

These State services do not necessarily require the use of an EHR product in order to access and utilize these services to perform HIE (though without an EHR product, HIE functionality would be limited). However, these HIE services are compatible with all certified EHR products and allow a more extensive HIE functionality than without such a system in place. To the extent that the VA and the tribal and IHS clinics use certified EHR products, their systems will be compatible with State HIE services.

### ***EHR adoption for tribal clinics***

Oregon has 10 tribal and Indian Health Service (IHS) clinics. These facilities are often in rural and isolated communities, and provide health care services to an expansive geographic area. Five tribal clinics use the IHS EHR Resource and Patient Management System (RPMS), in providing patient care. They include the following: Warm Springs Health Center, Warm Springs OR (IHS); Western Oregon Health Center, Chemawa, OR (IHS); Cow Creek Health & Wellness Center, Roseburg, OR (tribal); Yellowhawk Tribal Health Center, Pendleton, OR (tribal); and Siletz Community Health Center, Siletz, OR (tribal).<sup>22</sup>

Most tribal and IHS clinics in Oregon use the IHS RPMS EHR system. This system has recently become certified through ONC. However, only the most recent version of RPMS is certified, and most clinics with an RMPS system will need to upgrade their system in order to have the certified version. This will take time, and will require the assistance of the tribal REC or Oregon's REC, O-HITEC, for many clinics.

### ***EHR adoption for Veterans Administration health systems***

The Veterans Administration (VA) operates the EHR systems VistA and My HealtheVet. The VA reported a 100% adoption rate in Oregon in Oregon's 2006 Ambulatory EHR survey.<sup>23</sup> As of this writing, VistA is certified as a complete EHR system for ambulatory practices and as a modular EHR for inpatient settings. It will take time for clinics needing to upgrade to a certified system to do so.

### ***Data on providers eligible for Medicaid EHR incentives***

In order to be eligible to receive Medicaid EHR incentive payments, providers must meet certain Medicaid and/or needy individual patient thresholds. Providers in FQHCs or RHCs can assess their "needy individual" patient volume – including Medicaid, Children's Health Insurance Program (CHIP), sliding scale care and uncompensated care. All other providers must count Medicaid patients only (not including CHIP). For pediatricians, a minimum 20% of patients must be Medicaid and/or needy individual patients. For all other eligible professionals (physicians, nurse practitioners, certified nurse midwives, dentists, and physician assistants in FQHCs/RHCs led by a physician assistant), a minimum of 30% of patients must be Medicaid and/or needy

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<sup>22</sup>US DHHS Indian Health Services, Indian Health Services Directory, January 2011. Also, "IHS EHR Graphical User Interface Deployment Status" website, updated Jan. 20, 2011, accessed Jan. 26, 2011.

[http://www.ihs.gov/cio/ehr/index.cfm?module=gui\\_facilities](http://www.ihs.gov/cio/ehr/index.cfm?module=gui_facilities)

<sup>23</sup>Office for Oregon Health Policy and Research, Oregon Electronic Health Record Survey Report: Ambulatory Practices and Clinics, 2006, p. 3. Prepared by David M. Witter, Jr., Witter & Associates. Available at: <http://www.oregon.gov/OHPPR/docs/OR2006EHRSurvey.pdf>

individual patients depending on the practice setting. For more information on eligibility requirements, see pages 39-52.

Oregon estimates that 856 EPs will receive Medicaid EHR incentive payments, resulting in \$43,263,860 in incentive payments through 2021. These analyses assume that all EPs/EHs who meet the patient volume thresholds will adopt, implement, or upgrade (AIU) to certified EHR technology and meet meaningful use requirements.

For more information, see Oregon’s IAPD Appendix C: Estimated Incentives to Oregon Providers. Oregon will continue to explore its modeling methods and update these estimates in future updates of its SMHP and IAPD.

**Estimated total number of Eligible Professionals by Type and Setting**

	<b>Not FQHC/ RHC</b>	<b>FQHC</b>	<b>RHC</b>	<b>Both Settings</b>	<b>Total</b>
<b>Physicians (including Pediatricians) at 30% patient volume</b>	280	132	35	NA	447
<b>Additional Pediatricians at 20% patient volume</b>	55	NA	NA	NA	55
<b>Nurse Practitioners</b>	15	86	12	NA	113
<b>Dentists</b>	NA	NA	NA	229	229
<b>Physician Assistants</b>	NA	0	12	NA	12
<b>Totals</b>	<b>350</b>	<b>218</b>	<b>59</b>	<b>229</b>	<b>856</b>

An earlier analysis came to similar conclusions about likely participation, though it estimated proportions of providers rather than specific numbers. That analysis is based on the 2009 Oregon Physician Workforce Survey, which gathered data on the estimated number of physicians eligible for Medicaid EHR incentives. A summary of the results of this analysis is included as Appendix C. Although analysis of these responses can provide some indication of the proportion of potentially eligible physicians, the responses do not distinguish between Medicaid and CHIP patients. Since eligible professionals not in FQHCs or RHCs must only count Medicaid and not CHIP patients in their patient volume, these numbers are likely to be inflated. In addition, these analyses do not consider the role of Medicare Advantage and provider eligibility for Medicare EHR incentives.

Oregon received 1,831 relevant responses, resulting in the following findings.

- 6.3% of independent physicians not in FQHCs or RHCs (not including pediatricians) would be eligible.
- 58.4% of independent pediatricians not in FQHCs or RHCs would be eligible.
- For practitioners in hospital-owned practices, 62.4% of physicians (not including pediatricians) would be eligible, and 92.6% of pediatricians would be eligible.
- Finally, 93.8% of physicians in FQHCs or RHCs would be eligible.<sup>24</sup>

An updated initial analysis of the 2009 Oregon Physician Workforce Survey in April 2011 projected that as many as 705 physicians may be eligible based on Medicaid patient volume alone.

<sup>24</sup>Oregon Office of Health Policy and Research, Potential Medicare and Medicaid Incentive Payments Available to Oregon Eligible Professionals, prepared by David M. Witter, Jr., Witter & Associates. Updated December 1, 2010, p. 4.

### 3. Hospital EHR adoption

The majority of Oregon's 58 acute care hospitals, including the 25 critical access hospitals (CAHs), use EHRs. In 2009, 47 of Oregon's 58 hospitals either already had an EHR in place or anticipated implementing one in 2010. These hospitals represent 95% of Oregon's 2008 hospital discharges. These hospitals' EHRs are provided by nine vendors, all of which have CCHIT-certified products. Eleven acute care hospitals did not have EHRs and did not have plans to implement one by 2010; eight of these are critical access hospitals. However, all 11 have indicated plans to implement over the next five years.<sup>25</sup>

#### ***Multi-site***

The highest penetration or rate of EHR adoption in Oregon is found in hospitals and large health systems. In 2009, there were nine multi-hospital health systems with 35 hospitals. Among these 35 hospitals, 30 have implemented EHR systems. By early 2010, seven health systems had robust deployment of EHRs that are certified by the CCHIT, covering 27 of the 35 hospitals. Among five of the remaining hospitals without an EHR, three have formal plans to implement by 2013. The remaining two hospitals plan to implement within the next two to five years. It is anticipated that five of these hospitals will accelerate their implementation timelines because of recent changes in federal policy, including incentives.<sup>26</sup>

#### ***Data on hospitals eligible for Medicaid EHR incentives***

Overall, Oregon estimates that as many as 57 of the 58 Oregon hospitals are expected to be eligible for Medicaid incentive payments totaling \$64,413,518 through 2021. To be eligible to receive a Medicaid incentive payment, acute care and critical access hospitals must meet two requirements. For a more complete description of incentive program eligibility criteria for hospitals, see pages 39-43:

- First, they must have an average length of stay less than 25 days. All 58 Oregon hospitals currently meet this requirement and are expected to continue to do so.
- Second, a hospital must have at least 10% Medicaid patient volume. In 2009, analysis of Oregon hospital eligibility showed that, of Oregon's 58 hospitals, 49 would be eligible to receive Medicaid incentive payments, based on discharge rates. Thus, as many as nine of Oregon's hospitals may not be eligible to receive Medicaid incentives in 2011, due to low Medicaid patient volume. All but one of these nine hospitals may be able to meet patient volume requirements in the future, and have been included in Oregon's estimate.

These analyses assume that all hospitals that meet the eligibility criteria will adopt, implement, or upgrade (AIU) to certified EHR technology and/or meet meaningful use requirements.

### 4. Access to broadband technology

Oregon has a strong commitment to expand broadband access to all regions of the state. Oregon has significant geographic diversity, including highly urban, rural and remote areas, each with highly varying degrees of HIT capabilities. Broadband access is a critical element of the Strategic and Operational Plans for HIE.<sup>27</sup>

In November 2010, the Oregon Broadband Advisory Council submitted a report to the House Sustainability and Economic Development Committee for the Oregon Legislature which responds to a congressional mandate for a national map and will be used for an Oregon-specific map, due in early 2011. These maps, when completed, will show where the state's broadband Internet services are located, and what speeds and types of service are being

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<sup>25</sup> Oregon HIT Environmental Assessment, p. 5.

<sup>26</sup> Oregon HIE Strategic Plan, p. 27.

<sup>27</sup> Oregon Broadband Advisory Council, Broadband in Oregon report to the Oregon Legislature, November 1, 2010, p. 3.

used. This initiative will help inform state health IT efforts regarding availability of broadband services among Oregon's acute care hospitals and critical access hospitals, rural health centers and FQHCs, among others. This information will provide a basis for evaluation and planning efforts regarding broadband Internet access and service levels at hundreds of locations and communities throughout Oregon.<sup>28</sup>

Oregon is highly ranked in service availability for a large western state with a relatively small population, but broadband is not ubiquitously available across the state. The U.S. Department of Commerce reported in its February 2010 publication, *"Digital Nation: 21st Century America's Progress Toward Universal Broadband Internet Access,"* Oregon ranks eighth out of the 50 states for broadband reach based on household access to a fast internet connection.<sup>29</sup> Despite Oregon's favorable ranking in relation to other states, there are still business locations, residences and communities with limited or no service available.<sup>30</sup>

### **Broadband grants**

Oregon-based projects for broadband infrastructure, utilization and mapping have received more than \$52 million in federal loan and grant funding awards under the ARRA, more than \$20 million of which has gone to building and developing broadband infrastructure. These projects will be implemented over the next three years.

The Oregon Health Network (OHN) is a nonprofit membership-based organization that was created in 2007 in response to a \$20.2 million federal subsidy being awarded through the Federal Communications Commission (FCC) Rural Health Care Pilot Program (RHCPP). One of 62 RHCPP projects nationwide, OHN is Oregon's only RHCPP and is responsible for building the first state-wide broadband tele-health network in the state. The goal for the first phase of the organization is to connect 200 eligible RHCPP providers to the network and to each other. These include non-profit hospitals, clinics (rural, tribal, FQHC, mental health, etc.) and community colleges with health care education programs. The second phase will build out from that core broadband and provider footprint, expanding participation to all for-profit providers (and those not eligible for RHCPP funding). These non-eligible participants will include for-profit clinics, hospitals, long-term care and assisted living facilities, allied health/distance education, payers, pharmacies and government agencies.<sup>31</sup>

Through the FCC RHCPP, the OHN requires stringent service-level agreements with approved contracted telecommunications vendors to bring the high-speed, high-quality, reliable broadband connectivity required to support current and future HIT and telemedicine services and applications to providers across the state. This is accomplished through the FCC's open, competitive bidding process and providers have access to OHN's central network operations center (NOC), which manages the network connections 24 hours a day and seven days a week.

As of January 2011, OHN reports that it is on track to have 166 provider sites on their network by June 30, 2011. Of those, 95 have received their official funding commitment from the FCC and are at various stages of their build out. Of those 95, 48 are actively on the OHN being monitored by their NOC. These active sites include 15 hospitals, nine integrated delivery networks, 12 community colleges, 10 FQHCs, four rural health clinic and seven urban health clinics.<sup>32</sup>

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<sup>28</sup> Oregon HIE Strategic Plan, p. 63.

<sup>29</sup> Broadband report, p. 4.

<sup>30</sup> Broadband report, p. 3.

<sup>31</sup> Oregon HIE Strategic Plan, p. 63.

<sup>32</sup> Oregon Health Network, presentation to federal grantees quarterly meeting, "Project Update," January 10, 2011.

OHN itself is funded from multiple public and private sources. The infrastructure that OHN is building is primarily funded by the \$20.2 million FCC-sponsored subsidy that pays 85% of all installation and service fees. OHN pays 15% for non-recurring fees, and participants are responsible for the remaining 15% of monthly recurring costs. Across the state, 66 sites are actively participating with OHN, 33 sites are being monitored by the NOC. These sites are mainly located on the coast and along the population dense corridor associated with Oregon's major interstate highways.<sup>33</sup>

Barriers to broadband adoption in healthcare include a lack of demonstrated benefits and return on investment and sustainable funding for implementation and ongoing operational overhead costs. Interoperability and quality broadband access are technological concerns. Provider-level barriers include provider knowledge of, access to, and comfort with HIT. Concerns at the health systems level include technological interoperability, credentialing and privileging, and the difficulty of complying with evolving federal rules.<sup>34</sup>

Together, the broadband infrastructure initiative and the broadband mapping initiative are providing ongoing information about infrastructure gaps and allowing the Oregon to find ways to overcome challenges in broadband access for rural areas. Ultimately the goal is to ensure that both the middle and last miles of Oregon's broadband infrastructure are built throughout the state. Over the next three to five years, all communities in Oregon should have access to broadband Internet, which will help support widespread health IT projects, facilitated by local and regional efforts; making certain that providers and patients can engage in electronic exchange of clinical information to improve and support patient centered health care delivery.<sup>35</sup>

## **5. Current state of health information exchange**

### ***Recent legal and regulatory changes***

As mentioned in the Introduction section, when the Oregon Legislature passed HB 2009, it instituted a variety of reforms to Oregon's health system to contain costs and improve quality, including planning and implementing health IT. In particular, HB 2009 established HITOC to carry out and oversee HIT activities in Oregon.

Oregon's health reform law also mandated the creation of a comprehensive data collection program of all claims paid by all health care payers. Starting in mid-2011, the All Payer All Claims Database (APAC) will collect claims information from all payers for policy and analytical purposes covering services across health care settings (see page22 for more information).

### ***Health information exchange in Oregon***

HITOC acts as an advisory board to OHA on HIT issues. HITOC's initial focus has been oversight of the development of Oregon's health information exchange strategic and operational plans, which were approved by the Office of the National Coordinator for HIT in December, 2010. HITOC is now working on policy development and implementation activities.

Oregon's approach as described in the ONC-approved HIE plan is to leverage the investments made by existing regional and local HIOs with core central HIE services in the first phase of development, and to assign a state designated entity to assume operational governance in Phase 2. Current Phase 1 activities, as defined in Oregon's HIE Operational Plan, are ongoing. Major recent milestones include

- HITOC's acceptance of workgroup recommendations for:
  - a standard HIE consent policy,

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<sup>33</sup>Broadband report, p. 15-18.

<sup>34</sup>Broadband report, p. 23-24.

<sup>35</sup> Oregon HIE Strategic Plan, p. 63.

- a framework for the Accountability and Oversight Program for HIE in Oregon,
- a framework for financial sustainability planning, and
- a reconfirmation of the core central HIE services to be provided.
- Two placeholder legislative bills dealing with HIE consent and the establishment of a state designated entity have been introduced and will be further refined when the Oregon Legislature convenes in February.

HITOC's three workgroups will continue their work during 2011. The Technology Workgroup will continue discussions around potential ancillary services and begin work around the development of an RFP for the core HIE services. The Legal and Policy Workgroup will be developing standard data use agreements for intrastate HIE, as well as potentially developing agreements for use by emerging HIOs. The Finance Workgroup will continue work on the financial sustainability analysis that will be submitted to ONC later this year.

The HIE that results from this work will be essential for all the other health system and Medicaid reforms envisioned as part of the ongoing transformation of the health care system in Oregon, with which the Medicaid program is entwined.

### ***Health information organizations***

In Oregon, a number of regional and local health information organization (HIO) activities are supported by private, non-profit and public sector organizations. There are currently 11 organizations participating in HITOC's HIO Executive Panel. A few HIOs are operational or soon-to-be operational, and others are major health systems in Oregon exploring the possible expansion of their currently limited HIE services to serve as a local or regional HIO. There are eight health systems in Oregon currently offering limited HIE services among hospitals, affiliated clinics and/or providers; some of which are represented on the HIO Executive Panel, but not all. These efforts are at different stages of maturity and focus on a range of exchange activities.<sup>36</sup> Types of organizations actively committed to supporting HIOs include health systems and hospitals, individual practice associations (IPAs), county health departments and community health centers, among others. The majority of Oregon's HIOs are hospital systems and affiliated practices; a few have established connectivity with local providers and community-based practices.<sup>37</sup>

As Oregon's providers continue to focus their efforts on achieving meaningful use objectives, it seems reasonable to anticipate that regional and local HIOs within the state may increase services and expand geographically, primarily driven by designated medical service area(s). Future development may be tied to the objectives defined around HIE capability in Stage 2 and 3 Meaningful Use. Developing a strategy for how best to support and expand existing resources to accelerate intrastate and interstate HIE connectivity is vital.

Oregon's existing HIOs are noteworthy for a number of reasons, including geographic coverage, types of services offered and level of support by community stakeholders. Some of these efforts are overseen by boards of directors or advisory groups comprised of local stakeholders, health care leaders and representatives of organizations who are involved or plan to participate in intrastate HIE; others are being managed primarily by the local hospital. By and large, HIOs have organized with the mission to improve health care in each of their communities achieved through increased health IT adoption and HIE. Although these efforts share a common mission, they do vary in community history, selected technology, design and infrastructure, stage of development and demonstrated ability to exchange clinical data. The HIE Strategic Plan anticipates the

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<sup>36</sup> Oregon HIE Strategic Plan, p. 17

<sup>37</sup> Oregon HIE Strategic Plan, p. 19.

expansion of connectivity by the local and regional HIOs to include not only hospitals and affiliated providers, but also tribal clinics, FQHCs, RHCs, laboratories, pharmacies and other entities within the health care system. Connectivity with the Veterans Administration Medical Center in Portland and VA satellite clinics could be accomplished through a statewide NHIN gateway, or possibly through local agreements with individual HIOs.

#### *Veterans*

There is expected to be connectivity via National Health Information Network (NHIN) Exchange from Oregon's HIE core services that will ultimately run exchange services and connect local HIOs. The State HIE messaging services (transport of health data) will be based on Direct Project technical specifications. These specifications can interoperate with the NHIN Exchange specifications, allowing the two types of technologies to communicate with one another. It is also expected that the VA and its network of civilian providers will be able to exchange clinical information at the local community level across Oregon.

Oregon's health care providers and local HIOs expect to exchange clinical information with the Department of Defense installations located in various parts of the state via NHIN Exchange, local HIOs and the statewide HIE. It is expected that the Department of Defense will receive care summary records from local providers through HIOs and provide clinical information to local providers and/or from VA-related discharge/deactivations of military personnel. Both the VA and DoD utilize NHIN Exchange for HIE which is not dependent on certified EHR technology.

#### ***Interstate activities and issues***

Oregon's HIE Strategic Plan recognizes that patients frequently cross state borders seeking medical care, particularly at Oregon's borders with Washington and Idaho. Oregon collaborates with bordering states to address the HIE concerns that arise as a result of interstate activities. Working with the state coordinators for HIT in bordering states, Oregon is weighing policy challenges to seamless interstate HIE, and consulting with other state collaboratives and the ONC for emerging policies and best practices. Public health officials in Oregon and Washington are discussing a potential regional approach to syndromic surveillance, given that both states will be using the same system by 2013.

In addition, Oregon recently received one of seven awards from the Innovative Exchange Information Technology Systems Cooperative Agreement program with the U.S. Department of Health and Human Services. The \$48 million Cooperative Agreement will fund Oregon's efforts to build an information technology infrastructure to support a state health insurance exchange. To maximize the utility of Oregon's design and to facilitate the adoption of Oregon's model in other states, the Cooperative Agreement proposes engaging supporting states in an interstate advisory group. The group would meet periodically to help partner states keep up-to-date on our work and better understand Oregon's planned insurance exchange IT product. The proposed interstate group would gather valuable insight from stakeholders in other states and will provide another avenue for interstate collaboration on health IT. See page 27 for more information.

### **6. State activities supporting EHR adoption and statewide information exchange**

Oregon has several activities underway that directly support EHR adoption and statewide exchange of health information. In particular, activities within the Medicaid HIT Project, the HITOC team led by the State Coordinator for HIT, the Oregon Health Authority's new Office of HIT, and O-HITEC are being conducted with coordinated strategies.

#### ***Medicaid HIT Project***

The Medicaid HIT Project, within the Office of HIT in OHA, reports to the Chief Information Officer for DHS/OHA, as well as Oregon's Medicaid director. The Medicaid HIT project is tasked with carrying out or coordinating all

work under Oregon’s HIT Planning Advance Planning Document (PAPD), State Medicaid HIT Plan, and ultimately Oregon’s HIT Implementation APD (IAPD). This work includes developing the Medicaid EHR Incentive Program, encouraging all Medicaid providers to adopt and use EHRs in a meaningful way, and working with providers and state systems to ensure that providers can meet meaningful use objectives in Oregon, particularly pertaining to public health reporting.

In addition, the Medicaid HIT Project will develop the state Medicaid vision of integrating the DHS and OHA information technology systems to better serve Medicaid clients and providers. This involves sharing data as appropriate within and outside DHS/OHA and supporting the Medicaid share of the development of Oregon’s statewide health information exchange. The integration of these systems will manage costs for the state, improve health care and human services delivery, and improve the health of Oregonians served by Medicaid through better coordination and information sharing across all and DHS/OHA programs.

The internal sponsors of the Medicaid HIT Project are the State Medicaid Director and the CIO for DHS/OHA. In addition, strategic oversight is provided by an executive steering committee comprised of representatives from all major DHS/OHA agencies. Program development and coordination is overseen by the following subset of steering committee members (called the SWAT leadership team) that attends coordination and program development meetings at least twice a month. SWAT leadership team participants include:

- State Medicaid Director Judy Mohr-Peterson, who also serves as an ex-officio member of HITOC;
- John Koreski, Interim CIO, who also serves as a governor-appointed member of HITOC;
- Carol Robinson, State Coordinator for HIT and Director of HITOC;
- Aaron Karjala, the Deputy CIO who also serves as the vice-chair of HITOC’s Technology Workgroup;
- Jean Phillips, Deputy Administrator for Division of Medical Assistance Programs (DMAP);
- Rus Hargrave, OHA IT Director;
- Susan Otter, the Medicaid HIT Project Director; and
- Sean Kolmer, the Deputy Administrator of the Office of Health Policy and Research.

These meetings are currently focused on the successful development of the Medicaid EHR Incentive Program, including the intersection and coordination with the HIE planning efforts. This is the core staff that is initiating and participating in the discussion around joint goals and objectives and determining how to deploy resources to successfully implement the work being done.<sup>38</sup>

#### *Stakeholder engagement in the Medicaid HIT Project*

In addition to the DHS/OHA stakeholders, the Medicaid HIT Project has been working with stakeholder groups to provide information about the project, coordinate and collaborate around program development, and obtain input to guide Oregon’s development on multiple areas of state discretion. Stakeholder groups include HITOC and its diverse members, O-HITEC, Oregon Association of Hospitals and Health Systems (OAHHS), Oregon Medical Association, Medicaid managed care organizations, Medicaid dental care organizations, tribes, consumer groups, county and local health departments, and others. In November, the project solicited stakeholder responses in a web-based stakeholder survey (see page 48 and Appendix E for results). The project will continue to seek opportunities to meet with and present to these groups and their constituents, using these opportunities to share information about Oregon’s Medicaid EHR Incentive Program as well as to solicit input on the incentive program and other activities.

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<sup>38</sup>Addendum to Oregon HIE Strategic and Operational Plans, November 19, 2010.

*Medicaid relationships with HIT/HIE partners*

Oregon's Medicaid leadership and Medicaid HIT Project coordinate closely with the work of the HITOC and O-HITEC (Oregon's regional extension center). The state Medicaid director is an ex-officio member of HITOC. Also, the director of the Medicaid Health IT Project is a member of the HITOC Finance workgroup and provides updates to HITOC at monthly meetings. This creates an opportunity for HITOC to participate in discussions with Medicaid leadership and to strategize on joint goals and objectives. In addition, both the Medicaid HIT Project Director and the State Coordinator for HIT have a governance role in O-HITEC as members of O-HITEC's Advisory Council.

**Health Information Technology Oversight Council (HITOC)**

As mentioned earlier, HITOC was established by HB2009 as part of Oregon health reform to provide coordination between public-private partnerships around HIT efforts and to oversee all HIT efforts in Oregon. In particular, HITOC acts as an advisory group to OHA on HIT issues and is coordinating Oregon's public and private statewide efforts in health information technology, including EHR adoption and the development of statewide electronic health information exchange capacity and operations.

The council is comprised of 11 voting members appointed by the Governor and confirmed by the state Senate, representing the public and private sectors, specifically reflecting the geographic diversity of Oregon, including health care consumers, providers, business and other key stakeholders. This broad geographic representation ensures that the interests of every region of Oregon, a large and mostly rural state, are taken into account in HITOC's decision-making process.<sup>39</sup>

Oregon includes Medicaid and DHS/OHA representatives as members of HITOC and its committees and workgroups related to developing implementation plans for HIE. Oregon's Medicaid Director and Public Health IT Director have been added to HITOC as ex-officio members. The Deputy CIO of DHS/OHA serves as vice chair of the technology workgroup and the Interim CIO of DHS/OHA serves as a HITOC member.

Oregon's HIE Strategic Plan incorporates a phased approach. This was developed by an interdisciplinary strategic stakeholder workgroup which met from January 2010 to May 2010 to inform the development of the HIE Strategic Plan. During Phase 1 (current status), three workgroups (Finance, Legal & Policy, and Technology), two advisory panels (Consumer Advisory and HIO Executive) and two ad hoc stakeholder groups (e-prescribe and laboratory) have been formed and are actively meeting to develop the policy recommendations and implementation tasks as outlined in the HIE operational plan. There are currently more than 120 individuals representing 80 organizations involved in this effort.

At the HITOC retreat on January 20, 2011, workgroup recommendations on a standard consent policy for electronic exchange of health information, the implementation of an accountability and oversight program and a high-level financial sustainability strategy were approved. The technology workgroup has focused on implementation as outlined in the strategic and operational plans and are still on track, so no adjustments in strategy were needed by HITOC at the January, 2011 meeting. Phase 2 (anticipated in early 2012 will define the next stage of governance for statewide HIE and is contingent on legislation being passed by the 2011 Oregon Legislature and the development of a financial sustainability plan being endorsed by stakeholders and approved by ONC.

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<sup>39</sup> Oregon HIE Strategic Plan, p. 23.

*Stakeholder engagement in HITOC efforts*

Over the 15 months since its inception in October 2009, HITOC has instituted extensive stakeholder engagement both through its workgroup process (described above), but also through several large public forums, including an HIO Summit in April, 2010 attended by 60 people representing 40 organizations and a privacy and security public forum attended by more than 150 people in May 2010. HITOC held a series of public meetings across the state during June and July 2010 to gather input on the draft HIE Strategic Plan; more than 150 comments were received from more than 100 individuals and organizations. Ongoing stakeholder communications include ad hoc stakeholder presentations (more than 50 presentations to date) and a monthly update sent to over 900 stakeholders.

*Role supporting incentive program*

Providers and hospitals will need to exchange data to meet meaningful use criteria to be eligible for incentives. Oregon's initial HIE efforts, led by the HITOC, will facilitate e-prescribing, electronic laboratory ordering and results delivery, and exchange of clinical care summaries in 2011. Future stages of meaningful use are expected to increase requirements related to exchange, and Oregon's statewide HIE will seek to ensure that every provider and hospital in Oregon has the opportunity to meet these criteria.<sup>40</sup>

In addition to facilitating meaningful use for Oregon providers, HITOC efforts support the administration of the EHR incentive program in several ways, including:

- Communications with providers and stakeholders external to the state government, and
- Key stakeholder input on program development and activities by HITOC members.

Oregon's HITOC Director and State Coordinator for HIT directly supports the administration of the incentive program. The State Coordinator facilitates coordination with external stakeholders and other HIT efforts in the state. For example, she convenes a quarterly all federal HIT grantees coordination meeting that is attended by the Medicaid HIT Project director and other HIT grantees. She also serves as a member of the Medicaid HIT Project steering committee and SWAT leadership team. The State Coordinator for HIT continues to work with other state and private partners to explore funding opportunities for Oregon HIT that benefit various HIT efforts in the state, including the Medicaid HIT Project work.

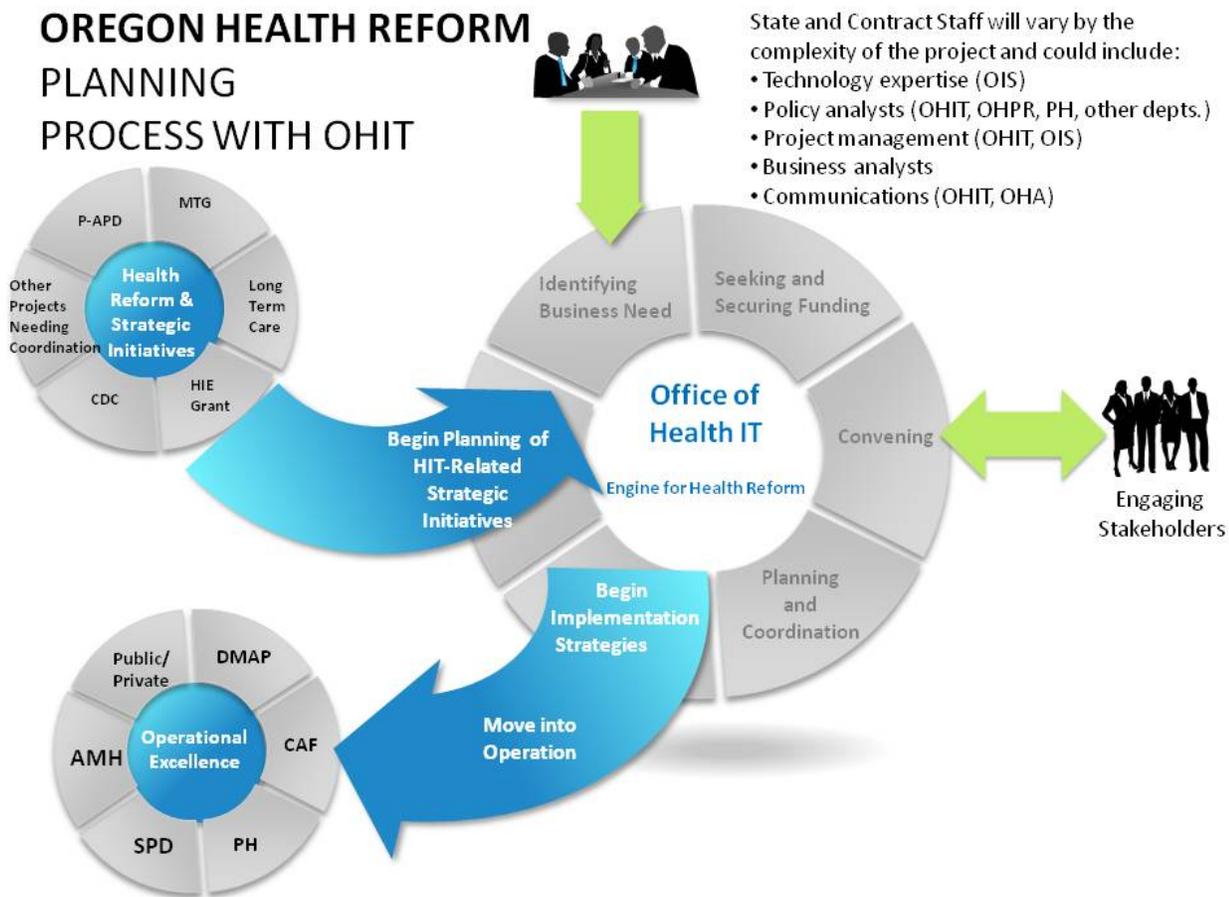
***Office of Health Information Technology***

Oregon's ongoing health reform efforts have fostered coordination and collaboration across many of the state's Medicaid-related programs. The newly formed Office of Health IT is designed to support the planning and policy development of health IT applications and programs across both OHA and DHS. This office will serve as a shared services resource for both OHA and DHS departments in need of planning and policy support while strategizing and adopting health IT. Centralized collaboration and coordinated service delivery also lead to fewer duplicative IT purchases, so that agencies will not need to purchase hardware and software with similar functions. OHIT enables Oregon to leverage resources and institutional knowledge across agencies, ensuring that the adoption of health IT technology will be as cost effective as possible.

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<sup>40</sup> Oregon HIE Strategic Plan, p. 3.

## OREGON HEALTH REFORM PLANNING PROCESS WITH OHIT



The initial staffing structure for the Office of Health IT includes shared staffing that will facilitate coordination between Oregon’s Medicaid HIT and HIE projects as well as carry out joint communication and outreach efforts. This structure demonstrates Oregon’s plans to leverage Medicaid matching funds as effectively as possible in the context of other state plans to achieve common health and health care goals.

### ***Oregon’s Regional Extension Center: O-HITEC***

O-HITEC, a division of OCHIN, assists Oregon clinicians to select, successfully implement, and meaningfully use certified EHR technology to improve the quality and value of health care. O-HITEC offers the following services: EHR vendor selection and installation assistance, meaningful use evaluation and certification, web-based training, seminars, coordinated participation in learning communities, benchmarking and data warehousing services, HIPAA evaluation and certification. It also offers services to make EHR adoption more affordable including group purchasing, discounted third party solutions, and insurance plans.

### ***Role supporting incentive program***

The Medicaid HIT Project works in close conjunction with O-HITEC to ensure consistency and coordination in efforts related to facilitating EHR adoption and meaningful use. The geographic and programmatic diversity of O-HITEC means it can provide support for the administration of the Medicaid EHR Incentive Program in a variety of ways:

- Technical assistance to small providers and critical access hospitals,
- Partnering in communication and outreach,

- Sharing subject matter expertise,
- Coordinating requests for information to clarify federal regulations,
- Coordinating to ensure Oregon-specific requirements related to incentives are appropriately conveyed by O-HITEC to the providers and CAHs they are supporting,
- Leveraging O-HITEC support for meaningful use when assigning risk to providers related to selection for audits,
- Alerting each other to risks, issues, concerns, and
- Coordinating with state public health staff related to practicalities of achieving meaningful use related to the three public health criteria.

## **7. Related state efforts**

In addition to the efforts listed above related to HITOC, OHIT, and close coordination with O-HITEC, Oregon's Medicaid HIT Project values working in closely with other HIT efforts underway in Oregon. In particular, the Medicaid HIT Project coordinates with the Office for Oregon Health Policy and Research (OHPR) and its efforts around an All Payer All Claims database (APAC), Oregon's Public Health Division and its efforts toward interoperability of immunization and public health surveillance activities, Addictions and Mental Health Division's efforts to develop a community behavioral health EHR, Oregon workforce efforts, DHS/OHA efforts to transform state systems, other HIT grants including Oregon's Medicaid Transformation Grant and Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration grant, and Oregon's MMIS certification, Medicaid Information Technology Architecture State Self Assessment (MITA SS-A), and the DHS/OHA 2009-2015 technology plan.

DHS/OHA are carrying out a comprehensive examination of information assets, such as the MMIS, which might be leveraged in the expansion of its master data management services initiative, keeping health information exchange in mind. Business processes such as provider management could be expanded to support this effort.

An All Payer All Claims Database is being developed and is envisioned as a potential decision support system for analysis of claims data. However, the State does not plan to use the database as a registry or directory of services for the HIE or other state system technology planning. The APAC will be leveraged, however, to support validation of patient volume attestation for Medicaid incentives.

### ***All Payer All Claims Database***

In 2009, the Oregon Legislature established a health care data reporting program. The Office for Oregon Health Policy and Research is creating a comprehensive data collection program of all claims paid by all health care payers, including commercial insurers, third party administrators, pharmacy benefit managers, Medicare, and Medicaid. The program will provide information for policy and analytical purposes covering services across health care settings. Once fully implemented and operational, Oregon's All Payer All Claims Database (APAC) will provide utilization data, outcome information and payment information on a statewide basis. The APAC is expected to be operational by summer 2011.

The database also represents an important resource for HIE planning and development, as well as validating eligibility for Medicaid incentive payments. As described in Section V of this document, determination of eligibility for Medicaid incentive payments requires information about the percentage of Medicaid beneficiaries under care by the eligible professional. The APAC will ultimately provide the information to validate the numbers of Medicaid and total patients reported by eligible professionals.

***Public health databases and interoperability***

The Office of Disease Prevention and Epidemiology (ODPE) collects and analyzes data on health behaviors, diseases and injuries, disseminates findings, and designs and promotes evidence-based programs and policies to improve the health and safety of all Oregonians. Within ODPE, the Acute and Communicable Disease Prevention (ACDP) program works with local health departments, other states and the Centers for Disease Control and Prevention (CDC) to prevent and control communicable diseases and outbreaks of acute diseases in Oregon. The Health Promotion and Chronic Disease Prevention (HPCDP) program works with hospitals and laboratories to collect population data to track cancer incidence.

The Office of Family Health (OFH) administers programs aimed at improving the overall health of Oregon's women, infants, and children through preventive health programs and services. The Oregon Immunization Program provides leadership to prevent and mitigate vaccine preventable disease for all Oregonians by reaching and maintaining high lifetime immunization coverage rates. The ongoing collaboration and integration of systems used by each of these offices are essential to understanding and improving the health of Oregonians. The systems described below are integrated to varying degrees and will be integral to phase 1 of Oregon's HIE.

***Oregon's ALERT Immunization Information System (IIS)***

ALERT IIS is a statewide system that contains records for 4.5 million individuals, including current and past Oregonians of all ages along with some residents of Washington. ALERT is used by more than 7,500 public and private health care providers and school staff from 1,500 different sites to link data and create accurate and up-to-date records and to provide accurate information on immunizations due and past due. ALERT receives approximately 80% of immunization records via electronic submission. By late spring 2011 Orpheus users will be able to directly query ALERT to complete case and contact investigations for vaccine preventable conditions.

The new ALERT IIS, which replaces and combines the old ALERT and IRIS registries, began rolling out the last week of November 2010 and is planned to complete statewide rollout by the summer of 2011.

The Oregon Immunization Program provides transition plans, technical documentation and staff training to help providers transition to the new ALERT IIS and submission of HL7 (Health Level Seven International) messages. Existing technical and operational staff members are available from both the Immunization Program and O-HITEC, to provide technical assistance or to work with the EHR vendor as needed by the provider sites to help providers achieve meaningful use. Providers in solo or small practices may not have vendor support and may require more attention than those in a larger practice. Also, the Immunization Program has two grants to support providers in their transition to submission of HL7 messages to the ALERT IIS. An IIS-EHR Interoperability grant, funded by CMS, initiated nine pilot systems to serve as models for seven different vendor EHRs to implement HL7 message exchange via a real-time web service (see page 26 for more information). A CDC interoperability grant will offer mini-grants to providers for technical assistance, to develop an interface, or to purchase software to enable the exchange of HL7 messages.

At present, 70 sites are submitting HL7 messages to ALERT IIS and another 30 sites are submitting HL7 messages to the old ALERT registry. Another 225 sites will be targeted to encourage their transition to HL7 message submission within the next 2 years.

The registry currently supports uni- and bi-directional batch processing of HL7 messages from EHRs in 2.3.1 and 2.4 formats. With the introduction of a web service in February 2011, ALERT IIS will support real-time data

exchange. HL7 messages in 2.5.1 format, which along with 2.3.1 is the ONC standard,<sup>41</sup> will be supported beginning in mid-2011. ALERT IIS accommodates CVX, CPT and NDC standardized vaccine code sets.

#### *Electronic laboratory reporting*

Electronic laboratory reports (ELR) from laboratories around the region are routed through a central repository within the Public Health Division. HL7 data received from laboratories are routed directly into the state's communicable disease reporting database (Orpheus, see below), as well as to various state program recipients such as the Oregon Childhood Lead Poisoning Prevention Program and local public health department partners via secure file transfer protocol (sFTP). The ELR system is also responsible for routing non-translated reports to various state programs (e.g., the Oregon State Cancer Registry).

#### *Oregon Public Health Epidemiology User System (Orpheus)*

Orpheus currently houses all communicable disease data, including sexually transmitted infections, tuberculosis, and HIV/AIDS case data dating back to 1983. ELRs are routed to Orpheus via HL7 and processed and investigated by local public health, and data for nationally notifiable diseases are transmitted to CDC using nationally recognized standards (i.e., NETSS and HL7). Providers do not interact with Orpheus directly, but they do report cases of communicable disease directly to local public health for investigation and follow-up.

#### *Syndromic surveillance*

This spring ODPE is implementing a comprehensive syndromic surveillance system from CDC, the Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) which will be used to collect and analyze health data for the purposes of detecting and characterizing trends of illness or injury in a timely manner. Oregon is one of 10 states that currently does not have a robust and ongoing syndromic surveillance system in place, though intermittent emergency department surveillance activities have taken place since 2003 (e.g., Olympic Track and Field Trials, 2007 winter storm). During these intermittent activities, chief complaint data files are submitted daily or weekly via sFTP, secure email, or the Health Alert Network and analyzed with CDC's Early Aberration Reporting System (EARS). Syndromic surveillance uses data to identify and predict trends as they are occurring, which often take the form of analyzing patients' chief complaints as they present for care in hospital emergency rooms and other acute care settings. Stakeholders, including entities outside of public health, can benefit from greater situational awareness of real-time disease activity across communities. Critical to the long-term success of this surveillance is the quick, efficient and automated transmission of critical data from clinical systems to the appropriate public health agencies. In addition to data received directly from hospitals, ELR and Orpheus data will be processed through ESSENCE.

#### *Interoperability between public health systems*

The public health systems described above are currently limited in terms of interoperability; only ELR and Orpheus have an established and ongoing link. ELRs are currently imported into Orpheus twice daily, coincident with the routing and distribution of those reports via fax to local health authorities (which use Orpheus to report).

Though ODPE and OFH collaborate and share information on an ad-hoc basis, efforts are underway to routinely exchange information between the Orpheus and ALERT, and Orpheus and ESSENCE. For ALERT, initial efforts to exchange information with Orpheus will use the same system of real-time web-service query available to providers. By summer 2011, ESSENCE will process data from Orpheus, hospital, providers, labs, and Oregon Poison Control Center for syndromic surveillance activities. Currently, ALERT and ELR are receiving data directly

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<sup>41</sup>Federal Register/Vol.75.144/170.205 (e).

from providers, hospitals and laboratories. Conversations about the utility of exchanging data between Orpheus and EHRs are underway.

### ***Behavioral health providers***

Oregon's behavioral health services are provided via community-based programs, acute care hospital programs, and the state psychiatric hospital. The Addictions and Mental Health Division within OHA has several HIT efforts underway.

The Behavioral Health Information Project (BHIP) is designed to provide an EHR and other clinical and administrative systems to support the state's behavioral health continuum of care. In particular, BHIP will implement a federally-certified EHR (Netsmart's Avatar) in Oregon's psychiatric hospital.

A sister project, Oregon WITS (Web Infrastructure for Treatment Services), aims to provide a web-based EHR for mental health and addiction services community-based programs and acute care hospital programs that would allow for exchange of patient data between the state psychiatric hospital and community providers. The OWITS application provides a secure, central location for meeting reporting requirements and allows states to manage provider and practitioner registrations and certifications. Part of the OWITS system for vouchers and claims is expected to go live in Oregon in April 2011 with a small group of providers and ultimately expand to all mental health and substance abuse providers in Oregon in 2012. The WITS vendor is seeking federal EHR certification for this product.

### ***Workforce development***

Oregon is leading cutting-edge efforts to train the HIT workforce through both OHSU's Department of Medical Informatics and Clinical Epidemiology and Oregon's community colleges, including Portland Community College (PCC). OHSU has received two federal stimulus grants from the ONC; one will train certificate and master's level students in informatics and the second names OHSU as one of five curriculum development centers around the country. OHSU was also selected to be the National Training and Dissemination Center for the latter project. PCC is the lead Oregon community college receiving money through the national Community College Consortia Program to partner with four other community colleges in Oregon to train and place 300 health IT workers in jobs. Each college is creating non-degree training programs that can be completed in six months or less.

### ***Other state HIT grants***

#### ***Medicaid Transformation Grant***

Oregon DHS received from a Medicaid Transformation Grant (MTG) for \$5.5 million in October 2007 to implement a Health Record Bank of Oregon (HRBO). The initial term of the grant award was 18 months from October 2007 through March 2009. CMS has extended the grant through March 2011.

The DHS Executive Committee for this grant approved a revised plan at its meeting March 10, 2010 meeting. The scope of the project has been amended and the balance of funds re-allocated to initiatives consistent with the original intent of the HRBO, achievable within the time available.

The revised project includes five mutually supportive component areas:

1. *Health Profiles for Children in Foster Care*. The original HRBO project focused on several target populations, the highest priority of which was children in the care and custody of the foster care program administered by DHS. DHS decided to enhance the capacity of its new OR-Kids Child Welfare information system which is scheduled to replace an outdated legacy system in early 2011, by adding functionality to generate a personal health report or "Health Profile" for children in its care. The new Health Profile function will aggregate and filter information from the MMIS claims database and

additional data from the Oregon immunization registry to generate on demand a Health Profile for each foster child. Grant funds will enable OR-Kids to develop and validate the utility of these Health Profiles in field. Health Profiles will be tailored to five audiences: case workers, parents and guardians, foster care providers, health care providers, and individual clients upon reaching 18 or emancipation. The default distribution method, as in the HRBO project, will continue to be “print and carry,” but this project component will also plan for future secure Web access.

2. *Immunization Information System (IIS) enhancements.* Immunization data is highly valued by the health care provider community. To make IIS data more available to providers and others who need it, and to enable providers with EHR systems to easily provide updated immunization information to the IIS, DHS is supporting the Public Health Division by amending the existing contract with Hewlett-Packard (HP), the IIS contracted vendor. The vendor is developing a bidirectional web services interface. The interface will allow real-time immunization data export to OR-Kids in support of the Health Profile, and as providers activate EHR information exchange capabilities, it will enable data exchange directly with those provider EHRs. Recognizing that the Oregon Immunization Program is governed by statute, all implementation plans would have to be reviewed by the Assistant Attorney General for Public Health. As mentioned earlier, the new IIS system is planned to complete statewide rollout by the summer of 2011. It is not expected that early challenges will interfere with the schedule for the MTG-funded interface enhancements.
3. *Immunization Information System (IIS) interfaces for health providers’ EMRs.* Immunization information for health care providers serving higher numbers of foster children, beyond the access provided by the Health Profile (above) will be further facilitated by strategic investments in EHR interfaces to IIS. DHS/OHA has solicited small proposals from providers operating EHRs to support the development, deployment and operation of EHR to IIS interfaces for the products of leading Oregon EMR vendors, serving Medicaid recipients. Nine projects have been initiated for an average of \$132,323 per recipient. EHR-enhanced interoperability grantees have been meeting regularly with Oregon’s Immunization Program, IIS and HP representatives to address issues and keep each grantee project moving forward. Most, if not all, of the grantees have achieved the Tier 1 milestone which triggers a second payment and moves the development process to milestone 2 activities (detailed project plan, work breakdown structure, timeline, budget and development of a working real-time HL-7 interface). This project remains on track for timely completion by March 31, 2011.
4. *Information policy and business analysis.* The HRBO project uncovered several foundational business and information technology policy challenges that must be addressed for current Medicaid operations and planning for future HIE. These challenges include approaches to managing: (a) foster child data, (b) professional and client identity verification, (c) presentation of family and other relationships and (d) adolescent data. The HRBO project’s discovery of these challenges and their implications for future HIT and Medicaid operations represent an achievement of the project upon which DHS can build over the remaining period of the grant and into subsequent work funded under the ARRA. The policy and business analyses are designed to capitalize on these findings, and generate new knowledge for DHS and CMS. The analyses will require involvement of state personnel including the Oregon Department of Justice and external consulting or university research groups with whom the State has standing contractual relationships.
5. *School-based health center project.* Because of efficiencies in execution of other projects, and with CMS approval, DHS added a fifth component of the Medicaid Transformation Grant focused on school-based health centers (SBHCs). DHS has executed, or is in the process of executing, contracts for purchasing at

least three federally-certified EHR systems with associated data reporting software, for training provider staff in their use and for support and maintenance of the systems for 2 years. Contract recipients will provide data services and deploy a customized process for SBHCs to report specific data elements to the state. As a result, SBHCs participating in the pilot will be able to bill Medicaid efficiently for their services to eligible persons, report data to the state to maintain certification, and comply with meaningful use criteria. Due to these efforts, eligible professionals within SBHCs may qualify for Medicaid EHR incentive payments. The goal is for this reporting process to eventually be available to all state-certified SBHCs in the Oregon SBHC Network.

For all five of the project components above, DHS strategy emphasizes working within existing contracts and work orders to the extent possible, in order to leverage existing relationships and mitigate schedule risk due to time consuming procurement processes. Finally, the components are designed to facilitate EHR adoption and meaningful use (including electronic submission to the immunization registry) and will facilitate Oregon's HIT and HIE planning and development as those efforts go forward.

#### *Health Insurance Exchange*

Oregon is actively pursuing the establishment of a health insurance exchange, as envisioned in federal and state health reform. Oregon's state Legislature is considering a bill to establish the Oregon Health Insurance Exchange Corporation, an independent public corporation that would offer health insurance plans to individuals and small employers and be the place for individuals to access the federal premium tax credits that will reduce the cost of insurance for many Oregonians.

Oregon is one of seven states or coalitions that received grant funding through the federal Insurance Exchange IT innovator program. Oregon plans to use its \$48 million innovation grant for:

- A seamless, easy to use eligibility determination process that will help individuals figure out whether they are eligible for Medicaid or federal premium tax credits;
- Access to health plan cost and quality information that Exchange consumers can use in selecting plans and providers;
- A process for easy enrollment into commercial health insurance plans and Medicaid; and
- Billing and payment functions (including administration of the new federal health insurance tax credits, in partnership with the federal government).

The IT Innovator grant funding supports the state's effort to modernize Medicaid eligibility and enrollment processes. This gives Oregon a singular opportunity to develop seamless and efficient enrollment systems for Oregonians regardless of whether they qualify for Medicaid or will purchase commercial insurance. Together, the health insurance exchange and eligibility and enrollment modernization projects will form a framework for achieving several of the IT goals in the DHS/OHA IT Technology plan and provide the basis for a broader service oriented architecture that will benefit other state systems and Medicaid-related programs.

#### *CHIPRA consortium*

The Tri-state Children's Health Improvement Consortium (T-CHIC) is an alliance between the Medicaid/CHIP programs of Alaska, Oregon and West Virginia formed with the goal of markedly improving children's health care quality. The Oregon-led consortium is working on a Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration to demonstrate the unique and combined impact of patient-centered care delivery models and health information technology (HIT) on the quality of children's healthcare, as measured by

a variety of indicators.<sup>42</sup>

The project aims to determine the level of feasibility for providers to report on CMS' recommended set of pediatric core measures through data captured in EHRs, as well as to determine the impact that these systems have on children's health outcomes. Alignment of T-CHIC activities with both national and state HIT development will be ensured through coordination of efforts with HITOC and the state Medicaid Director.

***MMIS, MITA and enterprise technology capabilities***

*Medicaid Information Technology Architecture State Self Assessment (MITA SS-A)*

The MITA SS-A Advance Planning Document (APD) was approved by the CMS in March 2011.

The impact of MITA SS-A on the State Medicaid program and other DHS/OHA programs is significant. The State will use APD funds specifically for:

- Funding of a project manager and staff for development of MITA SS-A APD, project planning, and oversight.
- Development of direction/steps for beginning MITA SS-A.
- Determination of resources needed for MITA SS-A. Development of an RFP to contract for professional services to support the MITA SS-A.
- Contracting for professional services to support Oregon's MITA SS-A.
- Evaluation of MMIS as target system vs. other DHS/OHA systems.
- Evaluation of DHS/OHA business processes in relation to current transformation initiatives.
- Collaboration within DHS/OHA agencies to share information and build consensus for MITA State-Self Assessment and future implementation.
- Assessment of implementation budget and staffing impact.

The MITA SS-A Framework Version 2.0 and Business Process Model are the guiding documents for the State Self-Assessment. The MITA SS-A mission, goals and objectives will be the guiding principles used to develop the tools necessary to transform the Oregon Medicaid enterprise and improve the administration of the Medicaid program.

Several major state initiatives may have a substantial impact on the scope of the MITA State Self-Assessment. These include the creation of the Oregon Health Authority and its rearrangement of responsibility for various Medicaid services; the state's health services transformation project, meant to plan a new, integrated health and services delivery system for Oregon's Medicaid programs; the Health Insurance Exchange IT project; and the Children, Adults and Families Self-Sufficiency Program that will improve and streamline the application process.

***Medicaid Management Information System (MMIS) replacement***

Oregon DHS implemented a new MMIS in December 2008. The new MMIS replaced a 27-year-old system that used outdated technology and could not be updated to support increasingly complex state and federal requirements. The old system was built to process 260,000 claims per month for 116,000 eligible clients. Today, Oregon's MMIS tracks approximately 430,000 clients and processes about 2 million claims each month. The new MMIS processes claims faster and more efficiently, and helps to detect and reduce fraud and errors. In addition, the new system will ensure that Oregon is in compliance with federal Medicaid requirements. The MMIS and the Provider Web Portal will be the backbone of the EHR Incentive Program. For more information, see page 52 related to the technology system required to implement the incentive program.

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<sup>42</sup> Oregon HIE Strategic Plan, p. 68.

*Enterprise technology capabilities: The DHS/OHA 2009-2015 Technology Plan*

The DHS/OHA Information Technology Governance Council has adopted a vision of rational, service-based architecture for state IT systems which seeks to enable enterprise capabilities to facilitate interoperability, data management and collaboration. This vision is contained in the DHS/OHS 2009-2015 Technology Plan, and includes an Enterprise Service Bus, Master Client and Provider indices, and other functionalities. Oregon will seek opportunities to pilot test this vision over the next several years. Oregon sees the Medicaid HIT planning effort as a substantial driver towards achieving the Medicaid related portion of Oregon's vision of a seamless health and human services delivery model and enterprise architecture. Future SMHP updates will describe these efforts in more detail.

The creation of the OHA set the stage for the governance and shared services that will allow Oregon to create the interoperability required to implement the MITA SS-A 2.0 framework for its Medicaid enterprise and to implement its 2009-2015 technology plan. The technology plan encompasses health insurance, federal financial and medical assistance programs, Women Infants and Children, and child welfare delivery. Many of Oregon's existing information systems are 20 to 30 years old, are increasingly expensive to maintain and operate and duplicate information and business processes. They limit service coordination and frustrate stakeholders.

The DHS/OHA 2009-2015 Technology Plan details how Oregon will integrate master data management services to connect the many systems of care. The ultimate goal is to provide a coordinated, consistent delivery of health and human services enabled by an IT infrastructure that supports improved outcomes by providing a comprehensive view of the clients and populations the State serves. The siloed systems that exist today will give way to a business architecture that provides stakeholders with a modular, functional view of human services business operations that is person-centric and service-oriented, in contrast to the prevailing program-centric organizational structure. This master data management services approach is the proposed solution for integrating the disparate data sources currently in place within the organization, and to thereby provide a more holistic view of the data, along with data governance provisions. As described previously, this anticipates the procurement of the information assets needed to operate and maintain health information exchange.

*Enhanced Funding Requirements: Seven Conditions and Standards*

CMS issued new standards and conditions on April 14, 2011, that must be met by states in order for Medicaid technology investments to be eligible for the enhanced-match funding. Oregon has reviewed these standards and conditions and intends to incorporate them as the State designs and implements technology in support of the Medicaid program. Oregon will respond to each standard and provide a status and plan in an SMHP update.

### III. Vision

#### Section Overview

- The Medicaid Health Information Technology project’s main goals are to increase Medicaid providers’ ability to achieve meaningful use of certified EHRs through a robust incentive program and a coordinated network of DHS/OHA systems that is connected to the statewide health information exchange.
- This work will contribute to Oregon’s overarching goal of a healthier population through:
  - Quality, efficient coordinated care through electronic access to clinical information,
  - Optimized patient experience through effective investment and management of infrastructure, operations and administration of the health information technology and technical assistance needed to support meaningful use of certified EHRs and health information exchange, and
  - Achievement of the best results through secure electronic data reporting and bidirectional exchange for increased population health.

#### 1. Medicaid HIT goals

The Medicaid HIT Project’s main goals are to enhance Medicaid providers’ ability to achieve meaningful use of certified EHRs through:

- A robust incentive program and other activities and
- A coordinated network of interoperable systems, supporting Medicaid clients, that is connected to the statewide health information exchange.

This fits into the Oregon Health Authority’s larger strategic approach:

#### Strategic Intent



#### 2. Imperatives

According to the CMS State Medicaid Director’s Letter of August 2010, HIT efforts funded by CMS must:

- Directly facilitate the adoption and meaningful use of EHR;
- Be consistent with the HIE vision and specifically secure messaging, e-prescribing, and the electronic reporting of laboratory data;
- Not be duplicative of other efforts;
- Be integrated into the Medicaid business enterprise;

- Not be qualified for MMIS funds, MMIS funds be used first when applicable;
- Have a well-defined, achievable scope with meaningful use of EHRs as the goal;
- Be able to sustain operations after the goal is met and HITECH funding is no longer available;
- Adhere to Medicaid Information Technology Architecture (MITA) principles;
- Follow the fair share principle of cost allocation with other beneficiaries; and
- Work with CMS to determine appropriate cost allocation.

***Project imperatives***

- Quickly maximize the adoption and meaningful use of certified EHRs by Medicaid providers through an incentive program and other activities that are efficient, responsive, and inclusive, while communicating and coordinating with the provider community and the entities that serve them.
- Understand the current state by identifying and mitigating barriers to adoption and meaningful use of certified EHRs by effectively scanning, assessing gaps and adjusting strategies where appropriate.
- By facilitating provider adoption and meaningful use of certified EHRs, support public health and Oregon’s health reform objectives of ensuring appropriate access to clinical and other health data to facilitate informed decision-making, policy development and demonstrate progress toward Oregon’s triple aim goals.
- Support Oregon’s statewide health information exchange by investing the Medicaid share for DHS/OHA participation in the exchange
- Develop a Medicaid Health Information Network to more effectively connect internal and external stakeholders with DHS/OHA systems that directly impact Medicaid clients and providers through connecting those systems to Oregon’s statewide health information exchange.

***Integrated state IT architecture for shared health services***

Future planning will support the integration of current and future IT systems over the next five years that impact Medicaid providers and clients. Medicaid clients in Oregon are the largest consumers of nearly all other DHS/OHA services, including the provision of mental health; self-sufficiency; aged and physically disabled services; Women, Infants, and Children; child welfare; and food stamps. Integration of the many DHS/OHA IT systems will help the state be more efficient, improve health care and human services delivery and improve the health of Oregon residents served by Medicaid and other DHS/OHA programs; all of which help to advance Oregon’s overall goal for improved health of its citizens. In the meantime, it is anticipated that these major state agency programs will function as nodes in the statewide HIE services architecture. Further, MMIS and Oregon’s managed care organizations can be expected to be active participants in HIE.

**3. Current and desired states**

Currently, state health information technology systems are inefficient or uncoordinated with respect to Medicaid providers and the DHS/OHA programs that work with them. While there is a large foundation of early EHR adopters, few of their systems are on the federal list of certified EHRs that meet the new ONC certification standards. The Oregon HIE Strategic Plan is built on a federated model of local and regional HIOs, with core statewide HIE services to support the HIOs and ensure basic information exchange capabilities for providers in areas where HIO services are not available. As Oregon’s HIO marketplace evolves, there may be areas of the state where more functionality in HIE will be needed and is not provided by the local market.

***Desired state***

- Oregon’s Medicaid-related systems exist in a coordinated Medicaid Health Information Network of interoperable systems supporting Medicaid clients.

- Oregon’s Medicaid-related systems participate in a statewide health information exchange where appropriate.
- The use of electronic health records and health information exchange will support the Oregon Health Authority’s triple aim goals:
  - Improve the lifelong health of all Oregonians,
  - Increase the quality, reliability, and availability of care for all Oregonians, and
  - Lower or contain the cost of care so it is affordable to everyone.
- Oregon providers are meaningful users of certified electronic health records.

Oregon has taken a comprehensive approach to the development of its State Medicaid HIT Plan (SMHP). The Medicaid HIT Planning Team is coordinating closely with the state HIE planning team, particularly around topical areas of overlap and leveraging resources. As the SMHP and State HIE Strategic Plan are integrally linked, the Medicaid HIT Planning Team will continue working closely with the State Coordinator for HIT to ensure that the SMHP builds upon, enhances and strengthens Oregon’s Strategic and Operational Plans for HIE.

Collectively, these efforts are all designed to help achieve statewide HIE and support achievement of Oregon’s overall goals for the health of its population. Oregon’s State Medicaid HIT Plan will identify goals for EHR adoption and participation in the incentives program for Medicaid providers. The state HIE Project Team will participate in the development of those targets, along with planning related to EHR adoption strategies and initiatives.

**4. Further development of Oregon’s Medicaid HIT vision and benchmarks**

Oregon will update this section, and include annual benchmarks, in future updates to this SMHP.

**5. Steps during the next year to encourage provider adoption**

Streamlining health care management with certified electronic health records will reduce medical errors and improve quality of care for thousands of Oregonians. EHRs will also produce significant savings for Medicaid over time by improving quality of care. The following table provides a summary of the specific steps the Medicaid HIT Project is planning to take in the next 12 months to encourage provider adoption and meaningful use of certified EHR technology.

**Steps to encourage provider adoption and meaningful use of certified EHR technology**

Step	Activity	Summary	Timeframe	
Activities supporting providers/hospitals eligible for the EHR Incentive Program	1	Environmental scan	Survey and scanning of EHR adoption	Fall 2011
	2	Medicaid EHR incentives for providers and hospitals	Implementing the Medicaid EHR Incentive Program, the strongest step Oregon can take to encourage adoption of certified EHRs	Summer 2011
	3	Ensuring technical assistance is available for providers and hospitals	Partnering with O-HITEC and other entities to ensure availability of technical assistance for all eligible professionals and hospitals in Oregon; coordinating with O-HITEC and other entities to ensure Oregon’s state-specific program requirements are communicated effectively	Ongoing

Activities supporting providers/hospitals eligible for the EHR Incentive Program	4	Direct educational and provider outreach	Development of website, social media, presentations, and educational materials; targeting specific provider types/hospitals to ensure messaging is most effective; outreach to ensure providers understand how they meet (or do not meet) specific eligibility criteria prior to applying for incentive program	Initial direct mail launch in spring 2011. Other activities ongoing
	5	Joint work through O-HITEC and other external partners	Leading a coordination group of key external partners to develop consistent messaging; providing materials and participating in provider outreach opportunities led by partner organizations	Ongoing
	6	Other EHR adoption and strategies	Develop departmental strategies to facilitate EHR adoption and Meaningful Use.	Ongoing
Activities assisting potentially non-eligible professs'/hospitals to adopt certified EHRs	7	Targeting high-risk critical access hospitals that may not be eligible for incentives	Explore partnering with O-HITEC and other organizations to assist four high-risk Critical Access Hospitals (CAHs) in adopting and implementing certified EHRs and achieving meaningful use	Spring 2011
	8	EHRs for long-term care providers	Explore activities to encourage or facilitate adoption and meaningful use of certified EHRs for long term care providers with a focus on Medicaid nursing facilities	Ongoing
	9	EHRs for behavioral health providers	Promote EHR adoption for community addictions and mental health providers delivering Medicaid services.	Ongoing
Activities promoting EHR Adoption and Meaningful Use via Health Information Exchange	10	Develop public health system strategies	Develop strategies to ensure Oregon's public health systems encourage meaningful use and enhance provider's participation in HIE	Ongoing
	11	Develop Oregon's HIE	Provide the Medicaid share of funding to develop, implement and operate Oregon's HIE	Ongoing
	12	Facilitate robust participation by Oregon/OHA systems in HIE	Develop strategy, policy, and architecture for Medicaid-related state systems to participate in state HIE; participate in development and design of core HIE services to ensure state perspective is represented	Spring/Summer 2011

Activities promoting EHR Adoption and Meaningful Use	13	Develop plan to connect and coordinate state Medicaid-related systems	Develop a Medicaid Health Information Network to coordinate and connect state systems that interact with providers via state HIE; pursue strategies that facilitate state vision of shared services information technology (IT) architecture	Fall 2011
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**6. Assumptions, dependencies and challenges**

Oregon's Medicaid EHR Incentive Program is on a fast track, and there are many interlinking activities and trends that could impact one another, resulting in potential barriers or delays of this plan. Oregon is fortunate to have many factors in its favor, and operates on the following set of assumptions.

- Oregon providers and hospitals continue to have a strong rate of EHR adoption.
- O-HITEC will educate and assist providers in the adoption and implementation of certified EHR technology and its meaningful use.
- Oregon will implement the CMS-approved Oregon HIE strategic and operational plans including scheduled rollout of Phase 1 services available to providers, hospitals, and local HIOs in 2011.
- DHS/OHA will function as envisioned in HB 2009 in their new roles as sister departments, sharing services and supporting the HIT investments made by the Oregon State Legislature. The Office of HIT will be fully operational in 2011.
- Oregon's participation in the MAPIR collaborative with a dozen other states allows Oregon to save time, resources, and costs; and will produce a high-quality incentive program application that meets expectations by eligible professionals and hospitals, and meets program requirements including state-specific requirements.
- Close coordination and collaboration with key stakeholders will result in an incentive program designed to be responsive to Oregon's specific Medicaid program environment and the needs of Oregon's eligible professionals and hospitals.

The State also faces challenges to implementing the incentive program, many of which are common to all states creating these programs. These include the following:

- Provider and hospital EHR certification status is uncertain and it will take time to explain the program's rules to Oregon's medical community. Oregon is communicating now with key stakeholder groups and addressing inquiries from eligible professionals and hospitals, to prepare for launching Oregon's incentive program.
- Although the program benefits from participating in the MAPIR collaborative, some additional time may be needed to allow appropriate processes to incorporate the interests of all 13 states. Oregon is actively involved in MAPIR design discussions and works closely with our local HP representatives to mitigate any avoidable delays and facilitate effective processes for the collaborative.
- Oregon is dependent upon CMS for effective implementation of the NLR, for appropriately communicating with Oregon providers, and for timely review and approval of this SMHP and the IAPD.

However, the project team is paying close attention to these and other factors to ensure they are dealt with expeditiously and do not delay the incentive program.

The State also faces challenges to implementing the incentive program due to specific circumstances of the health care delivery and Medicaid policy in Oregon. Three specific challenges are:

1. Medicare Advantage is a disadvantage in Oregon: Oregon has a high rate of Medicare Advantage plans in Oregon. Providers serving Medicare patients will look to qualify for a Medicare EHR incentive payment, but will not be able to count their Medicare Advantage estimated allowed charges toward the calculation for their incentive payment.<sup>43</sup> Although incentive payments are available for Medicare Advantage organizations, most Oregon providers accept multiple Medicare Advantage plans and are not employees of a single organization. Due to these organizational and fiscal relationships, many Oregon providers will not qualify for the maximum Medicare EHR incentive payment in their first year of participation.
2. CHIP is indistinguishable from Medicaid: Oregon has streamlined state health care programs to be known publicly as Oregon Health Plan (OHP) rather than by the funding source or program name. In addition, Oregon has been recognized as a national leader in enrolling children for health care by expanding health care coverage in the past two years to 70,000 children under the Healthy Kids program funded by CHIP. To qualify for a Medicaid EHR incentive payment, eligible professionals not practicing predominately in an FQHC or RHC must have 30% (20% for pediatricians) Medicaid patient volume which excludes CHIP. Providers have no way of knowing which children they see under the Oregon Health Plan are covered by Medicaid and which are covered by CHIP, and will over-calculate their patient volume. Oregon's incentive program staff will need to work directly with some applicants to ensure that they meet the patient volume thresholds. See page 57 for Oregon's approach to this issue.
3. Dental EHRs: Oregon Medicaid provides primary and emergency dental coverage for a large portion of Medicaid recipients. Oregon anticipates that more than 100 dentists may be eligible for Medicaid incentive payments based on patient volume. However, there are no certified electronic dental health record systems available. There are certified EHR dental modules, but these must be incorporated into a larger EHR system in order to allow a dentist to meet the requirements to adopt, implement, or upgrade to a certified EHR. Most eligible dentists in Oregon do not practice within an integrated health care setting, and therefore would not be using a larger EHR system, thus making them ineligible for incentive payments.

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<sup>43</sup>Section 495.102 states that Medicare incentive payment amounts are based on 75 percent of the estimated allowed charges for covered professional services furnished by the eligible professional during the payment year, as determined by claims submitted no later than two months after the end of the payment year.

## IV. Medicaid HIT Initiatives and Strategies

### *Section Overview*

- Oregon Medicaid has a key role in health information exchange implementation.
- Oregon proposes a coordinated network of Department of Human Services/Oregon Health Authority information systems known as the Medicaid Health Information Network.
- Oregon is planning specific strategies to improve EHR adoption within the long-term care and behavioral health communities, and to ensure technical assistance is available to all eligible professionals in Oregon.

The key role for the Medicaid HIT Project is to encourage the adoption and meaningful use of certified EHRs by Oregon's Medicaid providers, primarily through the implementation of Oregon's Medicaid EHR Incentive Program. The design of that program is described primarily in Sections V, VI and VII.

This section describes the other Medicaid HIT initiatives and strategies approved by CMS in Oregon's Planning Advance Planning Document, to encourage EHR adoption and to enhance Oregon's state systems that impact Oregon Medicaid providers using EHRs. These initiatives are being carried over from the PAPD Update to Oregon's SMHP and IAPD. Future SMHP and IAPD updates will report back on the results of these initiatives.

This section also describes Oregon's strategies related to technical assistance and legislation.

### **1. Medicaid role in health information exchange implementation**

With the completion of the health information exchange strategic and operational plans, HITOC has begun the next steps of implementation planning (see pages 15 and 19). Oregon received approval for allocating PAPD funding to include the Medicaid portion of ongoing planning for Oregon's state HIE Phase 1 implementation process, which includes:

- Development of Oregon's HIE consent policies,
- Development of Oregon's sustainable finance plan,
- Core services technology planning,
- Ancillary services technology planning,
- Development of an accountability and oversight program for HIO participation in statewide HIE,
- Uniform data sharing agreements,
- Development of privacy and security framework,
- Provider education, and
- Market research and consumer engagement.

As described in the PAPD update, the Medicaid portion of Oregon's state HIE Phase 1 is estimated at no more than 39% of state HIE planning costs. It is anticipated that additional guidance from CMS will inform the calculation of the Medicaid proportion of state HIE implementation costs.

### **2. Medicaid Health Information Network (MHIN)**

As described in Oregon's PAPD Update, Oregon proposes to develop a coordinated network of DHS/OHA systems that directly impact Medicaid providers and their ability to achieve meaningful use of EHRs. These efforts would line up with the DHS/OHA 2009-2015 Technology Plan (see page 29). Planning efforts will: define MHIN vision, scope, and goals; identify activities needed to connect providers to the MHIN systems where appropriate to achieve meaningful use of EHRs; and connect MHIN systems to the statewide HIE. Specific planning activities are described below.

***Organizational HIT capacity***

In a future SMHP update, develop an HIT Organizational Capacity and Implementation Plan component of this SMHP to support the business development needs of the newly formed Office of HIT, including to contracting for an organizational capability assessment, to identify HIT staffing capacities and gaps and development of state staff training on quality standards reporting and EHR adoption.

***MHIN technical plan***

This plan, to be incorporated into a future update of Oregon’s SMHP, will include a technical assessment of DHS/OHA HIT systems and a proposal to develop a MHIN that will support Medicaid providers using EHRs and Medicaid-related systems connecting internally and externally via Oregon’s statewide HIE. Further, this plan will assess and recommend approaches to leverage statewide HIE functionalities for MHIN purposes, such as the use of a single master provider index or record locator service for both MHIN purposes and for statewide HIE purposes.

***Planning for MHIN participation in Oregon’s HIE environment***

Oregon will plan to build interfaces for DHS/OHA systems within the MHIN to connect to a statewide HIE for data (e.g., laboratory) so that Medicaid providers can participate in data exchange, helping to advance the triple aim goals of the Oregon Health Authority. Systems include Oregon’s MMIS, public health systems, behavioral health systems, long-term care systems, the All Payer All Claims database program, and others.

***Planning for Medicaid participation in building HIE functionality***

Participate in HITOC planning around future HIE functionality including: secure message services, authentication services, record locator service, master patient and master provider registries, quality data reporting services and other services/products.

***Privacy and security planning***

Work with legal consultants and subject matter experts to evaluate and propose privacy and security policies, within Oregon’s MHIN and between state systems and statewide HIE. Deliverables may include data use agreements and other legal documents, and a privacy and security plan for inclusion in the SMHP, as well as policies and recommending changes to existing state laws, regulations and policies.

**3. Facilitating EHR adoption and meaningful use for all Medicaid providers to serve all Medicaid populations**

***Serving populations with unique needs***

Efforts to facilitate EHR adoption and meaningful use cannot be focused only on easy-to-reach and easy-to-serve populations. In fact, certain groups have an even greater need for coordinated care than others. As stated in Oregon’s HIE Strategic Plan, Oregon’s HIE strategy will keep these groups in mind at each stage of planning and implementation, and the Medicaid HIT Project can play a key role in the successful integration of these populations:. These include Medicaid beneficiaries including individuals who are:

- Medically underserved,
- Newborns and children,
- Elderly or disabled,
- Those with mental and substance abuse disorders, and/or
- American Indians and Alaskan Natives.

***Long-term care HIT plan***

As described in Oregon’s PAPD Update, the long-term care HIT plan (to be included in a later update to Oregon’s SMHP) will focus on exploring activities to encourage or facilitate adoption and meaningful use of certified EHRs for Medicaid nursing facilities in Oregon. Activities include an environmental scan of nursing facilities’ use of EHRs, exploring the CMS system ASPEN and its parent company ALPINE as sources for developing a low-cost EHR for nursing facilities, coordinating with stakeholders to identify other opportunities for facilitating EHR adoption. To facilitate this work and other work related to long-term care and HIT, the Medicaid HIT Executive Steering Committee includes a representative from DHS Seniors and Persons with Disabilities Division.

***Community behavioral health HIT plan***

As described in Oregon’s PAPD Update, the community behavioral health HIT plan (to be included in a later update to Oregon’s SMHP) will focus on activities to promote EHR adoption for community addictions and mental health providers delivering Medicaid services. Activities include an environmental scan of behavioral health providers’ use of EHR, planning for the release of a state-provided community-electronic behavioral health record (see page 25 for information on OWITS), linking community providers to the BHIP within the Oregon mental health state hospital system, working with HITOC to develop a behavioral health component to the state HIE strategic and operational plans, and working with HITOC around standards definitions for data transfer. To facilitate this work and other work related to community behavioral health and HIT, the Medicaid HIT Executive Steering Committee includes a representative from OHA Addictions and Mental Health Division.

**5. Other Medicaid HIT strategies**

***Technical assistance to providers***

The Medicaid HIT Project team works closely with O-HITEC to assess the technical assistance available to Medicaid providers. Oregon is assessing any gaps in technical assistance and identifying strategies to fill those gaps, either directly (e.g., via public health program technical assistance regarding meeting one of the public health meaningful use criteria) or by enhancing the technical assistance capacities of its partners, including O-HITEC.

In particular, Oregon is concerned about four critical access hospitals that do not currently have EHRs, and who may be unlikely to obtain one without significant assistance. These CAH’s may not be eligible for Medicaid incentive payments and are not within larger integrated health delivery systems. The Medicaid HIT Project is coordinating with O-HITEC and other partners to identify strategies to obtain and install EHRs for these CAHs, and provide comprehensive technical assistance to bring these hospitals to meaningful use.

## V. Medicaid EHR Incentive Program

### *Section Overview*

- Oregon has assessed all areas of state discretion, and has opted for approaches that maximize incentive payments to Oregon professionals and hospitals, where possible. For example, Oregon has chosen a three-year payment structure to maximize hospital incentive payments early in their participation in the program.
- Most Oregon eligible professionals will use patient encounter methodology for calculating patient volume. Eligible professionals in Oregon will also have the option to use the patient panel methodology to calculate patient volume if it is applicable for the provider's circumstances.
- Regarding meaningful use, Oregon is requesting approval to move the immunization registry reporting menu-set objective to the list of core objectives for Oregon's incentive program.
- Applicants will access the incentive program application via the Provider Web Portal, and will use Oregon's software application (called Medical Assistance Provider Incentive Repository, or MAPIR) to attest to their eligibility for incentives. MAPIR is being built under contract with Hewlett Packard (HP) through a collaborative of 13 states whose MMIS systems were built by HP.
- File exchange testing between the CMS National Level Repository (NLR) and MAPIR will take place as part of the CMS Group 2 states testing in winter/spring of 2011. Oregon has completed its connectivity testing with the NLR.
- The Medicaid EHR Incentive Program is being developed by Oregon's Medicaid HIT Project Team. Incentive program operations will be administered by Oregon's Medicaid agency operations section in conjunction with the Medicaid HIT Project Team.

### **1. Introduction**

Federal law and CMS regulation defines the Medicaid EHR Incentive Program and allows for particular areas of state discretion. Oregon has chosen to use the areas of state discretion to set state-specific rules to maximize provider eligibility for incentive payments while balancing the confines of CMS rules and state administrative efficiency. Some areas of state discretion include:

- Methodology for calculating patient volume (patient encounter, patient panel, and/or an alternate method),
- Out-of-state Medicaid patients allowed in patient volume calculations, and
- Hospital payment structure,
- Discretion to move four menu-set meaningful use criteria to the required set of core meaningful use measures.

Oregon is implementing the Medicaid EHR Incentive Program by building upon existing business processes where possible to streamline the process for providers. Examples of this are utilizing the Provider Web Portal for providers to apply to the incentive program, and using existing audit resources and existing provider support services.

## 2. Program Development

### 2A. Program rules

The following section describes the CMS rules for eligibility and calculation of payment amounts for eligible hospitals and professionals. Due to the complexity of some program rules, and refinements related to Oregon Medicaid policy or decisions on areas of state discretion, the Medicaid HIT Project has developed a Frequently Asked Questions (FAQs) feature on its website.<sup>44</sup> These FAQs are routinely updated and seek to address the common questions stakeholders have about Oregon's incentive program.

#### ***Eligible hospitals***

Hospitals may qualify for, and receive, both Medicare and Medicaid incentive payments. Requirements for each program are slightly different. To qualify for Medicaid incentive payments, hospitals must:

- Meet eligibility requirements (see below) and
- Adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology during their first participation year, and
- Successfully demonstrate meaningful use of certified EHR technology in subsequent participation years.

Most Oregon hospitals are expected to meet eligibility requirements for Medicaid incentive payments, and all appear to meet eligibility requirements for Medicare incentives. Although all hospitals in Oregon are expected to meet the eligibility requirements for hospital type, average length of stay, and CMS Certification Number (CCN), as many as nine of Oregon's 58 hospitals may not meet the 10% Medicaid patient volume criteria. For more information, see page 13 in the environmental scan section of this SMHP.

Communications by the State through the Oregon Association of Hospitals and Health Systems (OAHHS) have already begun the process of educating hospitals regarding the details of the patient volume requirements. As mentioned earlier, analysis of Oregon hospital eligibility have been shared and discussed with the Oregon Association of Hospitals and Health Systems (OAHHS) and with Oregon's hospitals (see page 13, and for the full results, see Appendix B). In addition to collaborating with the OAHHS who communicates with its members, Oregon's incentive program staff is working with O-HITEC, who will be providing technical assistance to all 25 CAHs and some of Oregon's 8 rural hospitals, to ensure that they communicate clearly around hospital eligibility and payment calculation for Medicaid EHR incentives. Further, incentive program staff has presented, or will be presenting, at several opportunities, including the rural hospital section meeting, OAHHS technical advisory committee, and the Healthcare Financial Management Association meeting for hospital and other health care financial managers.

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<sup>44</sup><http://www.oregon.gov/DHS/mhit/docs/mhit-fags.pdf>

### Recap of Federal Eligibility Rules for Hospitals

Eligible hospitals for the Medicaid program include either of the following:

- Acute Care Hospitals (including Critical Access Hospitals) having -
  - An average length of patient stay of 25 days or fewer
  - The last four digits CMS Certification Number (CCN) in the series = 0001-0879 or 1300-1399 and
  - 10% Medicaid patient volume\*
- Children's Hospitals having the last four digits CMS Certification Number in the series = 3300-3399

\*Eligible Hospital Patient Volume Methodology:

<b>Total Medicaid patient encounters**</b>
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<b>Total patient encounters**</b>

\*\*In any representative continuous 90-day period in the preceding calendar year

For hospitals, a **Medicaid encounter** means one of the following:

1. Services to an individual per inpatient discharge where:
  - Medicaid paid for part or all of the service; or
  - Medicaid paid all or part of the individual's premiums, co-payments, and/or cost-sharing
2. Services rendered in an emergency department on any one day where:
  - Medicaid paid for part or all of the service; or
  - Medicaid paid all or part of the individual's premiums, co-payments, and/or cost-sharing

#### Qualifying criteria for eligible hospitals:

Eligible hospitals may qualify for Medicaid incentive payments if they

- Adopt, implement, or upgrade to certified EHR technology during their first participation year or demonstrate meaningful use, and
- Demonstrate meaningful use of certified EHR technology in subsequent participation years.

Medicaid hospitals that qualify for incentive payments may begin receiving payments in any year from federal fiscal year (FFY) 2011 to FFY 2016. The federal fiscal year is October 1st to September 30th.

**Recap of Hospital payment calculation rules**

The Medicaid incentive payment amount is calculated once to determine the aggregate EHR incentive amount and then spread over all years of a hospital's payments. The aggregate EHR incentive amount is the product of the **Overall EHR Amount** and **the Medicaid Share**.

**Aggregate EHR Amount** (product of the Overall EHR amount and Medicaid Share)

**Overall EHR Amount**

The Overall EHR Amount is the product of an Initial Amount, the Medicare Share, and a Transition Factor calculated for each of four theoretical payment years and then summed.

Theoretical Year:	Year 1	Year 2	Year 3	Year 4
<b>Initial amount (also see table below) =</b>	(a base amount of \$2,000,000) + (Year 1 discharge-related amount)	(a base amount of \$2,000,000) + (Year 1 discharge-related amount x average annual rate of growth)	(a base amount of \$2,000,000) + (Year 2 discharge-related amount x average annual rate of growth)	(a base amount of \$2,000,000) + (Year 3 discharge-related amount x average annual rate of growth)
<b>Medicare share =</b>	1	1	1	1
<b>Transition factor =</b>	1.00	0.75	0.50	0.25
<b>Total Yearly EHR amount:</b>	(Initial amount) x (Medicare share) x (Transition factor)	(Initial amount) x (Medicare share) x (Transition factor)	(Initial amount) x (Medicare share) x (Transition factor)	(Initial amount) x (Medicare share) x (Transition factor)
<b>Overall EHR Amount =</b>	<b>Sum of the 4 Yearly EHR Amounts</b>			

*Initial amount (calculated for each theoretical payment year)*

The initial amount is the sum of a base amount and a discharge-related amount. The base amount is \$2,000,000, and the discharge-related amount provides an additional \$200 for estimated discharges between 1,150 and 23,000 discharges. No payment is made for discharges prior to the 1,150th discharge or for discharges after the 23,000th discharge. See table below.

	Hospitals with ≤ 1,149 discharges during the payment year	Hospitals with ≥ 1,150 ≤ 23,000 discharges during the payment year	Hospitals with ≥ 23,001 discharges during the payment year
<b>Base Amount</b>	\$2,000,000	\$2,000,000	\$2,000,000
<b>Discharge-Related Amount*</b>	\$0	\$200 x (n - 1,149) (n is the number of discharges during the payment year)	\$200 x (23,001 - 1,149)
<b>Adjusted by average annual rate of growth</b>	Average of most recent three years annual rate of growth in total discharges		
<b>Total Initial Amount</b>	\$2,000,000	Between \$2,000,000 and \$6,370,400 depending on the number of discharges	Limited by law to \$6,370,400

Hospital discharge data will be derived from discharges during the hospital fiscal year that ends during the federal fiscal year prior to the hospital fiscal year that serves as the first payment year.

**Medicaid share:**

The Medicaid share incorporates the proportion of Medicaid bed days out of total bed days adjusted for charity care. See formula below:

$$\frac{\text{Estimated \# of inpatient-bed-days attributable to Medicaid*, including: fee-for-service, managed care, pre-paid inpatient health plan, or pre-paid ambulatory care plan}}{(\div)} \times \frac{\text{Estimated total amount of the eligible hospital's charges during that period \underline{minus} charity care}}{\text{Estimated total amount of the eligible hospital's charges during that period \underline{including} charity care}}$$

Estimated total # of inpatient-bed-days for the eligible hospital during that period

\*Most hospitals will be eligible for both a Medicare and a Medicaid EHR incentive payment. For purposes of calculating the Medicaid share, a patient cannot be counted in the numerator if they would count for purposes of calculating the Medicare share for a Medicare incentive payment. Thus, in this respect the inpatient bed day of a dually eligible patient could not be counted in the Medicaid share numerator.

**Average Annual Growth Rate:**

To calculate the average annual growth rate the hospital will report the total discharges from the four most recent hospital fiscal year cost reports. Total discharges are the sum of *all inpatient discharges*. The annual growth rate calculation for each year is: [(Total Discharges for the Year) – (Total Discharges for the Previous Year)] ÷ (Total Discharges for the Previous Year). See the following example.

Fiscal Year	Total Discharges	Calculating Annual Growth Rate	Annual Growth Rate
2010	2,000	(2,000 – 1,918) ÷ 1,918	4.3%
2009	1,918	(1,918 – 1,835) ÷ 1,835	4.5%
2008	1,835	(1,835 – 1,745) ÷ 1,745	5.2%
2007	1,745		
<b>Average Annual Growth Rate</b>		<b>(4.4+4.5+5.2) ÷ 3</b>	<b>4.7%</b>

**Example calculation**

<b>Determination of Medicaid share for Hospital A</b>	
FY 2010 discharges	2,000
Medicaid inpatient bed days	7,000
Inpatient bed days	21,000
Total charges excluding charity care	\$8,700,000
Total charges for the period	\$10,000,000
<b>Determination of annual growth rate for Hospital A</b>	
FY 2010	4.3% annual growth rate
FY 2009	4.5% annual growth rate
FY 2008	5.2% annual growth rate
Average	4.7%

Medicaid Share calculation	$\frac{7,000}{21,000 \times (8,700,000/10,000,000)}$	= 0.38
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Aggregate EHR Incentive Amount							
	Initial amount			Transition factor	Yearly EHR amount (Initial x Transition)	Medicaid share	Aggregate EHR Incentive Amount (Yearly EHR Amount x Medicaid share)
	Base amount	Discharge related amount					
		Discharges (Years 2-4 adjusted by 4.7% average annual rate of growth)	Total discharge related amount				
Year 1	\$2m	200 x (2000-1149)	170,200	1	\$2,170,200		
Year 2	\$2m	200 x (2094-1149)	189,000	0.75	\$1,641,750		
Year 3	\$2m	200 x (2192-1149)	208,600	0.5	\$1,104,300		
Year 4	\$2m	200 x (2295-1149)	229,200	0.25	\$557,300		
<b>Total</b>					<b>\$5,473,550</b>	<b>0.38</b>	<b>\$2,079,949</b>

**Eligible professionals**

An eligible professional (EP) can receive \$63,750 over the course of six years. Eligible professionals can receive payments for up to six years; payment years do not need to be consecutive. Payment for Year 1 is \$21,250, and for each subsequent year is \$8,500. EPs must initiate participation no later than 2016. EPs may choose to assign their payments to an entity or employer as specified in the federal regulation.

Eligible professionals may qualify for Medicare and Medicaid incentive payments, but must choose which program in which to participate. Requirements for each program are slightly different. To qualify for Medicaid incentive payments, EPs must:

- Meet eligibility requirements (see text boxes below) and

- Adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology during their first participation year, and
- Successfully demonstrate meaningful use of certified EHR technology in subsequent participation years.

### Recap of Federal Eligibility Rules for Eligible Professionals

Under the Medicaid EHR Incentive Program, eligible professionals include the following:

- **Physicians** (MD, DO) – Doctor of Medicine and Doctor of Osteopathy<sup>45</sup> (Pediatricians have special eligibility and payment rules)
- **Nurse Practitioners** (NPs), including Nurse-Midwife Nurse Practitioners
- **Dentists**
- **Physician Assistants** (PAs) who provide services in a Federally Qualified Health Center (FQHC) or rural health clinic (RHC) that is led by a PA (see below)

A Physician Assistant (PA) must be in an FQHC/RHC that is “so led” by a PA. Federal rule defines “so led” to be:

1. When a PA is the primary provider in a clinic (e.g., when there is a part-time physician and full-time PA, the PA is considered to be the primary provider), or
2. When a PA is a clinical or medical director at a clinical site of practice, or
3. When a PA is an owner of the FQHC or RHC.

#### ***Patient volume criteria background***

To qualify for an EHR incentive payment, a Medicaid eligible professional (EP) must not be hospital-based (except those practicing in an FQHC/RHC) and must meet one of the following criteria:

- Have a minimum 30% Medicaid patient volume,
- Have a minimum 20% Medicaid patient volume, and is a pediatrician, or
- Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals.

#### ***Hospital-based***

A Medicaid EP is considered hospital-based if 90% or more of the EP's services are performed in a hospital inpatient or emergency room setting. This provision does not apply to EPs in an FQHC/RHC.

#### ***Medicaid encounters***

Medicaid encounters include services rendered on any one day to an individual where Medicaid paid for part or all of the service, premiums, co-payments, and/or cost-sharing. Children's Health Insurance Program (CHIP) patients do not count towards the Medicaid patient volume criteria.

#### ***Needy individual encounters***

Only providers who work predominantly in a FQHC or RHC may use “needy individual” encounters in the patient volume calculation. To be considered a provider who works predominantly in a FQHC/RHC, over 50% of his or her total patient encounters over a period of six months in the most recent calendar year must occur at the FQHC/RHC location.

Needy individual encounters include services rendered on any one day to an individual where:

- Medicaid (Title XIX) paid for part or all of the service, premiums, co-payments, and/or cost-sharing;
- CHIP (Title XXI) paid for part or all of the service, premiums, co-payments, and/or cost-sharing;
- Services were furnished at no cost by the provider; or
- Services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay.

<sup>45</sup> Although the CMS final rule indicates that some states may have Medicaid policy that considers optometrists to provide physician services which would qualify them for an incentive payment, Oregon Medicaid policy does not include optometrists as providing Medicaid physician services, and therefore optometrists are not eligible for a Medicaid incentive payment.

**Patient volume calculations for EPs**

The incentives for eligible professionals (EP) are paid to individual providers. Therefore, for group practices or clinics, each eligible professional may qualify for an incentive payment provided they meet all eligibility criteria and requirements. Each EP is eligible for only one incentive payment each year, regardless of how many practices or locations in which they provide services.

**Individual vs. group patient volume**

Eligible professionals may calculate their patient volume based on their individual patient encounters. However, the patient volume may be calculated on a group level. For providers in a clinic or group to use the group patient volume calculation, several factors must be met:

- The clinic or group practice’s patient volume is appropriate as a patient volume calculation for the EP.
- There is an auditable data source to support the clinic’s or group practice’s patient volume determination.
- All EPs in the group practice or clinic must use the same methodology for the payment year.
- The clinic or group practice uses the entire practice or clinic’s patient volume and does not limit patient volume in any way. This means the services of all providers in the group (including non-EPs) must be counted toward the group patient volume.
- If an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP’s outside encounters.

**Patient encounter methodology**

The patient encounter option stipulates that EPs must have a minimum of 30% (20% for pediatricians) of all patient encounters attributable to Medicaid during a 90-day period in the most recent calendar year prior to the year of reporting and is represented in the following formula:

$$\frac{\text{Total Medicaid (or needy individual*) patient encounters**}}{\text{Total patient encounters**}}$$

\*Providers who work predominantly in an FQHC/RHC may use “needy individual” encounters

\*\*In any representative 90-day period in the most recent calendar year.

**Patient panel methodology**

The patient panel option stipulates that EPs must have a minimum of 30% (20% for pediatricians) of the total Medicaid or needy individuals patient assigned to the EP, with at least one encounter taking place during the calendar year preceding the start of the 90-day period, plus unduplicated Medicaid or needy individual encounters in the same 90 day period.

$$\frac{\text{Total Medicaid (or needy individual*) patients assigned to the provider** with at least one encounter in the prior year} + \text{Unduplicated*** Medicaid (or needy individual*) encounters**}}{\text{Total patients assigned to the provider** with at least one encounter in the prior year **} + \text{Unduplicated*** encounters**}}$$

\*For providers who practice predominantly in a FQHC/RHC, use "needy individuals" which includes Medicaid along with other individuals.

\*\*In any representative continuous 90-day period in the preceding calendar year

\*\*\*Unduplicated means: a patient counted as assigned to a provider that also had an encounter should only be counted once in the calculation.

**Examples of eligible professional calculations**

<b>Patient Encounter Calculation Example</b>				
<b>Step</b>	<b>Calculation Component</b>	<b>Action</b>	<b>Example Notes</b>	<b>Example formula input</b>
Step 1	Time frame	Pick a 90-day period in the prior calendar year		Jan 1,2010 - Mar 31,2010
Step 2	Numerator	Count Oregon Health Plan (OHP) encounters in the selected 90-day period and reduce by CHIP proxy of 4.4%* *see page 57 for CHIP proxy description	Example - 300 OHP patients were seen on any one day where OHP paid for all or part of the encounter or where OHP paid for premiums or copays. Reduce number by 4.4% to eliminate CHIP encounters	$300 * 95.6\% = 287$
Step 3	Denominator	Count total encounters in the selected 90-day period	Example - 500 total patients in 90-day period	500
Step 4	Calculate Patient Volume	Divide Step 2 by Step 3	$287/500$	<b>60%</b>

<b>Patient Panel Calculation Example</b>				
<b>Step</b>	<b>Calculation Component</b>	<b>Action</b>	<b>Example Notes</b>	<b>Example formula input</b>
Step 1	Time frame	Pick a 90-day period in the prior calendar year		Jan 1,2010 - Mar 31,2010
Step 2	Numerator 1	Count patients on your panel in the selected 90-day period who had at least one OHP encounter in the entire prior calendar year and reduce by CHIP proxy of 4.4% (see page 57 for CHIP proxy description)	Example - 300 OHP patients on a panel in the 90 day period. Of those, 250 were seen at least once in 2010. Reduce number by 4.4% to eliminate CHIP patients.	$250 * 95.6\% = 239$
Step 3	Numerator 2	Count all other Medicaid patients not assigned to any panel who were seen in the selected 90 day period and reduce by CHIP proxy of 4.4%	Example - 100 additional Medicaid patients were seen who were not on any other providers' panel. Reduce by 4.4%.	$100 * 95.6\% = 96$
Step 4	Total Numerator	Add Step 1 and Step 2	$239 + 96$	335
Step 5	Denominator 1	Count <u>all</u> patients on your panel in the 90-day period selected who had at least one encounter in the entire prior CY	Example - 500 total patients on a panel in 90-day period; of those, 450 were seen in Jan-Dec 2010	450

Patient Panel Calculation Example				
Step 6	Denominator 2	Count <u>all</u> other patients not assigned to any panel who were seen in the selected 90 day period	Example - 200 additional patients were seen who were not on any other providers' panel	200
Step 7	Total Denominator	Add step 5 and step 6	450 + 200	650
Step 8	Calculate Patient Volume	Divide results of Step 4 by results of Step 7	335/650	52%

**2B. Oregon stakeholder input**

The project team has been working with stakeholder groups to obtain input to guide Oregon’s development on multiple areas of state discretion. Stakeholder groups include HITOC (in addition to key state executives, policy makers and state staff, members are representative of both large health systems and rural hospitals, health plans, tribal clinics, independent physician associations, business, and consumers). Strong support from Oregon Association of Hospitals and Health Systems (OAHHS), Oregon Medical Association, Medicaid managed care organizations, Medicaid dental care organizations, tribes, consumer groups, county and local health departments, and others has been evident throughout the planning process. The project team will continue to seek opportunities to meet with and present to these groups and their constituents, using these opportunities to share information about Oregon’s Medicaid EHR Incentive Program as well as to solicit input on areas of state discretion.

**Medicaid EHR Incentive Program stakeholder survey**

On November 19, 2010, the Medicaid HIT project invited Oregon stakeholders to participate in a Web-based survey. The survey was sent via e-mail to 1,057 stakeholders, targeting Medicaid providers that meet the incentive program categories for eligible professional, hospitals, Medicaid managed care organizations (MCOs), professional organization representatives and key stakeholder organizations. Of these, 137 stakeholders responded, for a response rate of 13%. Full survey results can be found in Appendix E.

The purpose of the survey was to obtain quick feedback that would inform and guide the project’s analysis. Survey areas included provider eligibility, focusing on patient volume methodologies, hospital eligibility and project communication and outreach. See the table below response rates by type of respondent.

**Medicaid HIT Stakeholder Survey Respondents**

Respondent Type	Number	Percentage
Individual health care providers	36	26%
Group representatives such as clinic, managed care organization, or health care professional representatives	48	35%
Other stakeholders	41	30%
Hospital representatives	12	9%
<b>Total</b>	<b>137</b>	<b>100%</b>

*Patient volume calculation: Survey results*

While the majority (61%) of the respondents reported they would choose the patient encounter method compared to a small handful (9%) who chose patient panel, most (53%) felt that Oregon should offer the choice. Only 7% felt that the patient encounter method alone should be offered and 40% were not sure. Many

respondents (45%) were also not sure whether including out-of-state patients would make a difference in whether a provider would qualify for the program. (For a description of patient volume methodologies, patient encounter and patient panel, please see pages44-48.)

*Patient volume calculation: Targeted stakeholder outreach*

Based on the survey results demonstrating that at least a few providers would select the patient panel methodology, and that most stakeholders supported offering providers the option between patient encounter and patient panel methods, project staff sought further stakeholder input from Medicaid MCOs and provider associations. In December 2010, staff met with representatives of seven MCO or association organizations that represent providers from different geographic regions in both urban and rural settings. These discussions focused on whether patient panel calculations could be appropriately documented for verification or audit purposes.

Stakeholder organizations reported that documentation required to support the patient panel methodology would vary significantly depending on the practices of the clinic or MCO, but appropriate documentation may be possible for some providers and/or some MCOs. Even if the MCOs can provide the information on Medicaid patients, providers would need to have the capability of compiling the information on all the other plans that they accept. In some cases that would be manageable, in others very challenging, and probably impossible for those offices that are currently on paper records. Further, patients come on and off Medicaid, and move between provider offices. This could make it difficult for providers to define a panel that is static enough to validate.

**2C. Oregon-specific decisions**

As mentioned earlier, while CMS set most of the rules for the incentive program, each state has several areas of state discretion. As noted in the above section, the project has been gathering input from various stakeholder groups to guide Oregon's development of multiple areas of state discretion. Oregon's decisions for these areas are presented in this section.

***Decision - Methodologies for eligible professional patient volume: Oregon will adopt the patient encounter and patient panel methodologies.***

CMS requires that states be able to verify and audit patient volume calculations for eligible professionals. The optimal scenario is to adopt calculation methods that will allow the most providers to qualify for the program without creating undue administrative burden for applicants or for the incentive program staff processing applications.

The adoption of both the patient encounter and patient panel methodologies gives the greatest flexibility for Oregon providers to qualify for incentive payments. Recent communications with CMS indicate that a patient panel methodology must apply to both individual patient volume calculations, as well as to group patient volume calculations. Although Oregon had prepared for the likelihood of allowing patient panel for individual calculations, the Medicaid HIT Project Team had not anticipated the inclusion of a group patient panel methodology in the MAPIR design. Until a design change can be made, Oregon incentive program staff will work directly with providers using group patient panel methodology to select the MAPIR individual patient panel and provide additional documentation to support the group information.

Oregon is interested in ideas for alternate methodologies that would allow more professionals to become eligible for incentives. Oregon will continue to explore ideas for an alternate methodology for future years of the program.

***Decision - Out-of-state patients:*** Oregon will allow providers to include out-of-state Medicaid patients towards patient volume to increase the eligibility of providers for incentive payments.

Oregon will work with its border states to develop an approach to validate out-of-state patient encounters.

***Decision - Medicaid managed care plan not to exceed 105% capitation rate:*** Oregon will not disburse incentive payments through Medicaid managed care plans, but will make payments directly to providers (or their assignees) and hospitals via MMIS.

Due to this decision, there are no extra steps needed to assure the incentive payment for Medicaid managed care providers does not exceed 105% capitation rate.

***Decision - Payment structure for eligible hospitals:*** Oregon's hospital payment structure is as follows:

- Year One Participation = 50% aggregate EHR incentive amount
- Year Two Participation = 40% aggregate EHR incentive amount
- Year Three Participation = 10% aggregate EHR incentive amount

Oregon selected a three-year payment structure for hospital incentives that maximizes payments early in the program. This decision was based on stakeholder feedback and a financial analysis of the impact of incentives on the ability of critical access hospitals' ability to purchase EHRs and the technical assistance and reduction of income required to meet meaningful use criteria. The result is that hospitals will be paid over three years of qualified participation in the Oregon Medicaid EHR Incentive Program.

As with eligible professionals, Oregon will authorize and pay the full amount of each incentive payment due to the hospital through the MMIS system.

***Decision - Payments to entities promoting adoption of EHRs:*** Oregon providers will not be making payments to "entities promoting the adoption of certified EHR technology" because Oregon has not designated any such entities.

CMS allows eligible professionals to voluntarily assign their incentive payments to their clinic or employer or to state-designated entities, defined in federal rule as, "entities promoting the adoption of certified EHR technology." CMS requires states to ensure that any assignments to these latter entities are made voluntarily by the eligible professional, and that no more than 5% of such payments is retained by the entity for costs unrelated to EHR technology adoption.

CMS requires "entities promoting the adoption of certified EHR technology" to be designated by the state and subsequently approved by the US DHHS Secretary, and defines their functions as:

- Enabling oversight of the business, operational and legal issues involved in the adoption and implementation of certified EHR technology or
- Enabling the exchange and use of electronic clinical and administrative data between participating providers, in a secure manner, including maintaining the physical and organizational relationship integral to the adoption of certified EHR technology by eligible professionals.

"Entities promoting the adoption of certified EHR technology" differ somewhat in purpose and function from Regional Extension Centers (RECs). RECs receive federal grant funds to provide technical assistance to primary care, small, and solo practice clinicians in selection, acquisition, implementation and meaningful use of certified

EHR technology. Eligible professionals engage RECs and may use a portion of their incentive payment to pay for REC services, but unless a REC is state-designated as an “entity promoting the adoption of certified EHR technology,” an eligible professional may not assign their incentive payment to a REC at the time of application.

At this time, Oregon does not foresee designating any such entities in the future, but is interested in any further clarification from CMS as to the nature of these entities and their relationships with eligible professionals.

***Decision - Meaningful use menu-set items:*** Oregon is requesting CMS approval to move the immunization registry reporting objective to the list of core objectives for the Medicaid EHR Incentive Program.

The Medicaid HIT Project leadership and staff worked closely with the OHA Public Health Division and other stakeholders to weigh the costs and benefits of moving any of the four discretionary menu-set meaningful use objectives to the core set for Oregon. This included an evaluation of public health system readiness to accept the data and an assessment of provider burden and benefit.

*Potential benefit to Medicaid population*

Data in Oregon’s ALERT immunization registry are consolidated to ensure a complete, accurate record for every Oregonian, and are used to keep the population up-to-date and protected against vaccine preventable disease. The state also needs to gather this information to make policy decisions, as in times of epidemics such as H1N1. The immunization meaningful use requirement presents an opportunity for the state to capture data it needs to do its job for the benefit of both the public and private sectors. The Medicaid population often changes clinics and providers, and having accurate immunization records would help the individual health of Medicaid clients, as well as overall population health.

*Impact to providers, including any potential barriers*

To meet the immunization registry reporting objective, providers will need to configure their EHRs to transmit messages to Oregon’s registry, and some providers will need to purchase additional technical modules associated with meeting this requirement. However, providers are likely to see specific benefits related to eliminating the need for duplicate entry of immunizations, and receiving immunizations registry information electronically.

There is concern that has been voiced by a few providers, that some may perceive that the elimination of choice by making immunization registry reporting a core objective would add burden to those implementing certified EHRs, while others have expressed support for the recommendation.

*Status of ALERT: Oregon’s new immunization registry*

In terms of technical capacity, Oregon’s ALERT IIS immunization registry is ready to accept provider submissions required to meet the meaningful use requirement.

- *ALERT rollout status:* The new ALERT IIS, which replaces and combines the old ALERT and IRIS registries, began rolling out the last week of November 2010 and is planned to complete statewide rollout by the summer of 2011.
- *ALERT standards:* The ALERT IIS immunization registry currently supports one of two standard formats required by ONC to meet the requirements of this program for certified EHRs (HL7 messages in 2.3.1 format), and will support the second messaging format by mid-2011 (HL7 messages in 2.5.1 format). ALERT IIS accommodates standardized vaccine code sets as required by certified EHRs.
- *ALERT participation:* At present, 70 sites are submitting HL7 messages to ALERT IIS and another 30 sites are submitting HL7 messages to the old ALERT registry. Another 225 sites will be targeted to encourage

their transition to HL7 message submission within the next 2 years. There are currently approximately 1,500 total sites reporting to the immunization registries in Oregon.

- *Technical assistance and support:* The Immunization Program provides transition plans, technical documentation and staff training to help providers transition to the new ALERT IIS and submission of HL7 messages. Existing technical and operational staff from both the Immunization Program and O-HITEC, Oregon's Regional Extension Center, will be available to provide technical assistance to providers or to work with the EHR vendors as needed. Providers in solo or small practices may not have vendor support and may require more attention than those in a larger practice. O-HITEC is still defining how support will be provided to providers, but is aware of the need.

#### *Technical support grants for immunization registry interoperability*

The Immunization Program has two grants to support providers in their transition to submission of HL7 messages to the ALERT IIS. A CMS IIS-EHR Interoperability grant funded nine pilot systems to serve as models for seven different vendor EHRs to implement HL7 message exchange via a real-time web service. A CDC interoperability grant will offer mini-grants to providers for technical assistance, to develop an interface, or to purchase software to enable exchange of HL7 messages.

The placement of all of the Public Health meaningful use objectives in the menu set, and none in core, has raised concerns that Public Health needs are not central to the implementation of HIE and meaningful use at the federal level. With this request for approval to move one of the Public Health objectives, immunization registry reporting, to core Oregon wants to send an unequivocal statement that Public Health needs are every bit as "core" as the objectives focusing on direct patient care.

***Decision - Oregon Administrative Rules:*** *New Oregon Administrative Rules will be needed to support the operations and auditing of the Medicaid EHR Incentive Program, and will align with the current Medicaid OARs.* Project staff members are working with Medicaid rules coordinators and operations and policy staff to draft incentive program rules, convene a Rules Advisory Committee (scheduled for mid-February), solicit and address public comments, and finalize rules in spring or summer 2011.

### **3. Technology**

This section describes the technology systems required to implement the incentive program, and use of technology to communicate with providers about incentives.

#### **3A. Systems needed to implement the incentive program**

Oregon will use its MMIS, including the Provider Web Portal, and a new software application, MAPIR, integrated into MMIS to implement its Medicaid EHR Incentive Program.

##### ***Oregon MMIS***

Oregon's current MMIS is undergoing CMS certification. Medicaid contracts with HP for its MMIS, which went live on December 9, 2008. Incentive payments to eligible professionals and hospitals will be processed through the MMIS and all fiscal functions related to the incentive payments, such as tax reporting, will be captured by the MMIS.

##### ***The Provider Web Portal***

Medicaid providers seeking to participate in the EHR Incentive Program will interface with the MMIS via the Provider Web Portal. Once the provider has logged into the Provider Web Portal they will select the "EHR Incentive Program" option to either initiate or continue their application for an incentive payment. Upon selecting this option they will exit the Provider Web Portal and be sent to the MAPIR application where all

Medicaid EHR Incentive Program functionality related to the incentive program will be executed and stored (see below).

The Provider Web Portal is a secure site that requires the user to have signed a security agreement. Online help is available to guide the user through any issues and a toll-free number is available for user support. The portal provides free, real-time information to providers and is available 24 hours a day, seven days a week, except regularly scheduled down time on the weekend. The modifications to the Provider Web Portal to accommodate Oregon's incentive program will be minimal and should not impact any other state systems. The existing security developed for the Provider Web Portal will be leveraged to provide authentication such that only providers registered in the Oregon MMIS will have access to the MAPIR application. Once the provider has passed through that authentication, they will be able to enter Oregon's incentive program attestation system, MAPIR. Including MAPIR within the Provider Web Portal encourages providers to increase participation in other electronic processes that are conducted through the Provider Web Portal.

*Medical Assistance Provider Incentive Repository (MAPIR)*

MAPIR is a web-based software application that providers and hospitals will use to apply for their incentive payment. MAPIR is developed and purchased by a collaborative of 13 states led by Pennsylvania. Oregon joined the MAPIR collaborative in fall 2010. HP is building MAPIR under its contract with Pennsylvania for their MMIS system, and each state is paying an even share of the costs of the core MAPIR application via its state MMIS contract with HP. Pennsylvania received CMS approval of an HIT IAPD for core MAPIR – this document will be appended to Oregon's HIT IAPD. Oregon is pursuing contract amendments to secure MAPIR: one to purchase core MAPIR and another amendment to purchase the installation, integration, configuration, testing, and any customization work required to integrate MAPIR into Oregon's MMIS environment and to launch the state's incentive program.

MAPIR will support in part or in whole the following aspects of professional and hospital attestation and payment processes required to carry out Oregon's Medicaid EHR Incentive program:

- Provider applicant verification,
- Provider applicant eligibility determination(including NLR confirmation),
- Provider applicant attestation,
- Provider application payee determination,
- Application submittal confirmation/electronic signature or secure confirmation,
- Medicaid payment determination (including NLR confirmation), and
- Payment generation.

In addition, MAPIR will interface with the National Level Repository (NLR) as well as individual states' MMIS to allow providers to complete applications and generate incentive payments to eligible professionals and hospitals. MAPIR will have both a provider and a user component (for use by the Medicaid HIT Project staff). MAPIR will be scalable to allow for growth in provider participation volume, and expansion or extensions of the Medicaid EHR Incentive Program. MAPIR is configurable to allow Oregon the flexibility to make program decisions allowed within federal regulation that may be different from the other 12 MAPIR state programs.

The following list summarizes how MAPIR fits into the larger context of State information systems:

- MAPIR interacts with the NLR to facilitate file transactions to and from CMS.
- MAPIR interacts with the Oregon MMIS (inclusive of the payment functionality within the MMIS, often referred to SFMA - Statewide Financial Management Application) for the purpose of information exchange and EHR Incentive Payment processing.

- The DHS/OHA Provider Web Portal is the security access point and gateway to MAPIR. Through the Provider Web Portal the EHR applicant accesses MAPIR.
- The MAPIR application does not interface with any other systems. MAPIR is a sub-system of the MMIS.
- All new components (hardware, software, email and licenses) that support MAPIR are not intended at this time to integrate or be integrated into any other state or federal information system.

**System changes needed and timeframe**

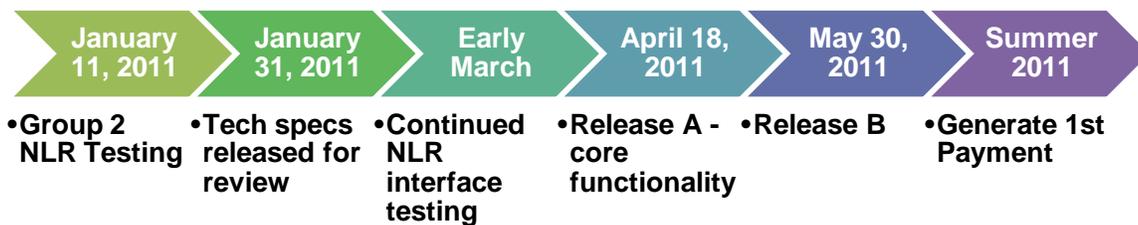
To implement Oregon’s incentive program, MMIS system changes will be required, including work to integrate MAPIR into Oregon’s existing MMIS and Provider Web Portal. As part of this integration, Oregon will develop and follow a set of state-specific MAPIR requirements. The goal for the State is to minimize customization of the MAPIR application to the extent possible, while assuring that the application is fully compliant with state statute, departmental policy, and administrative rules. However, setting up the configurable items within MAPIR to meet Oregon’s requirements and some limited customization of MAPIR may be needed to implement Oregon’s incentive program.

Oregon has worked closely with the MAPIR design team in Pennsylvania to ensure that the MAPIR design is flexible enough to integrate Oregon’s business process and at the same time be robust enough to support all aspects of the state’s Medicaid EHR Incentive Program. It is anticipated that only modest changes will be made to the MMIS; most adjustments would relate to making payments to providers via Electronic Funds Transfer. With the Provider Web Portal, it is anticipated that the security features currently resident within the portal application will be sufficient to support secure access for eligible professionals and hospitals to initiate their applications and to complete their attestations of having adopted, upgraded, or implemented EHR technology.

Any modifications to Oregon’s MMIS will be included in Oregon’s HIT IAPD as a separate chapter to update Oregon’s MMIS IAPD. The IAPD for the Medicaid HIT Project is being submitted concurrently with this SMHP to CMS in April 2011.

The timeframe for modifications to Oregon’s information systems that will support the Medicaid EHR Incentive Program will in large part be driven by the HP Multi-State Collaborative for MAPIR. Following each release of the application, the core components will be integrated into Oregon’s MMIS and Provider Web Portal. Once the application meets the rigors of the user acceptance test, a full integration test with the Oregon’s MMIS and Provider Web Portal will be executed. Validation testing with the National Level Repository to certify that file exchanges with the NLR are accurate and successful will determine the systems technical readiness. Once the system is validated in production, a determination will be made as to Oregon’s program readiness. The stated goal is to be ready to generate Medicaid EHR incentive payments to eligible professionals and eligible hospitals in summer 2011. The expectation is that all of the core and custom components of the system necessary to accomplish that goal will be in place and fully operational by that date.

*MAPIR Timeline*



***Method and timing of interface with NLR***

All MAPIR states, including Oregon, are part of CMS’s Group 2 for NLR testing. HP will be conducting all file exchange testing between the NLR and the MAPIR application during the development of Release 1 of MAPIR. Oregon has completed all of the requisite data use agreement forms and identified a state secure point of entry contact individual from the state’s MMIS contractor, HP Enterprise Services, and identified a state alternate representative and completed the appropriate form for that function.

NLR Interface Testing for connectivity was facilitated by the Oregon contractor, HP Enterprises, and was successfully completed in January 2011.

The MAPIR application will transmit and receive all NLR file transactions. In Oregon these transactions will be interchanged between the two systems via GEN-TRAN on a daily basis, completed nightly in a scheduled series of batch executed transactions. MAPIR functionality outlined in the MAPIR Detailed Design Document and in the Detailed Technical Design delineates the hierarchy of transactions, the procedures for scheduling and initiating the transactions, and the procedures for handling error reports and potential interruptions in service.

***Data collection for meaningful use/quality measures, short-term and long-term***

MAPIR will not capture meaningful use in 2011. However, MAPIR will allow dual eligible hospitals that have been deemed meaningful users by CMS for the Medicare incentive program to choose to attest to being a meaningful user in 2011. For 2012 and beyond, Oregon will use MAPIR or another system yet to be determined to collect meaningful use attestations. Applicants will be provided a web-based application that includes a description of each meaningful use objective, clinical quality measure, and an associated area to attest their exclusion, or provide the required information to satisfy the objective.

***Automation of payment***

Using the MMIS, Oregon intends to make EHR incentive payments via Electronic Funds Transfer (EFT). Payments will be processed weekly on Fridays. MMIS processes payments on a daily cycle, and processes recoveries for outstanding debts once a week. As the EHR incentive payment is unique, not associated with a provider claim, it is anticipated that upon completion of processing of an approved Medicaid EHR Incentive Program application, acknowledgement from the National Level Repository that payment is authorized, and any and all pre-payment verifications have been completed, the payment authorization will be sent to the State Fiscal Management system, the EFT will be generated to the provider in the next scheduled weekly payment cycle (i.e. next Friday except scheduled down days), and a remittance advice will be forwarded to the provider with the details of the payment.

**3B. Using technology to communicate with providers**

***Website***

General program information is currently available on the Medicaid HIT Project’s EHR Incentive Program website at [www.MedicaidEHRIncentives.oregon.gov](http://www.MedicaidEHRIncentives.oregon.gov). The site provides information about program eligibility, EHR certification criteria, incentive amounts, hospital payment structure, meaningful use, and will include specific instructions on how to apply for the program in Oregon. The site will be updated as program decisions are finalized. As mentioned previously, a frequently asked questions feature is actively monitored and augmented as new questions surrounding the program emerge. Links to CMS, O-HITEC, ONC, and other related web sites are included. The public can e-subscribe to receive notice of updates to the web site.

Currently there is an effort to develop a more provider-friendly structure for the Oregon Medicaid EHR Incentive Program site. The target audience is potential eligible providers of the Medicare and Medicaid EHR incentive programs. The website will also provide general information about the Medicare program with direct links to the

CMS website. The website will also provide information regarding changes to statute, federal regulation and state administrative rules. Those who subscribe to the website and who apply for an incentive payment in Oregon will receive law, policy and program updates via e-mail from the Medicaid EHR Incentive Program.

#### *Continuity Plan*

There will be a time when providers can register in the CMS National Level Repository but MAPIR is not ready to accept providers' EHR incentive application and attestation. Oregon will use the Provider Web Portal login page to inform providers of the date they can submit their EHR incentive application and attestation. There will be a message on the page stating "If you've registered with the CMS National Level Repository come back on [date] to submit your EHR incentive application and attestation to the State of Oregon."

Oregon intends to use reporting tools to extract a list of newly registered providers in CMS National Level Repository on a regular basis. Oregon will email providers on that list, informing them of the date Oregon will be ready to accept provider attestations. Oregon will also conduct a broad outreach approach to inform providers of the application and attestation date by posting information on the program website and sending emails to the program's e-subscriber list.

#### ***Program application communication***

Oregon will favor electronic transmission, primarily electronic mail, for all possible communications regarding the Medicaid EHR Incentive Program. In addition, Oregon will use mail when required by state regulation, and telephone when appropriate, to communicate with providers regarding their status in the program.

#### *Provider Web Portal and MAPIR communication*

Oregon will use the existing Provider Web Portal as the secure gateway to access MAPIR for enrolling prospective eligible professionals and hospitals. The MAPIR application process allows a provider to complete the full application for an incentive payment. If a provider answers questions that deems them ineligible for an incentive payment, at the end of the application the provider will be presented with a review screen that has all of the potential disqualifying answers entered. The provider will then be presented with three options: correct answers to application questions, submit the application with the outstanding issues, or solicit assistance by contacting the incentive program staff.

#### ***Suspensions, denials and acceptances***

MAPIR installation will include an e-mail server to process e-mail notifications from MAPIR to applicants regarding the status of their attestations. The incentive program staff will use e-mail to notify applicants of their application status of suspension, denial or acceptance. Suspension status may include telephone consultations between incentive program staff and providers to resolve the issues. After an application has been thoroughly reviewed and eligibility determination has been made, notification of denial with a reason statement or acceptance with incentive payment amount will be sent using electronic notification to the e-mail address indicated upon application.

#### ***Withdrawal***

Eligible providers may request "withdrawal" of their application by contacting Oregon Incentive Program staff directly. The MAPIR application does not have a "withdrawal" request function. A passive way to withdraw an application is that any incomplete or suspended application in MAPIR will automatically expire after a designated period of time that is yet to be determined by Oregon.

#### 4. Pre-qualification and CHIP proxy strategy

Oregon plans to develop a strong pre-qualification strategy to reach out to potential eligible professionals prior to application to the program. Oregon will work closely with CMS when developing a pre-qualification strategy. MMIS data warehouse queries will be used heavily in determining potential provider eligibility and specific provider outreach.

Medicaid HIT Project staff will be working with OHA research analysts to analyze MMIS historical data in the MMIS data warehouse: Decision Support and Surveillance Utilization Review System (DSSURS). Project staff members have obtained a copy of the MMIS data warehouse analysis tool, Business Objects. OHA research staff will assist project staff in the development of standard queries to address the program needs.

##### ***Oregon Health Plan: CHIP and Medicaid patients are indistinguishable to providers***

Oregon has made substantial progress in streamlining state health care programs, including Medicaid and CHIP, into one program: the Oregon Health Plan. As mentioned earlier, beneficiaries and providers have no clear indication to which program the patient is enrolled. Since eligibility for incentives is based on Medicaid patient volume, and does not include CHIP patients, providers will be unable to determine their Medicaid patient volume without relying on guidance from Oregon's incentive program staff. Oregon's MMIS system differentiates the paying source using detailed codes for eligibility that can be easily traceable to the claim.

Oregon proposes the following "CHIP proxy" strategy to address this issue and provide ways for providers to determine Medicaid patient volume: Identify an average proportion of CHIP encounters out of all encounters, called a "CHIP proxy." Providers will identify their total Oregon Health Plan patient volume and reduce by the CHIP proxy when applying for incentives. Using this method will benefit some providers whose actual CHIP patient encounters are higher than the statewide average, and may disadvantage those whose CHIP volume is lower than average. However, any provider who believes they may meet the Medicaid patient volume threshold, but does not meet the threshold after reducing their Oregon Health Plan by the statewide CHIP proxy, can work with program staff to analyze and report their actual data. Incentive program staff will use the state proxy along with MMIS data to verify the Medicaid patient volume.

As described on page 70 some incentive payments will be selected for an audit. For providers using the CHIP proxy, the auditor will assess whether the total Oregon Health Plan encounters were accurately represented, and will not attempt to evaluate a provider's actual Medicaid-only encounters. Thus, there would be no penalty for providers who have an actual CHIP patient volume higher than the statewide proxy. For providers who request their specific data, the audit will assess whether the Medicaid encounters were accurately represented, given the information provided by the state. For example, if the state makes an error in the number of CHIP encounters, the provider would not be liable for any implications of that error.

Oregon proposes to use one proxy of 4.4% to apply to both eligible professionals and hospitals. This proxy is derived from the following calculations of statewide CHIP proportion of Oregon Health Plan encounters:

- 4.36% for all provider claims except where the billing provider is a hospital. Because Oregon expects many eligible professionals to use a group patient volume calculation, which includes all billing and ancillary providers, Oregon is planning to use all provider claims except hospitals in the calculation of the statewide CHIP proportion of OHP encounters.
- 4.45% for hospitals, using the same methodology by calculating all encounters where the billing provider is a hospital.

For example:

- Provider A has 500 Oregon Health Plan patient encounters and 1200 total patient encounters.

- Oregon has an average of 4.4% CHIP-to-total Oregon Health Plan encounters.
- Provider A must reduce its Oregon Health Plan encounters by 4.4% and attest to the resulting number: 478, or 40%.
- Providers who are unable to meet the 30% patient volume with this reduction, but believe that they could meet it otherwise, can provide their total number of encounters request the state provide the specific number of CHIP encounters for the 90-day period of their choosing.

#### *Communications with providers*

The CHIP proxy approach will need to be carefully explained to providers. The program will use language such as the following in communications with providers:

OHA wants to work with eligible professionals to ensure that every eligible provider who wants to participate in the incentive program can qualify. Part of qualification is determination of Medicaid patient volume, which must be at least 30% (20% for pediatricians). Because providers will not know which patients are enrolled in the CHIP program, there are two options for calculating patient volume.

The first option uses a statewide CHIP proxy in the calculation. OHA has determined that, on average, CHIP patient encounters are 4.4% of OHP encounters statewide. *[Will outline next steps.]* Most providers who are eligible will be able to attest to having at least 30% Medicaid patient volume with this method. *[Mention audit process.]*

However, if you think that you do have 30% Medicaid patient volume, but the above calculation does not show that, OHA staff can work with you to carry out a personalized analysis of your Medicaid and CHIP patient volume using state data. Contact the Medicaid EHR Incentive Program staff *[include email and phone numbers]*.

## **5. Program operations**

### **5A. Organization**

The Oregon Medicaid EHR Incentive Program is developed by the Medicaid HIT Project Team, which resides within the organizational structure of OHIT, under the CIO, but with oversight and project leadership by Oregon's Medicaid director. Oregon's HIT IAPD includes further descriptions of the staffing and organizational structure of the Medicaid HIT project.

Although the planning and implementation of the incentive program is under the Medicaid HIT Project (within OHIT), the operations for the program will be folded into the Medicaid organizational structure. The Medicaid HIT Project will manage Oregon's Medicaid HIT IAPD, and will carry out further planning and implementation described in this SMHP, including work on related initiatives and work required for later changes to the incentive program (such as later stages of meaningful use).

### **5B. Support services**

#### ***Call center, help desk***

A support center will be needed to assist providers with the incentive program application process. Oregon will use the existing in-house Provider Service Center unit with additional staff to assist providers with incentive program questions. Current Provider Service Center and Provider Enrollment unit staff will be trained to handle the most common questions about the incentive program. In addition, dedicated support staff will be trained to address detailed incentive program questions related to eligibility, completing Oregon's online application via MAPIR and registration with the NLR, etc.

### ***Oregon Health Plan provider enrollment***

The Provider Enrollment unit within OHA's Division of Medical Assistance Programs (DMAP) enrolls providers such as hospitals, healthcare professionals, laboratories, managed care organizations, third-party agents and clinics. The enrollment process varies depending on the provider type, and billing and organizational structure. In the recent past, providers working for managed care organizations or FQHCs were enrolled with minimal information such as name and provider type. Starting in 2011, DMAP has altered the provider enrollment process to require the National Provider Identifier (NPI) of each health care practitioner providing services under OHP regardless of organizational structure. This change directly benefits the needs of the Medicaid EHR Incentive Program to establish more information for the providers.

However, this change alone is not enough to enroll providers with complete information necessary to receive incentive payments. The Medicaid HIT staff is working closely with the Provider Enrollment unit to establish processes to fully enroll providers with DMAP in order to receive incentive payments. Some eligible professionals working for managed care organizations, FQHCs, RHCs and Indian Health Services will need to provide new information to Provider Enrollment to receive an incentive payment, such as tax identification number, professional license, taxonomy and practice location. This information is to be provided to the Provider Enrollment unit prior to application for a Medicaid EHR incentive payment. Oregon will provide general and targeted provider outreach in order to disseminate appropriate information to potential eligible providers. The Medicaid HIT staff and Provider Enrollment unit will develop the additional enrollment process to minimize burden on the provider community.

### ***Appeals process***

The incentive program will establish Oregon Administrative Rules (OARs) regarding the appeals process that will supplement the existing process outlined in OAR 410-120-1560. To provide alternatives to the use of formal appeals, providers will be encouraged to discuss any issues with Provider Service Unit staff and the Medicaid EHR Incentive Program staff, and may escalate the concern to the incentive program manager. An informal conference may be requested by the provider to give an opportunity to settle the matter without a formal appeal.

A formal decision regarding a provider's incentive payment must be made by the incentive program for the provider to submit an appeal. Formal decisions include denial of application for an incentive payment or incentive payment amount determination.

The provider may file a formal appeal by submitting the request in writing to the incentive program, DMAP or the DMAP Provider Services Unit. The provider is not required to follow a specific format as long as it provides a clear expression of the disagreement with a decision made by the Medicaid EHR Incentive Program. The provider appeal request is considered timely if received within 180 calendar days of the date of the incentive program decision. The reasons a provider can cite as basis for an appeal regarding the incentive program include, but are not limited to: an incentive payment, an incentive payment amount, a provider eligibility determination, the demonstration of adopting, implementing or upgrading, or meaningful use eligibility. The request should identify the decision made by the incentive program, and the reason the provider disagrees with the decision. The burden of presenting evidence to support a provider appeal is on the provider.

Provider appeals will be processed by DMAP or a party designated to review appeals independent of the Medicaid EHR Incentive Program staff. However, the incentive program staff may be consulted by the appeals reviewer to better understand complex programmatic rules. A provider appeal may be processed via written review, formal conference, administrative review, or contested case hearing depending on the nature of the

appeal. Providers will be notified in writing of the date, time and location of the conference or hearing. Once the appeal is processed and a decision made, the provider will be notified in writing of the decision.

## **6. Legislative approach**

There are no current legislative changes anticipated to carry out the incentive program. However, if any are identified, Oregon's Legislature is convening in the first half of 2011 and could take up a proposal from the Medicaid program.

The Medicaid HIT project team provides bill analysis for Oregon's Medicaid agency on bills related to electronic exchange of information, and will continue to support the Medicaid Director as needed throughout the 2011 legislative session.

## VI. Outreach Communications Plan

### *Section Overview*

- Oregon’s communication plan targets providers who may be eligible for both the Medicare and Medicaid incentive programs to provide assistance to the widest range of providers possible.
- The three core messages will be the announcement of the incentive program, connecting providers to O-HITEC for assistance and providing updates on the incentive program.
- Regular email announcements will be sent to the e-subscribe list for the Medicaid HIT Project website. However, to reach all providers directly, Oregon will send three direct mail pieces in the first half of 2011, augmented by messaging through existing organizational channels such as Medicaid contractors, provider associations, and others.

### **1. Overview**

The communication plan identifies target audiences, communication messages, and tools and timelines through summer of 2011. A more detailed version of this plan is attached as Appendix D. The following is a summary of the components of that plan.

### **2. Target audiences**

#### ***Providers***

Health care providers in Oregon may be eligible for either or both the Medicaid EHR Incentive Program and the Medicare EHR Incentive Program. Although the focus of the Medicaid EHR Incentive Program is providers who are potentially eligible for Medicaid incentive payments, the Medicaid eligibility criteria are steep – 30% Medicaid patient volume for most providers, and 10% Medicaid patient volume for hospitals. Many Oregon Medicaid providers will not be eligible for a Medicaid incentive, but may be eligible under the Medicare incentive program. However, any Oregon provider may look to OHA for information about the incentives programs, so the communications plan will communicate with as wide an audience of Oregon providers as possible and attempt to provide providers information relative to both programs as much as possible.

#### ***Key partner organizations***

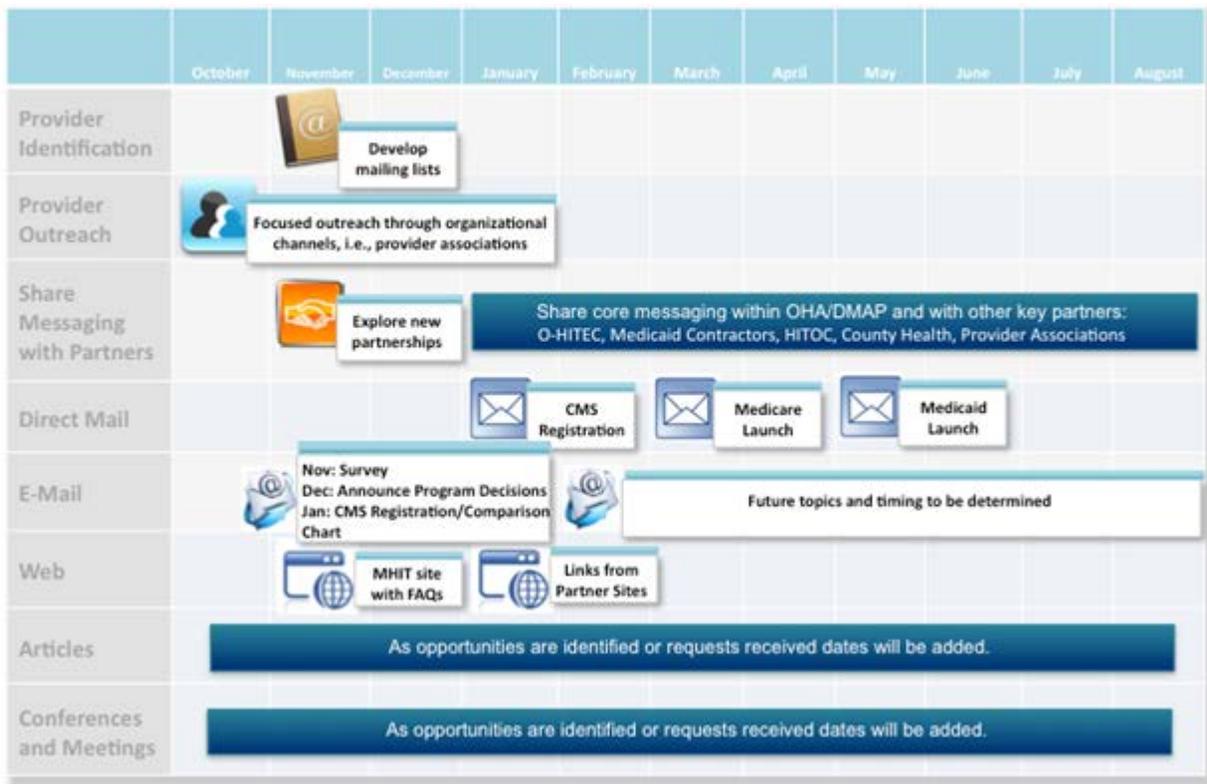
Key partner organizations will also be leveraged to communicate to providers about incentives. Organizations include Medicaid contractors, provider associations, and others.

### **3. Messages**

To produce a successful, comprehensive, coordinated communication strategy, it will be essential to ensure that provider communications from OHA, as well as key external partners, about the incentive program complement and build on consistent messaging. Communication tools will focus on the distribution of the three core messaging processes:

- Announce incentive program – including program information and links to CMS for specifics including meaningful use criteria and Medicaid incentives;
- Connect providers to O-HITEC for technical assistance; O-HITEC, a division of OCHIN, is funded by the Office of the National Coordinator to help providers eligible for the incentive programs adopt and implement EHRs; and
- Provide updates on Oregon’s Medicaid EHR Incentive Program including any Oregon specific decisions when available.

## 2010-11 Medicaid Incentive Provider Communication Plan



### 4. Preliminary communication plan timeline and tools

As represented in the graphic on the previous page, tools will include direct communications to providers as well as leveraging partner organizations and electronic communication. Regular email announcements will be sent to the e-subscribe list for the Medicaid HIT Project website. However, to ensure contact with all Oregon providers, three direct mail pieces in the first half of 2011 will be the primary tools for OHA to communicate directly with all providers about the EHR Incentive programs. One goal of the mailings will be to encourage providers to e-subscribe to the Medicaid incentive webpage to receive updates. This direct communication will be augmented by distributing messaging through existing organizational channels such as Medicaid contractors and provider associations, among others.

## VII. Pre-payment Verification and Post-payment Audit Strategies

### *Section Overview*

- Oregon will conduct pre-payment verification and post-payment audits of applicants and incentive payments made to ensure compliance with federal and state rules.
- Pre-payment verification processes will be conducted by incentive program staff at the time of application.
- Medicaid patient volume for eligible professionals will be verified using MMIS data and, eventually, using Oregon's All Payer All Claims database.
- Hospital patient volume will be verified using Medicare cost reports. Oregon expects to amend its verification processes upon further guidance from CMS about the Medicare plan for auditing incentive payments.
- Oregon will use the DHS Office of Payment Accuracy and Recovery for audit oversight of the program. Selection of incentive payments subject to audit will be based on a risk-based sampling strategy.

### **1. Overview**

As part of the oversight of the Medicaid EHR Incentive Program, Oregon will implement several audit strategies. Oregon is responsible for tracking and verifying the activities of Medicaid eligible professionals that receive incentive payments. Oregon has divided these activities into two categories: pre-payment verification and post-payment audit. The pre-payment verifications will be conducted by the incentive program staff with focus on validating and reviewing information available at the time of an application prior to any payment made. The post-payment audit will be done by third party trained auditors after payments have been made to ensure the validity of provider attestations in their application and that the payments made to providers were accurate.

In order to reduce provider burden, and maintain integrity and efficacy of the oversight process, Oregon will use existing data sources and activities where possible. Methods include:

- Leveraging existing provider enrollment, claims, and other data in the MMIS system and DSSURS data warehouse and in the soon-to-come All Payer All Claims Database; as well as information and data reported to OHA such as HRSA reports and Medicare hospital cost reports
- Leveraging existing processes, including provider appeals, post-payment audits under the DHS Office of Payment Accuracy and Recovery (OPAR), and provider support via the existing Provider Support Services unit
- Reducing complexity for eligible professionals and hospitals by providing access to the Incentive Program application via the existing Provider Web Portal
- Making incentive payments using the existing state fiscal management system via MMIS
- Using electronic systems for payment (Electronic Funds Transfer) and application notifications and communications (e-mail)
- Encouraging compliance and program integrity by allowing applicants to upload documents during application to the program.
- Using targeted pre-qualification activities to communicate early with potentially eligible professionals and hospitals about their eligibility prior to applying to the program.
- Folding program operations into the existing Medicaid organizational structure

## **2. Pre-payment verifications**

The pre-payment verification processes will be conducted by incentive program staff when a provider applies for an Oregon Medicaid EHR incentive payment. The pre-payment verification processes will use various levels of scrutiny depending upon the information type and risk associated. Pre-payment controls will include methods to verify provider information; patient volume; adoption, implementation, or upgrade of certified EHR technology; eligibility requirements; and appropriate payment amounts. This list is not all-inclusive and Oregon ensures processes will be in place to validate information as required per the final rule.

Oregon will use the MAPIR system to capture data elements required for the incentive program. Additional information will be retrieved from the MMIS data warehouse, DSSURS, and analyzed by the incentive program staff to verify information provided by the providers in MAPIR prior to a payment being processed. The Medicaid HIT project team will design queries for DSSURS that verify attestation information within a business intelligence tool. These queries will provide the team with the information required to decide whether it is appropriate to pass the application on the path towards payment or if the application requires further action before determination.

Oregon will use pre-payment controls to verify the overall content of provider attestations. Pre-payment control types include the following:

- a. *Automated MAPIR suspension:* In the course of completing the application to the state, MAPIR will automate the suspension of an application based on pre-set triggers. The application will be placed in a queue for Oregon Medicaid HIT staff to manually review.
- b. *Manual review:* After the MAPIR application has been completed but prior to payment, Oregon Medicaid HIT staff will complete a review based on specified information reported in the application.

### **2A. Verify eligible professional information**

#### ***Active Oregon Medicaid provider***

The existing provider information from MMIS will serve as a mechanism to check that the provider is an active Medicaid provider with Oregon. The MAPIR software will pull only active providers from the MMIS.

#### ***Provider information***

MAPIR will capture identifying provider information which includes provider name, National Provider Identifier, Taxpayer Identification Number and National Level Registry (NLR) status. The information will be cross-checked to the NLR via the MAPIR-NLR interface. If there are any discrepancies, the incentive program staff will review and assess.

#### ***Participation year and program eligibility validation process***

Provider eligibility, based on participation year and program will be checked using NLR's program participation data. While still in development, future releases of MAPIR are expected to capture all years of participation in the EHR Incentive Program (Medicaid/Medicare), based on information transmitted to MAPIR from the NLR in the various interfaces.

#### ***Provider licensing, sanctions, qualifications***

Part of the attestation will be that the provider attests within the MAPIR application to being properly licensed and not sanctioned by professional boards in any of the states in which they practice and/or at the federal level. The NLR will perform a verification of sanctions at the federal level. At the initial part of the application process, MAPIR will interface with the NLR and receive any information regarding federal sanctions.

License checks will be done manually after a completed application has been submitted and will precede payment. There are multiple licensing boards in Oregon which provide web site license look-ups allowing multiple search options. The Medicaid EHR Incentive Program will verify the provider has an active license and is not sanctioned by entering the license number in the license look-ups. Some state licensing boards interface directly with MMIS to update the licensing status. The incentive program staff will do manual license checks for provider types who do not have an interface to their licensing board.

The Oregon license check will be completed and the results documented by the incentive program staff processing the application. If the license is active in Oregon without sanctions, the provider will be checked against the NLR for a second time preceding payment to see if there are any federal sanctions or sanctions taken in other states. Providers who are not licensed and/or have sanctions in another state and/or at the federal level will be sent a denial letter for participation in Oregon's Medicaid EHR Incentive Program.

The Medicaid HIT staff will review the Medicaid Integrity Group's 2010 Program Instruction and coordinate with the Provider Enrollment unit to identify changes that have been and need to be implemented in Oregon. As instructed by CMS, the Medicaid HIT staff will review the Best Practices for Medicaid Program Integrity Units' Collection of Disclosures in Provider Enrollment (August 2010) to align any provider verification efforts for the incentive program.

***Verify adoption, implementation and upgrade of certified EHR technology***

The MAPIR application will require applicants to select and attest to their EHR system certification number maintained in the system and developed from the ONC HIT products list. MAPIR will require providers to select a certified EHR from a dropdown list.

Oregon will verify adoption, implementation or upgrade of certified EHR technology in one of two ways. Oregon intends to customize the application to allow for the capture and recording of the provider's relationship with O-HITEC. If providers use O-HITEC assistance, the incentive program staff can verify matches with the O-HITEC client list. The incentive program will receive frequent lists from O-HITEC indicating providers who have signed a contract for a certified EHR system. Providers will be encouraged to submit proof of purchase or demonstration of a signed contract by uploading the documents into MAPIR prior to completing the application.

***Meaningful use***

MAPIR will be used to collect attestation of meaningful use data. Oregon anticipates MAPIR will capture meaningful use in 2012. Because providers will qualify in Year 1 of their participation via adopt, implement, or upgrade (in 2011, all applicants); meaningful use reporting is not required in Year 1 of participation. Following CMS guidance, Oregon will not give providers the option to submit meaningful use data in 2011. However, MAPIR will allow dual eligible hospitals that have been deemed meaningful users by CMS for the Medicare incentive program to choose to attest to being a meaningful user in 2011. Oregon will develop a process for 2012 to verify meaningful use data attested to in MAPIR. The electronic capture of clinical quality measures will commence in Oregon's second year of accepting meaningful use, which is 2013. The means by which Oregon will receive these measures is in the developmental stages.

Please see page 73 for activities undertaken by Oregon's Public Health Division to validate test messages sent by providers seeking to meet meaningful use criteria for Medicare incentives starting in 2011.

***Payments are made in accordance with program requirements***

The program will ensure that payments are not made for more than a total of six years, no provider begins receiving payments after 2016, payments cease after 2021, and that a hospital does not receive an incentive

payment after FY2016 unless the hospital received a payment in the prior fiscal year. Reports utilizing data stored in MAPIR, NLR, and MMIS will allow staff to track what year, what amount, and under what program payments were made based on the following processes:

- MAPIR will interact with the NLR (which tracks payments) and MMIS (which tracks payments) and compiles that information into a "record" for a specific incentive payment for an eligible professional or hospital.
- MAPIR is configurable to support the state decision on the structure for hospital payments.
- MAPIR will send hospital and EP payment calculations to the NLR which will authorize the payment and then return it to MAPIR in the interface.
- MAPIR will then send the payment transaction record to MMIS to generate the payment.
- Likewise, MMIS will send the generated payment information back to MAPIR and the cycle will repeat, alerting the NLR that a payment has been made.
- This data will be stored in MAPIR, as well as any adjustments made to payments.
- The "system of record" for EHR Payments in Oregon is the MMIS (and ultimately the NLR).

Oregon will assure that Medicaid EHR incentive payments are paid directly to the EP or an employer or facility to which the EP has assigned payments, without any reduction or rebate. Oregon will authorize the full amount of each incentive payment due to a provider and generate that payment via EFT directly to the provider (or their assignee) or hospital. Systematic and/or manual checks will be put in place to ensure that the EHR incentive payments are not reduced by DHS or by any other state agency so as to reconcile and/or make payment against any liens or recoupment balances. Oregon will incorporate into its post-payment audit function a review of the audited EHR incentive payments, so as to validate that the incentive payment amount calculation and the actual incentive payment made reconcile. Any discrepancies found will be addressed and resolved. These actions will be taken by Oregon to assure that all hospital and EP payments are made consistent with the Statute and regulation.

### ***Accounting practices***

Oregon is committed to accurately tracking and accounting for funds and activities under its 90% match for program development, implementation, and administration and its 100% Federal Financial Participation (FFP) for incentive payments. In general, the Medicaid HIT project has financial budget codes and indexes that are used only for these funds, and keeps them separate from other enhanced MMIS FFP. Project management routinely assesses expenditures and adjusts projections for these funds to ensure that only the appropriate funds are charged to the program. In addition, the 100% incentive payments will be made out of Oregon's MMIS, which will assign a separate, specific code within the system to indicate that payments are for incentives. Incentive payment budgets will be managed by a separate unit from the Medicaid HIT project, which will manage the 90% HIT match.

### **2B. Verify patient volume for eligible professionals**

To collect patient volume information from applicants, the MAPIR application will pull each provider location associated with the applicant's NPI. The applicant will enter the numerator and denominator patient volume data per location for a 90-day period in MAPIR.

### ***Medicaid encounters***

Applicants will be required to separately enter their Medicaid encounters for in-state Medicaid, Medicaid encounters for out-of-state Medicaid, and total encounters for a 90-day period. This reported data will be calculated as a percentage automatically, so applicants can see whether they meet the required proportion of Medicaid encounters.

To verify the number of Medicaid encounters, the number of Medicaid patient encounters during the 90-day period specified by the applicant will be derived from MMIS and other data sources. These MMIS encounters will include claims data and “shadow claims” – encounter data submitted by Medicaid managed care organizations. Incentive program staff will compare the MMIS data to the applicant’s reported encounters to verify.

However, to validate that the applicant has 30% Medicaid patient volume, verification of the Medicaid encounters alone is not sufficient. Oregon will eventually use its All Payer All Claims database (APAC) to verify the total encounters (denominator). The capacity to verify patient volume data will be limited until the database is operational and contains data from all payers relevant for the incentive program reporting periods. Although it is anticipated that the APAC will begin collecting data by summer 2011, it may not contain complete data for some time after that. EPs will be encouraged during this time to upload documents to verify the patient volume data. Until the APAC has the data needed for the incentive program, incentive program staff will verify EP patient volume using MMIS data for the number of Medicaid encounters only.

#### *Medicaid and CHIP claims not in MMIS*

Most Medicaid and CHIP claims reside in Oregon's MMIS system. There is a small portion of Title XIX (Medicaid) and Title XXI (CHIP) funds that supports access to medical care that is not processed through MMIS. These other programs, such as CCare and the Family Health Insurance Assistance Program, record data separately and have different data traceability.

The Oregon Health Authority's Public Health Division provides administration of the CCare program. CCare administers Medicaid funds to providers who provide family planning services. The funded services are reimbursed by the state directly to a clinic and do not tie the service to a specific provider. Clinics providing CCare services are able to connect the provider to the service and funding. The incentive program does have data to support providers using the group patient volume calculation for eligibility. However, if an eligible professional providing CCare services applies to the incentive program using the individual patient volume calculation, the provider may choose to submit acceptance documents at application to support the patient volume.

There are two programs in Oregon, the Family Health Insurance Assistance Program and Healthy Kids, that pay for private insurance premiums using Medicaid and CHIP funds. The Medicaid HIT staff is currently researching if there is a mechanism to trace the funded premium directly to a provider. In the future, the APAC database may be the missing link to tie the provider with the client who received the funded premium.

#### ***Medicaid paid premiums***

Oregon Medicaid pays the premiums for some Medicare beneficiaries and others receiving premium subsidies in Oregon who are not otherwise covered by Oregon Health Plan benefits. While the enrollees in these plan types may be tracked in MMIS, their encounters and claims are not. In addition, providers do not know which patients have their premiums paid by Medicaid.

Oregon understands that some providers will request assistance from the incentive program staff to identify those patients for whom Medicaid paid premiums, so they might meet the 30% Medicaid patient volume threshold requirement. Oregon is exploring options on how to work with providers to identify encounters for which Medicaid paid premiums. Providers will submit information to the incentive program staff identifying their patients so that staff can identify which patients' encounters can be added to the Medicaid patient volume calculation. Incentive program staff will upload and store the documentation submitted by providers in MAPIR, making it available should an audit be needed.

### ***Patient panel***

Program staff members anticipate that a small proportion of eligible professionals will choose the patient panel method to determine patient volume and an even smaller proportion will use group patient panel volume. Oregon's MMIS and APAC will not reflect data about patients assigned to a provider's panel. Oregon will require that specific documentation of panel size be available in the case of an audit, and will encourage providers to upload documentation of panel size to the MAPIR application. Incentive payment staff will cross-reference the data where possible by analyzing the number of Medicaid encounters within the prior calendar year as a proxy to verify Medicaid panel data. If a provider does not provide supporting documentation at application, Oregon will rely on its post-payment audit strategies to verify panel data.

### ***Needy individual encounters***

Needy individual encounters will be verified using the following methods for each of the “needy individual” encounter types:

- Person who is receiving assistance under Title XIX (Medicaid); patient volume will be verified by using MMIS data for the number of Medicaid encounters,
- Person who is receiving assistance under Title XXI (CHIP); patient volume will be verified by using MMIS data for the number of CHIP encounters,
- Person who is furnished uncompensated care by the provider; patient volume will be verified using reports or billing data supplied by the provider,
- Person for whom charges are reduced by the provider on a sliding scale basis based on the individual’s ability to pay; patient volume will be verified using reports or billing data supplied by the provider.

Oregon will use the following methods to obtain verification sources, such as HRSA reports, for encounters related to uncompensated care and reduction of charges on a sliding scale:

1. Prior to application: As part of the initial communication and pre-qualification process, program staff will request each FQHC/RHC send this data to the state.
2. During the application process: EPs will be able to provide data by uploading it as a PDF to the MAPIR application. MMIS data will be used to determine whether the EP has at least 30% Medicaid/CHIP patient volume.
3. Audit strategy: if the state was not able to validate at least 30% needy individual via received data reports supplied by the EP or FQHC/RHC and the EP does not have at least 30% Medicaid/CHIP patient volume, then Oregon will rely on post-payment audit sampling strategy to ensure accuracy of the needy individual data.

### ***Out-of-state Medicaid patients***

Oregon anticipates that a number of providers will only qualify for incentive payments by including out-of-state Medicaid patients to meet the patient volume threshold. Oregon does not currently have agreements for verification in place with other states, however, is working to put these in place. If agreements are not in place at the time a provider applies, Oregon will use post-payment audits to verify out-of-state patient data.

### ***Verify eligible professional practice status***

#### ***Provider hospital-based EP status***

As part of the pre-payment verification process, Oregon will use data from the MMIS system to determine if the information that the EP attests to is reasonable. Oregon will access existing data sources for more detailed checks when a threshold of reasonable comparison between MMIS and attestation date is not met. The provider must attest to a question in the MAPIR application asking if they are hospital-based and respond with a “yes” or “no” answer. Oregon will use MMIS place of service data tracked in MMIS to verify that less than 90% of

Medicaid encounters occurred in a hospital setting in the prior calendar year. The following hospital-based calculation method will be used:

***For the prior calendar year Medicaid encounters tracked in MMIS:***

$$\frac{\text{Medicaid Emergency Department encounters} + \text{Medicaid Inpatient Discharges}}{\text{All Medicaid encounters (all Place of Service Codes)}}$$

***'Practices Predominantly'***

Providers must attest to a question in the MAPIR application asking if they practice predominantly in an FQHC/RHC and respond with a “yes” or “no” answer. The incentive program staff will review the providers’ MMIS service code locations for the 90-day period they are using for their patient volume calculations to estimate whether the provider appeared to practice predominantly in an FQHC/RHC. Ultimately, Oregon anticipates using the APAC to validate this information. Until then, MMIS data will identify providers who are unlikely to practice predominantly in an FQHC/RHC.

**2C. Verify eligible hospital information**

***Verify patient volume for eligible hospitals***

All hospitals in Oregon are required to file Medicare cost reports and submit them to Oregon’s Medicaid program. Hospital patient volume will be verified using Medicare cost reports prior to a payment being distributed. Oregon will amend the hospital verification process once it is aware of the Medicare plan for auditing and further guidance from CMS is received. Oregon hopes this will limit duplication of efforts in verifying hospital data before payment and auditing submissions after payment.

Patient volume will be verified by using the Medicare cost reports. Oregon will consider whether Databank data collected by Oregon’s Office for Health Policy and Research could serve as a proxy in some cases if Medicare cost report data are not available when needed. Eligible hospital patient volume will be verified by using MMIS data for the number of Medicaid encounters. Eligible hospitals will be encouraged to upload verifiable data documents to support the attested information. All of these data sources will be used to analyze patient volume and average length of stay.

***Hospital payment calculation***

Oregon will require that the hospital attest to the necessary data elements to make the hospital payment calculation through MAPIR. Oregon will use these Medicare hospital cost reports in a pre-payment control process to verify the data elements to which the hospitals have attested. The hospital payment calculation will be made during the first year of participation in the Medicaid EHR Incentive Program. MAPIR will track the year of participation for the hospital, and indicate the payment amount for each of the three years of participation.

Oregon providers will be required to apply a CHIP proxy when attesting to patient volume to adjust for the inability to distinguish CHIP patients from Medicaid patients. The CHIP proxy will not be applied to the Medicaid inpatient bed days for the hospital payment calculation because Oregon hospitals are able to distinguish CHIP from Medicaid in the inpatient setting.

The following table lists the Medicare cost report data sources Oregon will use to validate hospital payment calculation information:

<b>Component</b>	<b>2552-96 (Old)</b>	<b>2552-10 (New)</b>
Medicaid IP Bed Days	= S-3, I Col. 5, Lns. 1-2 + S-3, I Col. 5, Lns. 6-10	= S-3, I Col. 7, Lns. 1-2 + S-3, I Col. 7, Lns. 8-12
Total IP Bed Days	= S-3, I Col. 6, Lns. 1-2 + S-3, I Col. 6, Lns. 6-10	= S-3, I Col. 8, Lns. 1-2 + S-3, I Col. 8, Lns. 8-12
Total Discharges	S-3, I Col. 15, Ln. 12	S-3, I Col. 15, Ln. 14
Total Charges	C, I Col. 8, Ln. 101	C, I Col. 8, Ln. 200
Charity Charges	S-10, Ln. 30	S-10, Ln. 20

### **3. Post-payment audit**

#### ***Audit administration***

Oregon’s audit plan seeks to ensure that incentive payments are made only to qualified providers and the correct amounts are disbursed. Auditing will also inform the incentive program staff of which pre-payment verification methods need adjustment each year. Oregon will use the existing Medicaid Provider Audit Unit (PAU) from the DHS/OHA Office of Payment Accuracy and Recovery (OPAR) for audit oversight of the program. OPAR is housed under the Director’s Office for DHS/OHA. PAU has been the auditor of OHA Division of Medical Assistance Programs’ providers for many years. The Oregon REC (O-HITEC) is not a part of the auditing process or affiliated in any way with OPAR.

Oregon administrative rules will be created where appropriate to clearly outline the authority to audit providers and recover any overpayments involving the Medicaid EHR Incentive Program. Oregon will also include information regarding the possibility of being audited in communications and the Provider manual for the Medicaid EHR Incentive Program.

Oregon will audit a portion of providers each year receiving Medicaid EHR incentive payments. This does not indicate that all providers will be audited at some point during their participation (for up to six years) nor does this indicate that providers can only be audited once during their participation in the Medicaid EHR Incentive Program. At this point in time, Oregon will not be able use data mining to audit providers.

Oregon will submit an audit email address to CMS at least 15 days prior to the incentive program launch. State staff will work with CMS to coordinate when CMS audits hospitals so State staff can audit the eligibility portions for which Oregon is responsible.

#### ***Sampling***

Oregon’s audits will be sampled annually based on the previous year’s participation. A valid random sample will be taken from the entire provider applicant population, whether or not they received Medicaid EHR incentive payments for the participating year. Oregon will incorporate risk into the sampling methodology.

The providers will be stratified by pre-determined variables to mean “risk.” The risk variables will be identified on an annual basis, and adjusted as needed to respond to information learned by program and audit staff.

*Risk Variables may include, but are not limited to the following:*

- Did not use technical assistance by a trusted source (e.g., REC, other entity assisting providers such as an integrated health network or independent physician association) through each step of implementing the EHR system,
- EPs with patient volumes close to the threshold,
- EPs with out-of-state Medicaid patients,
- EPs with an audit finding in previous years,
- Hospitals (due to size of payment).

#### ***Payment adjustments***

If an audit reveals that a payment was over- or under-paid, the auditing unit will notify the incentive program staff. The person or entity subject to a payment adjustment will receive a written mailed notice of the amount and reason promptly, but not longer than 30 days from identification of the issue. The incentive program will be responsible for making payment adjustments involving under payments (e.g., by providing an additional payment via MMIS). The payment adjustment for under payments will be made via EFT in MMIS as authorized by manager overseeing the Medicaid EHR Incentive Program.

OPAR will be responsible for collecting over payments. In the case of overpayments, the person or entity that received the overpayment must repay the amount specified within 30 calendar days from the mailing date of the written notification prescribed in OAR 407-120-1505. OPAR will use existing collection methods established by administrative rule to recoup overpayments. A provider may request in writing a payment plan. If the provider does not repay the overpayment, Oregon may pursue the recoupment via several methods. Overpayments not paid may be pursued through collections or civil action. OHA and DHS may also suspend or terminate a provider's enrollment in OHP.

The specific audit activities are not an aspect of MAPIR, but MAPIR will be used to support oversight activities. Overpayments identified by the state will be documented and tracked in MAPIR along with any payment adjustments. Once documented, MAPIR will communicate with the NLR via the interface to provide the corrected information.

Oregon may reduce the amount of incentive payment to pay off debt if an eligible provider or incentive payment recipient owes a debt under a collection mandate to the state of Oregon. The incentive payment is considered paid to the eligible provider even when part or all of the incentive may offset the debt. Oregon may not reduce the incentive payment amount for any other purpose unless allowed by federal or state regulation.

#### **4. Fraud and abuse**

##### ***Enforcement***

Any case of suspected fraud or abuse detected by Oregon's Medicaid EHR Incentive Program or OPAR auditing staff will be referred to the appropriate law enforcement agency. Oregon's Medicaid program will also be informed of the suspected fraud or abuse.

##### **Department of Justice -Medicaid Fraud Control Unit**

1515 SW 5th Avenue, Suite 410

Portland, Oregon 97201

Phone (503) 229-5725 / Fax (503) 229-5459

**Department of Human Services Provider Audit Unit**

500 Summer St. NE

Salem, Oregon 97301-1097

Phone (503) 945-6691 / Fax (503) 947-5400

## VIII. Public Health

### *Section Overview*

- The Medicaid HIT Project Team includes a public health initiative that will promote and enhance Medicaid provider use of EHRs by fostering information exchange between providers/hospitals and Oregon Public Health Division (OPHD) data systems.
- The initiative will work with providers and state partners to develop technical assistance documentation and guidance for the three Stage 1 public health meaningful use objectives: submission of electronic laboratory reports, immunization data and syndromic surveillance data.
- The initiative will evaluate the capacity of public health systems that are first to receive and validate meaningful use data.
- Public Health will evaluate the readiness of the current public health infrastructure to participate in statewide health information exchange and participate in state planning around state-system participation in HIE.

### **1. Overview**

The Public Health Initiative is a component of the Medicaid HIT Planning Project. The initiative will focus on promoting and enhancing Medicaid provider use of EHRs by fostering information exchange with Oregon Public Health Division (OPHD) data systems effectively and easily through Oregon's Medicaid Health Information Network (MHIN). The work of this group includes 1) planning for and designing interfaces between OPHD data systems and Oregon's statewide health information exchange systems; 2) implementation and maintenance planning; and 3) pursuing strategies to enable Oregon providers to meet the all three Stage 1 public health meaningful use objectives with minimal burden.

Public Health will work with providers and state partners to develop technical assistance documentation and guidance to promote the successful demonstration of the three Stage 1 public health meaningful use objectives: submission of electronic laboratory reports (ELR), submission of immunization data to the state immunization registry (ALERT), and submission of syndromic surveillance data to the state syndromic surveillance system (Early Aberration Reporting System, or EARS, and Electronic Surveillance System for the Early Notification of Community-based Epidemics, known as ESSENCE). The strategies outlined below will be consistent for each meaningful use measure. The Initiative Team will work on planning activities consistent with Medicaid HIT Project goals and public health leadership goals described in the Medicaid HIT PAPD. Public Health will collaborate and coordinate with internal DHS/OHA and external stakeholders, and will establish and meet project timelines and goals in collaboration with the Medicaid HIT project team, tactical leads, and Public Health programmatic leads. Initiative staff will provide Public Health informatics consultation and perspective with regard to planning, design and implementation of Public Health HIE capabilities, including the development of the Public Health services and data model design and specifications. The Initiative Team will help lead planning and design phases for HIE interface development to meet public health meaningful use objectives and will facilitate Public Health service availability for HIE participants.

The scope of the Initiative work plan focuses on the three public health systems with Stage 1 meaningful use objectives (immunizations, syndromic surveillance and electronic laboratory reporting), but also includes all OPHD information systems that are likely to participate in bi-directional health information exchange through the Oregon HIE. At a minimum the following systems/services will be included: ALERT, ELR, Oregon State Public

Health Laboratory (OSPHL), Oregon State Cancer Registry (OSCaR), Oregon Public Health Epidemiology User System (Orpheus), Syndromic Surveillance (EARS or ESSENCE), as well as other systems that exchange health information with providers (e.g., emergency medical services, Physician Orders for Life Sustaining Treatment and FamilyNet).

## **2. Provider outreach**

The Initiative will assist providers in meeting their public health meaningful use requirements by defining those requirements and providing outreach in the form of technical assistance and guidance around submission and validation of messages sent to OPHD from provider EHRs. As with all initiatives within the Medicaid HIT Project, the public health efforts will be coordinated with stakeholders to ensure that efforts are valuable for providers and meet the goals of the project.

Public Health Initiative will:

1. Work with state web partners to develop resource pages for providers to keep them aware of the status of Initiative projects and as a place to store technical assistance documentation;
2. Collaborate with providers and evaluate other state and regional methodologies to determine the best means for providing technical assistance to providers;
3. Draft technical assistance documentation for providers (including which data elements are required by meaningful use and must be included to meet any Oregon program specifications, methods for secure transmission of data, verification of receipt of data, methods for testing and validation, and contact information for questions);
4. Provide guidance and technical assistance, which will be pretested by selected providers and maintained, updated and available on the state web page; and
5. In addition to state subject matter experts, technical assistance entities such as O-HITEC and the Medicaid Help Desk will be trained to facilitate providers' ability to successfully meet Public Health meaningful use requirements

## **3. Meeting meaningful use**

The next step is to test EHR systems to ensure they have the capability to exchange data to validate meaningful use. OPHD will receive data from providers and validate messages. During Step 2, the Initiative Team will evaluate the capacity of those public health systems that will be the first to receive data and validate the data that are received, including ALERT, Syndromic Surveillance and ELR. The activities for exchanging and validating meaningful use will be similar for each of the Public Health requirements.

Public Health Initiative will:

1. Work with subject matter experts for ELR, ALERT, and EARS/ESSENCE to assess resource needs and plans to validate test messages from eligible professionals for the three Stage 1 Public Health meaningful use objectives;
2. Work with OPHD systems that are not included in Stage 1 meaningful use efforts for readiness to receive clinical data from providers that will minimize the reporting burden (e.g., notifiable condition reporting [Orpheus, ELR], state cancer registry [OSCaR], HIV care coordination [CareAssist; Medical Monitoring Project (MMP)]; child health care coordination [Early Hearing Detection and Intervention (EHDI), ALERT, Child Health Profile (CHP); emergency medical services (EMS)]);
3. In collaboration with OPHD subject matter experts, develop documentation for confirming receipt of data, testing specifications, confirmation of data receipt, and validation of data;
4. Develop/enhance interfaces between state systems to facilitate data sharing (e.g., ALERT – Orpheus; Orpheus – EARS/ESSENCE; ELR – Orpheus; ALERT – EHDI; ALERT – CHP; ALERT – EMS; Orpheus – EMS);

5. Communicate directly with providers to facilitate data submission and validation (including receipt acknowledgement and validation of data); and
6. Share syndromic surveillance data with providers via web interface to enhance situational awareness of community health status.

#### **4. Public health services participation in HIE**

OPHD will also participate in Oregon's HIE. For the Public Health Initiative, this means developing one or more interfaces to the state HIE, facilitating bi-directional data sharing, enabling access to public health services for providers and contributing to the development of a shared services and data architecture. To fully realize the opportunities and challenges of OPHD's involvement in a statewide HIE, the Initiative will:

1. Complete a scan, document the readiness and requirements of the current OPHD infrastructure;
2. Describe the policy framework and technical capacity of OPHD systems that contain health related data (including legal barriers to data sharing);
3. Assess other state public health models for participation in HIE to characterize and evaluate such things as: information content, data standards and volume; shared services and business processes; bi-directional HIE interface design; messaging; and operational, security and privacy policies;
4. Identify Public Health services, data, and reports that providers can access through the HIE to improve care coordination, reduce costs, and demonstrate meaningful use of EHR adoption;
5. Collaborate with state partners to participate in the development of HIE functionality that includes architectural design principles and data structure specifications for one or more OPHD interfaces that enables bi-directional exchange with providers and meets national standards for healthcare interoperability; and
6. Facilitate collaboration and communication across public health programs and with other DHS/OHA programs, direct and foster buy-in from governance and other stakeholders, such as laboratories, health plans, counties, prisons, schools and tribes, around the public health strategy and state participation in HIE.

## **IX. Conclusion**

This document lays out the State's plans for expeditiously and efficiently implementing the Medicaid EHR Incentive Program to maximize and expedite incentives to Oregon providers. Launching Oregon's incentive program is the primary focus for the Medicaid HIT Project over the next 6-12 months.

This SMHP is the first of several. Oregon will submit annual SMHP and IAPD updates, and other updates as needed. Oregon is submitting an HIT IAPD concurrently with this SMHP. Further, Oregon anticipates providing SMHP and IAPD updates to CMS before the end of 2011, to include updated environmental scan results, strategies for meaningful use reporting and validation, Medicaid participation in health information exchange, annual benchmarks, an HIT roadmap, and other items.

Oregon is poised to continue its implementation work, and looks forward to working with its stakeholders and CMS to ensure that Oregon's strategies to facilitate adoption and meaningful use of electronic health records are successful. These strategies will ultimately help Oregon achieve the goals of federal and state health reform: improved population health, increased quality, reliability, and availability of care for all Oregonians, and lowered or contained costs of care to make it affordable to all.

## **Oregon Medicaid HIT Plan Appendices**

**Appendix A: Crosswalk of CMS Questions Addressed in SMHP**

**Appendix B: Potential Incentive Payments to Oregon Hospitals**

**Appendix C: Potential Incentive Payments to Oregon Eligible Professionals**

**Appendix D: Provider Communications Plan**

**Appendix E: Oregon Medicaid HIT Stakeholder Survey**

**Appendix F: Medicaid Acronyms**

**Appendix A: Crosswalk of CMS Questions Addressed in SMHP**

Section	Ques #	Description	Location in SMHP	Deferred?
A	1	What is the current extent of EHR adoption by practitioners and by hospitals? How recent is this data? Does it provide specificity about the types of EHRs in use by the State’s providers? Is it specific to just Medicaid or an assessment of overall statewide use of EHRs? Does the SMA have data or estimates on eligible providers broken out by types of provider? Does the SMA have data on EHR adoption by types of provider (e.g. children’s hospitals, acute care hospitals, pediatricians, nurse practitioners, etc.)?	Pages 4-13	
A	2	To what extent does broadband internet access pose a challenge to HIT/E in the State’s rural areas? Did the State receive any broadband grants?	Pages 13-15	
A	3	Does the State have Federally-QualifiedHealthCenter networks that have received or are receiving HIT/EHR funding from the Health Resources Services Administration (HRSA)? Please describe.	Page 7	
A	4	Does the State have Veterans Administration or Indian Health Service clinical facilities that are operating EHRs? Please describe.	Page 11 & 17	
A	5	What stakeholders are engaged in any existing HIT/E activities and how would the extent of their involvement be characterized?	Pages 18 & 20	
A	6	Does the State Medicaid Agency (SMA) have HIT/E relationships with other entities? If so, what is the nature (governance, fiscal, geographic scope, etc) of these activities?	Pages 17 & 19	
A	7	Specifically, if there are health information exchange organizations in the State, what is their governance structure and is the SMA involved? ** How extensive is their geographic reach and scope of participation?	Page 16	Partially

<b>Section</b>	<b>Ques #</b>	<b>Description</b>	<b>Location in SMHP</b>	<b>Deferred?</b>
A	8	Please describe the role of the MMIS in the SMA’s current HIT/E environment. Has the State coordinated their HIT Plan with their MITA transition plans and if so, briefly describe how.	Page 28	
A	9	What State activities are currently underway or in the planning phase to facilitate HIE and EHR adoption? What role does the SMA play? Who else is currently involved? For example, how are the regional extension centers (RECs) assisting Medicaid eligible providers to implement EHR systems and achieve meaningful use?	Pages 15, 17-19	
A	10	Explain the SMA’s relationship to the State HIT Coordinator and how the activities planned under the ONC-funded HIE cooperative agreement and the Regional Extension Centers (and Local Extension Centers, if applicable) would help support the administration of the EHR Incentive Program.	Pages 17, 19-21, 36, 38	
A	11	What other activities does the SMA currently have underway that will likely influence the direction of the EHR Incentive Program over the next five years?	Pages 22-28, 36-38	
A	12	Have there been any recent changes (of a significant degree) to State laws or regulations that might affect the implementation of the EHR Incentive Program? Please describe.	Page 15	
A	13	Are there any HIT/E activities that cross State borders? Is there significant crossing of State lines for accessing health care services by Medicaid beneficiaries? Please describe.	Page 17	
A	14	What is the current interoperability status of the State Immunization registry and Public Health Surveillance reporting database(s)?	Pages 23-25	
A	15	If the State was awarded an HIT-related grant, such as a Transformation Grant or a CHIPRA HIT grant, please include a brief description.	Pages 25-27	

Section	Ques #	Description	Location in SMHP	Deferred?
B	1	Looking forward to the next five years, what specific HIT/E goals and objectives does the SMA expect to achieve? Be as specific as possible; e.g., the percentage of eligible providers adopting and meaningfully using certified EHR technology, the extent of access to HIE, etc.	Pages 30-32	Partially
B	2	What will the SMA’s IT system architecture (potentially including the MMIS) look like in five years to support achieving the SMA’s long term goals and objectives? Internet portals? Enterprise Service Bus? Master Patient Index? Record Locator Service?	Pages 28-29	Partially
B	3	How will Medicaid providers interface with the SMA IT system as it relates to the EHR Incentive Program (registration, reporting of MU data, etc.)?	Pages 52-53	
B	4	Given what is known about HIE governance structures currently in place, what should be in place by 5 years from now in order to achieve the SMA’s HIT/E goals and objectives? While we do not expect the SMA to know the specific organizations will be involved, etc., we would appreciate a discussion of this in the context of what is missing today that would need to be in place five years from now to ensure EHR adoption and meaningful use of EHR technologies.		Yes
B	5	What specific steps is the SMA planning to take in the next 12 months to encourage provider adoption of certified EHR technology?	Pages 32-34	
B	6	If the State has FQHCs with HRSA HIT/EHR funding, how will those resources and experiences be leveraged by the SMA to encourage EHR adoption?		Yes
B	7	How will the SMA assess and/or provide technical assistance to Medicaid providers around adoption and meaningful use of certified EHR technology?	Page 38	

<b>Section</b>	<b>Ques #</b>	<b>Description</b>	<b>Location in SMHP</b>	<b>Deferred?</b>
B	8	How will the SMA assure that populations with unique needs, such as children, are appropriately addressed by the EHR Incentive Program?	Page 37	
B	9	If the State included in a description of a HIT-related grant award (or awards) in Section A, to the extent known, how will that grant, or grants, be leveraged for implementing the EHR Incentive Program, e.g. actual grant products, knowledge/lessons learned, stakeholder relationships, governance structures, legal/consent policies and agreements, etc.?		Yes
B	10	Does the SMA anticipate the need for new or State legislation or changes to existing State laws in order to implement the EHR Incentive Program and/or facilitate a successful EHR Incentive Program (e.g. State laws that may restrict the exchange of certain kinds of health information)? Please describe.	Page 60	
B	End - No #	Please include other issues that the SMA believes need to be addressed, institutions that will need to be present and interoperability arrangements that will need to exist in the next five years to achieve its goals.		Yes
C	1	How will the SMA verify that providers are not sanctioned, are properly licensed/qualified providers?	Page 64	
C	2	How will the SMA verify whether EPs are hospital-based or not?	Page 68	
C	3	How will the SMA verify the overall content of provider attestations?	Pages 64-65	
C	4	How will the SMA communicate to its providers regarding their eligibility, payments, etc?	Pages 57, 61-62	
C	5	What methodology will the SMA use to calculate patient volume?	Pages 48-49	
C	6.1	What data sources will the SMA use to verify patient volume for EPs and acute care hospitals?	Page 66	

<b>Section</b>	<b>Ques #</b>	<b>Description</b>	<b>Location in SMHP</b>	<b>Deferred?</b>
C	6.2	How will the SMA verify adopt, implement or upgrade of certified electronic health record technology by providers?	Page 65	
C	7.1	How will the SMA verify that EPs at FQHC/RHCs meet the practices predominately requirement?	Page 68	
C	7.2	How will the SMA verify meaningful use of certified electronic health record technology for providers' second participation years?		Yes
C	8	Will the SMA be proposing any changes to the MU definition as permissible per rule-making? If so, please provide details on the expected benefit to the Medicaid population as well as how the SMA assessed the issue of additional provider reporting and financial burden.	Page 51	
C	9	How will the SMA verify providers' use of certified electronic health record technology?	Page 65	
C	10	How will the SMA collect providers' meaningful use data, including the reporting of clinical quality measures? Does the State envision different approaches for the short-term and a different approach for the longer-term?	Pages 55, 65	
C	11	How will this data collection and analysis process align with the collection of other clinical quality measures data, such as CHIPRA?		Yes
C	12	What IT, fiscal and communication systems will be used to implement the EHR Incentive Program?	Pages 52-53	
C	13	What IT systems changes are needed by the SMA to implement the EHR Incentive Program?	Page 54	
C	14	What is the SMA's IT timeframe for systems modifications?	Page 54	
C	15	When does the SMA anticipate being ready to test an interface with the CMS National Level Repository (NLR)?	Page 55	
C	16	What is the SMA's plan for accepting the registration data for its Medicaid providers from the CMS NLR (e.g. mainframe to mainframe interface or another means)?	Page 55	

Section	Ques #	Description	Location in SMHP	Deferred?
C	17	What kind of website will the SMA host for Medicaid providers for enrollment, program information, etc?	Page 55	
C	18	Does the SMA anticipate modifications to the MMIS and if so, when does the SMA anticipate submitting an MMIS I-APD?	Pages 53-54	
C	19	What kinds of call centers/help desks and other means will be established to address EP and hospital questions regarding the incentive program?	Page 58	
C	20	What will the SMA establish as a provider appeal process relative to: a) the incentive payments, b) provider eligibility determinations, and c) demonstration of efforts to adopt, implement or upgrade and meaningful use certified EHR technology?	Page 59	
C	21	What will be the process to assure that all Federal funding, both for the 100 percent incentive payments, as well as the 90 percent HIT Administrative match, are accounted for separately for the HITECH provisions and not reported in a commingled manner with the enhanced MMIS FFP?	Page 65	
C	22.1	What is the SMA’s anticipated frequency for making the EHR Incentive payments (e.g. monthly, semi-monthly, etc.)?	Page 55	
C	22.2	What will be the process to assure that Medicaid provider payments are paid directly to the provider (or an employer or facility to which the provider has assigned payments) without any deduction or rebate?	Page 66	
C	23	What will be the process to assure that Medicaid payments go to an entity promoting the adoption of certified EHR technology, as designated by the state and approved by the US DHHS Secretary, are made only if participation in such a payment arrangement is voluntary by the EP and that no more than 5 percent of such payments is retained for costs unrelated to EHR technology adoption?	Page 50	

Section	Ques #	Description	Location in SMHP	Deferred?
C	24	What will be the process to assure that there are fiscal arrangements with providers to disburse incentive payments through Medicaid managed care plans does not exceed 105 percent of the capitation rate per 42 CFR Part 438.6, as well as a methodology for verifying such information?	Page 50	
C	25	What will be the process to assure that all hospital calculations and EP payment incentives (including tracking EPs' 15% of the net average allowable costs of certified EHR technology) are made consistent with the Statute and regulation?	Page 69	
C	26	What will be the role of existing SMA contractors in implementing the EHR Incentive Program – such as MMIS, PBM, fiscal agent, managed care contractors, etc.?	Page 52	
C	27	<p>States should explicitly describe what their assumptions are, and where the path and timing of their plans have dependencies based upon:</p> <ul style="list-style-type: none"> <li>• The role of CMS (e.g. the development and support of the National Level Repository; provider outreach/help desk support)</li> <li>• The status/availability of certified EHR technology</li> <li>• The role, approved plans and status of the Regional Extension Centers</li> <li>• The role, approved plans and status of the HIE cooperative agreements</li> <li>• State-specific readiness factors</li> </ul>	Pages 36-38	

Section	Ques #	Description	Location in SMHP	Deferred?
D	1	Describe the methods the SMA will employ to identify suspected fraud and abuse, including noting if contractors will be used. Please identify what audit elements will be addressed through pre-payment controls or other methods and which audit elements will be addressed post-payment.	Pages 64, 71	
D	2	How will the SMA track the total dollar amount of overpayments identified by the State as a result of oversight activities conducted during the FFY?	Page 71	
D	3	Describe the actions the SMA will take when fraud and abuse is detected.	Page 71	
D	4	Is the SMA planning to leverage existing data sources to verify meaningful use (e.g. HIEs, pharmacy hubs, immunization registries, public health surveillance databases, etc.)? Please describe.	Page 65	Partially
D	5	Will the state be using sampling as part of audit strategy? If yes, what sampling methodology will be performed?* (i.e. probe sampling; random sampling)	Page 70	
D	6	What methods will the SMA use to reduce provider burden and maintain integrity and efficacy of oversight process (e.g. above examples about leveraging existing data sources, piggy-backing on existing audit mechanisms/activities, etc)?	Page 63	
D	7	Where are program integrity operations located within the State Medicaid Agency, and how will responsibility for EHR incentive payment oversight be allocated?	Page 58	

Section	Ques #	Description	Location in SMHP	Deferred?
E	1	Provide CMS with a graphical as well as narrative pathway that clearly shows where the SMA is starting from (As-Is) today, where it expects to be five years from now (To-Be), and how it plans to get there.		Yes
E	2	What are the SMA's expectations re provider EHR technology adoption over time? Annual benchmarks by provider type?		Yes
E	3	Describe the annual benchmarks for each of the SMA's goals that will serve as clearly measurable indicators of progress along this scenario.		Yes
E	4	Discuss annual benchmarks for audit and oversight activities.		Yes

## Appendix B: Potential Incentive Payments to Oregon Hospitals

Estimated Maximum Potential Medicare & Medicaid Incentive Payments to Oregon Hospitals with Meaningful Use in 2011, 2012, 2013 under the Final Rule (\$ in thousands) based on CY2009 data.				Potential Medicare			Eligible for Medicaid: >10% of Patient Discharges (5)		Potential Medicaid: Ignoring 10% Eligibility Requirement		Potential Medicare & Medicaid Combined Payments	
Health Systems (bold), Hospitals	Oregon Hospital Type (1)	Pymt Type	Location	Acute Discharges 2009	Year 1 (100%)	Over 4 Years	% Medicaid discharges	Eligible for Incentive (5)	Year 1 (100%)	Over 4 Years	Year 1 (100%)	Over 4 Years
<b>DISCLAIMER: These estimates of potential incentive payments are based on available information regarding hospital volume and characteristics as well as information about Medicare and Medicaid rules. The amounts and actual results may vary substantially from these estimates based on the individual circumstances of particular hospitals, changes in rules and other known or unknown factors.</b>												
<b>Providence Health System</b>			Portland									
Providence St Vincent Medical Ctr	DRG	PPS	Portland	29,136	2,735	6,839	10.2%	Y	619	1,547	3,354	8,385
Providence Portland Medical Ctr	DRG	PPS	Portland	20,209	2,944	7,361	12.5%	Y	703	1,758	3,648	9,119
Providence Medford Medical Center	DRG	PPS	Medford	5,626	1,920	4,799	14.6%	Y	399	998	2,319	5,797
Providence Willamette Falls Hospital (2)	DRG	PPS	Oregon City	5,116	1,312	3,279	19.9%	Y	511	1,277	1,822	4,556
Providence Milwaukie Hospital	DRG	PPS	Milwaukie	2,910	1,307	3,269	19.7%	Y	430	1,075	1,737	4,344
Providence Newberg Hospital	Type B	PPS	Newberg	2,062	1,133	2,832	16.3%	Y	281	702	1,414	3,534
Providence Hood River Memorial Hospital	Type B	CAH	Hood River	1,674	unknown	unknown	23.0%	Y	423	1,057	unknown	unknown
Providence Seaside Hospital	Type B	CAH	Seaside	935	unknown	unknown	12.3%	Y	221	553	unknown	unknown
Total - Providence Health System				67,668	11,351	28,378			3,586	8,966	14,294	35,734
<b>Legacy Health System</b>			Portland									
Legacy Emanuel Hospital & Hlth Ctr	DRG	PPS	Portland	17,896	1,038	2,595	27.1%	Y	1,747	4,368	2,785	6,962
The Children's Hospital at Legacy Emanuel				included with Legacy Emanuel Hospital								
Legacy Good Samaritan Hosp & Med Ctr	DRG	PPS	Portland	10,898	2,123	5,307	7.3%	N	326	816	2,449	6,122
Legacy Meridian Park Hospital	DRG	PPS	Tualatin	8,191	1,936	4,841	5.9%	N	194	484	2,130	5,325
Legacy Mount Hood Medical Center	DRG	PPS	Gresham	5,847	1,450	3,625	19.4%	Y	547	1,367	1,997	4,992
Total - Legacy Health System				42,832	6,547	16,366			2,814	7,035	9,360	23,401
<b>Oregon Health &amp; Science University</b>			Portland									
OHSU Hospital	DRG	PPS	Portland	29,290	1,976	4,940	23.2%	Y	1,623	4,056	3,599	8,997
Doernbecher Children's Hospital				with OHSU Hospital								
Total - Oregon Health & Science University				29,290	1,976	4,940			1,623	4,056	3,599	8,997
<b>PeaceHealth, Oregon &amp; Siuslaw Regions</b>			Eugene									
Sacred Heart Medical Ctr River Bend	DRG	PPS	Eugene	23,770	3,030	7,575	16.2%	Y	1,218	3,045	4,248	10,620
Sacred Heart Medical Ctr Univ Dist	DRG	PPS	Eugene	2,970	1,115	2,789	21.1%	Y	597	1,493	1,713	4,282
Peace Harbor Hospital	Type B	CAH	Florence	1,324	unknown	unknown	11.4%	Y	185	462	unknown	unknown
Cottage Grove Community Hospital	Type B	CAH	Cottage Grove	410	unknown	unknown	8.5%	N	149	373	unknown	unknown
Total - PeaceHealth				28,474	4,145	10,363			2,149	5,372	5,960	14,901
<b>Asante Health System</b>			Medford									
Rogue Valley Medical Center	DRG	PPS	Medford	13,958	2,468	6,171	15.5%	Y	837	2,093	3,306	8,264
Three Rivers Comm Hospital	DRG, Type	PPS	Grants Pass	7,379	2,109	5,273	16.3%	Y	484	1,211	2,594	6,484
Total - Asante Health System				21,337	4,578	11,444			1,321	3,304	5,899	14,748

<b>Salem Health</b>												
Salem Hospital	DRG	PPS	Salem	20,218	2,904	7,260	15.6%	Y	1,018	2,545	3,922	9,805
West Valley Hospital	Type B	CAH	Dallas	93	unknown	unknown	5.4%	N	94	236	unknown	unknown
Total - Salem Health				20,311	2,904	7,260			1,112	2,781	3,922	9,805
<b>Samaritan Health Services, Inc.</b>												
Corvallis												
Good Samaritan Regional Medical Center	DRG	PPS	Corvallis	7,939	1,947	4,867	10.5%	Y	370	924	2,316	5,791
Samaritan Albany General Hospital	DRG	PPS	Albany	3,344	1,342	3,356	27.6%	Y	590	1,475	1,932	4,831
Samaritan Lebanon Community Hospital	Type B	CAH	Lebanon	1,859	unknown	unknown	25.9%	Y	461	1,153	unknown	unknown
Samaritan North Lincoln Hospital	Type B	CAH	Lincoln City	1,288	unknown	unknown	22.2%	Y	475	1,187	unknown	unknown
Samaritan Pacific Communities Hospital	Type B	CAH	Newport	1,371	unknown	unknown	27.6%	Y	466	1,165	unknown	unknown
Total - Samaritan Health Services, Inc.				15,801	3,289	8,222			2,362	5,905	4,249	10,621
<b>St. Charles Health System</b>												
Bend												
St Charles Medical Center - Bend	DRG	PPS	Bend	13,836	2,193	5,484	12.2%	Y	587	1,467	2,780	6,950
St Charles Medical Center - Redmond	Type B	PPS	Redmond	2,350	1,292	3,231	15.2%	Y	265	663	1,557	3,894
Mountain View Hospital	Type B	CAH	Madras	1,113	unknown	unknown	27.6%	Y	518	1,294	unknown	unknown
Pioneer Memorial Hospital (P)	Type B	CAH	Prineville	758	unknown	unknown	19.1%	Y	283	709	unknown	unknown
Total - Cascade Healthcare Community				18,057	3,486	8,715			1,653	4,132	4,338	10,844
<b>Kaiser Permanente Northwest</b>												
Portland												
Kaiser Sunnyside Medical Center (4)	DRG	PPS	Clackamas	18,854	2,637	6,593	2.1%	N	121	303	2,758	6,896
Total - Kaiser Permanente Northwest				18,854	2,637	6,593			121	303	2,758	6,896
<b>Adventist Health Northwest</b>												
Portland												
Adventist Medical Center	DRG	PPS	Portland	8,988	1,740	4,351	16.7%	Y	624	1,561	2,365	5,912
Tillamook County General Hospital	Type A	CAH	Tillamook	1,102	unknown	unknown	11.2%	Y	171	429	unknown	unknown
Total - Adventist Health Northwest				10,090	1,740	4,351			796	1,990	2,365	5,912
<b>Catholic Health Initiatives</b>												
Roseburg												
Mercy Medical Center	DRG, Type	PPS	Roseburg	7,617	2,094	5,236	23.1%	Y	564	1,411	2,659	6,647
St Anthony Hospital	Type A	CAH	Pendleton	1,794	unknown	unknown	23.0%	Y	290	725	unknown	unknown
Total - Catholic Health Initiatives				9,411	2,094	5,236			854	2,136	2,659	6,647
<b>Trinity Health</b>												
Ontario												
Holy Rosary Medical Center (3)	Type A	PPS	Ontario	2,836	1,435	3,588	23.6%	Y	392	980	1,827	4,568
St Elizabeth Health Services (3)	Type A	CAH	Baker City	754	unknown	unknown	15.4%	Y	245	613	unknown	unknown
Total - Trinity Health				3,590	1,435	3,588			637	1,593	1,827	4,568

<b>Other Hospitals</b>												
Bay Area Hospital	DRG	PPS	Coos Bay	7,648	2,051	5,128	17.4%	Y	525	1,313	2,577	6,441
McKenzie-Willamette Medical Center	DRG	PPS	Springfield	6,597	991	2,476	12.5%	Y	348	870	1,338	3,346
Sky Lakes (Merle West) Medical Center	DRG	PPS	Klamath Falls	6,066	1,574	3,934	22.7%	Y	584	1,459	2,157	5,393
Tuality Healthcare	DRG	PPS	Hillsboro	5,161	1,468	3,670	19.7%	Y	428	1,069	1,896	4,739
Willamette Valley Med Ctr	DRG, Type	PPS	McMinnville	4,161	1,603	4,007	16.3%	Y	322	805	1,925	4,812
Silverton Hospital	Type B	PPS	Silverton	3,728	356	890	36.6%	Y	972	2,429	1,328	3,319
Mid-Columbia Medical Center	Type B	PPS	The Dalles	2,277	1,204	3,010	23.6%	Y	428	1,071	1,632	4,081
Good Shepherd Medical Center	Type A	CAH	Hermiston	2,212	unknown	unknown	25.2%	Y	466	1,166	unknown	unknown
Columbia Memorial Hospital	Type B	CAH	Astoria	1,804	unknown	unknown	14.6%	Y	261	653	unknown	unknown
Grande Ronde Hospital	Type A	CAH	LaGrande	1,718	unknown	unknown	15.5%	Y	293	733	unknown	unknown
Ashland Community Hospital	Type B	PPS	Ashland	1,641	1,196	2,989	14.7%	Y	255	639	1,451	3,628
Santiam Memorial Hospital	Type B	PPS	Stayton	1,017	630	1,576	18.7%	Y	316	791	947	2,367
Coquille Valley Hospital	Type B	CAH	Coquille	704	unknown	unknown	13.2%	Y	162	406	unknown	unknown
Wallowa Memorial Hospital	Type A	CAH	Enterprise	482	unknown	unknown	10.4%	Y	156	391	unknown	unknown
Curry General Hospital	Type A	CAH	Gold Beach	753	unknown	unknown	16.7%	Y	300	749	unknown	unknown
Lower Umpqua Hospital	Type B	CAH	Reedsport	543	unknown	unknown	6.3%	N	164	409	unknown	unknown
Lake District Hospital	Type A	CAH	Lakeview	436	unknown	unknown	12.8%	Y	201	504	unknown	unknown
Southern Coos Hospital & Health Center	Type B	CAH	Bandon	407	unknown	unknown	5.4%	N	131	327	unknown	unknown
Harney District Hospital	Type A	CAH	Burns	549	unknown	unknown	6.6%	N	105	263	unknown	unknown
Blue Mountain Hospital	Type A	CAH	John Day	366	unknown	unknown	12.8%	Y	281	702	unknown	unknown
Pioneer Memorial Hospital (H)	Type A	CAH	Heppner	74	unknown	unknown	8.1%	N	161	402	unknown	unknown
<b>Total - 58 Oregon Hospitals</b>				<b>334,059</b>	<b>57,254</b>	<b>143,136</b>			<b>25,887</b>	<b>64,717</b>		
<b>Total - 48 Oregon Hospitals Eligible for Medicaid Incentives with 10% or more Medicaid Discharges</b>									<b>24,442</b>	<b>61,106</b>		
<b>Footnotes</b>												
(1) Hospital Types												
DRG: DRGs, hospitals are reimbursed a flat weight based on a patient's diagnosis and treatment. DRG hospitals are generally located in urban areas and have more than 50 beds.												
The Office of Rural Health has defined a hospital as rural if it is at least 10 miles outside the center of a city of 40,000 or more population.												
Rural hospitals are classified as Types A, B, or C for Medicaid reimbursement purposes.												
Type A: Rural hospitals that have 50 beds or less and are greater than 30 miles from another acute inpatient facility are reimbursed at 100% of reasonable cost by Medicaid.												
Type B: Rural hospitals with 50 or fewer beds and located 30 miles or less from another acute inpatient care facility are reimbursed at 100% of cost by Medicaid.												
Type C: Rural hospitals with more than 50 beds, but are not a referral center. These hospitals are treated as DRG hospitals for Medicare and Medicaid reimbursements for services.												
CAH (Critical Access Hospital): CAHs are 25 or fewer beds and located 35 miles or more (15 miles for mountainous terrain or areas with only secondary roads) from another hospital or CAH.												
CAHs must meet a number of other criteria and requirements and be formally designated as a CAH. CAHs receive enhanced Medicare reimbursement at 101% of reasonable costs.												
Source: Oregon's Acute Care Hospitals Capacity, Utilization and Financial Trends, 2005 to 2007. Office for Oregon Health Policy and Research, April 2009, pp. 1-4.												
Available at <a href="http://oregon.gov/OHPPR/RSCH/docs/Hospital_Report/Hospital_Report_2009.pdf">http://oregon.gov/OHPPR/RSCH/docs/Hospital_Report/Hospital_Report_2009.pdf</a> .												
(2) Joined the Providence Health System effective October 1, 2009.												
(3) Transferred from Catholic Health Initiatives to Trinity Health effective March 31, 2010.												
(4) Kaiser Sunnyside Med Cntr ARRA payments estimated assuming zero charity care given limitations in Kaiser DataBank information.												
<b>(5) &gt;10% Patient Volume Required to receive any Medicaid incentive payments. This calculation based on discharges.</b>												

## Appendix C: Potential Incentive Payments to Eligible Professionals

### Potential Medicare and Medicaid Incentive Payments Available to Oregon Eligible Professionals

Updated December 1, 2010

The American Recovery and Reinvestment Act of 2009 (ARRA) establishes incentive payments through Medicare and Medicaid for the meaningful use of certified electronic health record (EHR) technology by “eligible professionals and hospitals”. The Congressional Budget Office (CBO) estimates outlays for the combined Medicare and Medicaid incentives to be \$34 billion over fiscal years 2009 through 2016.

#### I. Medicare Incentive Payments

“Eligible Professionals” (predominantly physicians) may receive Medicare incentive payments of up to 75% of allowed **Part B** charges for demonstrating the “meaningful use” of certified EHRs. “Meaningful EHR use” is defined as: use of a certified EHR, including electronic prescribing, electronic exchange of health information to improve quality of health care such as promoting care coordination, and submission of clinical quality and other required measures in accordance with Final Rules from Centers for Medicare and Medicaid (CMS) issued in July 2010. The CMS EHR incentive payments website is available at <http://www.cms.gov/EHRIncentivePrograms/>.

Key definitions, phasing and processes regarding certified EHRs, meaningful use, health information exchange and quality measures are specified in the rules from the CMS and the Federal Office of the National Coordinator (ONC) for Health Information Technology.

**Eligible Professionals:** Medicare physician incentive payments provide up to \$44,000 per eligible professional over five years for demonstrated meaningful use beginning in 2011 or 2012. The maximum payments over the five years are year 1: \$18,000, year 2: \$12,000, year 3: \$8,000, year 4: \$4,000 and year 5: \$2,000. The maximum payments are lower if meaningful use criteria are first demonstrated in 2013 (\$42,000) or 2014 (\$35,000). For eligible professionals practicing in health professions shortage areas, the incentive payments amounts are increased by 10% (year 1: \$19,800, five year maximum \$48,400). Incentive payments are equal to 75% of the allowed Part B charges during the reporting year. No incentive payment may be made to a hospital-based eligible professional such as a pathologist, anesthesiologist or emergency physician who furnishes substantially all services in a hospital setting (inpatient or outpatient) through the use of facilities and equipment supplied by the hospital, including qualified electronic health records.

To receive the maximum first year incentive payment of \$18,000, an eligible professional would need to (a) meet the meaningful use criteria and (b) provide \$24,000 of allowed **Part B** charges.

#### II. Medicaid Incentive Payments

ARRA specifies parameters for Medicaid incentive payments but states have some latitude in structuring the incentive program to meet the special needs of their Medicaid populations. The Oregon Medicaid program is in the process of determining how it plans to implement Medicaid incentive payments. Information about the Oregon Medicaid incentive payments program is available at <http://www.oregon.gov/DHS/mhit/incentive.shtml>.

**Eligible Professionals:** Medicaid provider incentive payments provide up to \$63,750 per eligible professional over six years. Providers must qualify for incentives no later than 2016 to receive maximum

payments. In year 1 of participation providers must either adopt/implement or upgrade to a certified EHR and demonstrate meaningful use to receive an incentive, and then demonstrate meaningful use in years 2-6 to continue to receive incentives. Payment amounts are: year 1: \$21,250, years 2-6: \$8,500 per year.

Medicaid incentive payments are available to physicians and other practitioner (including nurse practitioners, dentists, certified nurse midwives, and physicians' assistants in certain settings) that (a) meet the meaningful use of certified EHR criteria and related criteria, and (b) serve a sufficient proportion of Medicaid clients. These eligibility levels vary by the type of physician/provider practice setting as follows:

- Professionals other than pediatricians: a minimum of 30% Medicaid population but not including Children's Health Insurance Program (CHIP) clients.
- Pediatricians: a minimum of 20% Medicaid population but not including CHIP clients.
- Fully qualified health center (FQHC) or rural health center (RHC): a minimum of 30% "needy individuals" including Medicaid, Children's Health Insurance Program (CHIP), uninsured sliding scale or free care.

Similar to Medicare, no incentive payment may be made to a hospital-based eligible professional such as a pathologist, anesthesiologist or emergency physician who furnishes substantially all services in a hospital inpatient or emergency room setting through the use of facilities and equipment supplied by the hospital, including qualified electronic health records.

### III. Medicare and/or Medicaid Incentive Payments

**Eligible Professionals** that are eligible for both Medicare and Medicaid incentive payments must choose whether they wish to receive Medicare or Medicaid payments. Providers cannot receive payments from both programs.

### IV. Potential Incentive Payments for Oregon Providers

#### Oregon Physician Eligibility for Incentive Payments

The 2009 Oregon Physicians Workforce Survey (PWS) included questions that can help estimate the likely numbers of Oregon physicians that may be eligible to receive Medicare or Medicaid incentive payments. Attachment A shows the number of PWS responses by specialty and practice settings as well as the percentage of those physicians that could be eligible to receive incentive payments from Medicare or Medicaid. Attachment A also shows the percentage of physicians that could qualify in either Medicare or Medicaid:

- 81% of physicians in private clinics or offices could be eligible for either Medicare or Medicaid incentive payments assuming they utilize a certified EHR system and meet the meaningful use and other criteria.
- 97% physicians in FQHCs or RHCs, and
- 95% of physicians in hospital ambulatory care clinics could be eligible for incentive payments.

**Caution: actual eligibility for incentive payments and the amounts of the payments is critically dependent on the adoption of certified EHR systems and satisfying meaningful use and other criteria. Additionally, providers may incur significant costs to adopt EHR systems and demonstrate meaningful use.**

The 2009 Ambulatory EHR Inventory provides additional information about the levels of EHR adoption. The survey is available at <http://www.oregon.gov/OHPPR/HITOC/docs/OR2009EHRSurvey.pdf>.

### IV. Oregon and Federal Health Reform Impacts

The 2009 Oregon Legislature enacted legislation to expand coverage under the Oregon Health Plan and provide other forms of health reform. The expansion in the Oregon Health Plan and Medicaid

program is likely to increase the number of professionals that may be eligible to receive Medicaid incentive payments, assuming those professionals meet the meaningful use criteria. Similarly, Federal health reforms included in the Patient Protection and Affordable Care Act of 2010 are likely to affect the volumes of Medicaid patients in many practice settings.

Oregon Physicians Potentially Eligible Medicare or Medicaid Incentive Payments

Attachment A

	Medicare 10%+ Medicare (1)	Medicare 10%+ Medicare (1)	Medicare 10%+ Medicare (1)	Medicaid 30%+ Medicaid	Medicaid 20%+ Medicaid	Medicaid 30%+ Medicaid & Uninsured	Medicaid 30%+ Medicaid	Medicaid 20%+ Medicaid	Medicaid 20%+ Medicaid	Other Medicare or Medicaid	Other Medicare or Medicaid	Other Medicare or Medicaid	
ARRA Definition	All ambulatory office or clinic settings	All ambulatory office or clinic settings	All ambulatory office or clinic settings	Independent practice other than pediatrics	Independent practice - pediatrics	FGHC or RHC	Hospital owned practice other than pediatrics	Hospital owned practices, pediatrics		Independent practices (ALL)	FGHC or RHC	Hospital owned practices	
Physician Workforce Survey Definition	Private Clinic or Office	Community & Public Health Clinics	Hospital Ambulatory Care Clinics	Private Clinic or Office other than Pediatrics	Private Clinic or Office - Pediatrics	Community & Public Health Clinics	Hospital Ambulatory Care Clinics	Hospital Ambulatory Care Clinics		Private Clinic or Office (ALL)	Community & Public Health Clinics	Hospital Ambulatory Care Clinics	
<b>Estimated Maximum Percentage of Oregon Physicians Potentially Eligible for Medicare or Medicaid Incentive Payments</b>													
Based on 2008 Oregon Physician Workforce Survey (PWS) responses providing financial sponsorship information.													
Responses, % Meeting Criteria	n	%	n	%	n	%	n	%	n	%	n	%	
<b>Eligible Specialists</b>													
Family/General Medicine	32+	88.0%	72	55.6%	45	91.1%	32+	62%	72	100.0%	45	33.3%	
Obstetrics and/or Gynecology	119	45.4%	5	20.0%	1+	42.9%	119	31.9%	5	100.0%	1+	92.9%	
General Internal Medicine	170	90.6%	1+	28.6%	31	100.0%	170	3.5%	1+	78.6%	31	61.3%	
General Pediatrics	112	1.8%	5	20.0%	+	25.0%	lower of (b) >	112	66.1%	5	100.0%	+	100.0%
General Surgery	53	96.2%			2	100.0%	53	3.8%			2	100.0%	
Internal Medicine Subspecialty	143	97.9%	3	33.3%	12	100.0%	143	4.9%	3	100.0%	12	66.7%	
Pediatric Subspecialty	61	41.0%	1	0.0%	23	17.4%	lower of (b) >	61	44.3%	1	100.0%	23	91.3%
Surgical Subspecialty	24	83.3%			2	100.0%	24	4.2%			2	100.0%	
Anesthesiology	+	75.0%			5	100.0%	+	0.0%			5	80.0%	
Dermatology	27	92.6%			27	0.0%					27	92.6%	
Emergency Medicine	2	50.0%			2	100.0%			2	100.0%			
Neurological Surgery	11	100.0%			11	9.1%					11	100.0%	
Neurology	31	87.1%			1	100.0%	31	0.0%			1	0.0%	
Occupational/Environmental Med	17	0.0%			+	0.0%	17	0.0%			+	0.0%	
Ophthalmology	7+	96.6%			5	60.0%	7+	1.4%			5	100.0%	
Orthopedics	72	88.9%			3	100.0%	72	1.4%			3	100.0%	
Otolaryngology	31	87.1%			+	100.0%	31	6.5%			+	100.0%	
Pathology	5	80.0%				0.0%	5	0.0%			5	80.0%	
Physical Med & Rehabilitation	17	64.7%			2	100.0%	17	0.0%			2	50.0%	
Plastic Surgery	22	54.5%				0.0%	22	0.0%			22	54.5%	
Preventive Medicine	2	0.0%				0.0%	2	0.0%			2	0.0%	
Psychiatry	85	25.9%	26	57.7%	7	57.1%	85	2.4%	26	84.6%	7	0.0%	
Radiology	12	91.7%			5	100.0%	12	0.0%			5	100.0%	
Urology	27	96.3%			1	0.0%	27	3.7%			1	0.0%	
Other	70	64.3%	+	25.0%	1+	92.9%	70	2.9%	+	75.0%	1+	50.0%	
Overall	1,616	72.1%	180	48.6%	138	76.3%	1,342	8.8%	178	68.4%	180	83.8%	
									168	82.4%	27	82.8%	
											1,616	80.7%	
											180	87.7%	
											138	84.8%	
(1) Medicare incentive payments to Eligible Professionals meeting the meaning of use objectives are based on 75% of allowed Part B Medicare charges. That is, there is no minimum volume of Medicare services required to receive incentive payments. Physicians with a patient mix of 10% or more Medicare patients are judged likely to qualify for the maximum Medicare incentive payment.													
2008 Oregon Physician Workforce Survey:													
Total available survey responses							3,744	Analysis by Witter & Associates					
Clinical practice responses							3,269	Direct questions or comments to David Witter					
Clinical - financial sponsorship response:							2,636	503-222-6469 <a href="mailto:dwitter@acl.com">dwitter@acl.com</a>					
Useable financial sponsorship response:							2,451	April 2010, updated October 11, 2011					
Responses in the 3 settings covered by this analysis							1,831						

## **Appendix D: Communications Plan**

### **Medicaid Electronic Health Records Incentive Program Provider Communications Plan**

#### **Scope**

The Medicaid Health Information Technology Program (HIT) is responsible for the development and implementation of Oregon's Medicaid Electronic Health Records (EHR) Incentive Program including provider communications. The critical timing of getting information to Oregon providers about the Medicaid EHR Incentive Program heightens the need for the immediate development of a communications plan for the Medicaid EHR Incentive Program. Therefore, this document will focus on the provider communications relating to the Medicaid and Medicare EHR Incentive Programs.

The Office of Health IT will be working on the design, development, and related follow-up for an integrated external communications strategy, plan and approach for the implementation phase of statewide Health Information Exchange, including provider communications relating to the Medicaid and Medicare EHR Incentive Programs, consumer communications around personal health records, consent and privacy and security issues, state HIT planning for the Health Information Technology Oversight Council (HITOC) and any other related HIT statewide efforts including coordination with overall Oregon Health Authority (OHA) communications efforts.

Once the overall HIT communications strategy is finalized by the Office of Health IT and the Oregon Health Authority in early 2011, this document could be expanded to include additional information for the messaging to providers about health information exchange and any programs that are developed to support broader adoption of electronic health records.

#### **1. Communication Strategy Approach**

The communication efforts through the Medicaid EHR Incentive Program outlined in this document are critical to reach Oregon providers. However, it is essential for a successful comprehensive, coordinated communication strategy around issues of health information technology to ensure that all provider messaging from OHA, particularly through Department of Medical Assistance Programs (DMAP), Medicaid HIT, the Office of Health IT and HITOC, as well as other key partners, such as O-HITEC, complements and builds on consistent messaging using plain, clear language. It is important to recognize that in many instances

separate communications will be required since partners have different focuses, timing and requirements from federal funding entities; however providers need to see and hear consistent, clear messages across all programs related to health information technology.

## 2. Current Status

There was a pressing need for some initial messaging and outreach to key stakeholders prior to the finalization of this communication plan. Coordination with O-HITEC, Oregon's Regional Extension Center was critical. An approach to initial messaging was agreed upon by the Medicaid HIT project team, OHA Communications and O-HITEC. An example of the initial messaging is included in Appendix A. The goal is to use consistent messaging across all communication tools for eligible providers.

Preliminary outreach has focused on core constituencies including Oregon Medical Association, Oregon Association of Hospitals and Health Systems, and Medicaid Contractors. One suggestion from the Oregon Medical Association (OMA) is to produce a joint Oregon EHR newsletter and perhaps host a joint website with other core stakeholders including O-HITEC, OMA and other provider associations. Those possible joint communication tools are not included in the list of deliverables and on the timeline because there would need to be more exploratory conversations to define what might be possible.

## 3. Definition of Audience

Providers in Oregon may be eligible for both the Medicaid EHR Incentive Program and the Medicare EHR Incentive Program. Although the focus of the Medicaid EHR Incentive Program is providers who are potentially eligible for Medicaid incentive payments, the Medicaid eligibility criteria are steep – 30% Medicaid patient volume for most providers, and 10% Medicaid patient volume for hospitals. Many Oregon Medicaid providers will not be eligible for a Medicaid incentive, but would likely be eligible under the Medicare incentive program. However, any Oregon provider may look to OHA/DMAP for information about the incentives programs, so this communications plan will endeavor to communicate with as wide an audience of Oregon providers as possible.

Providers can be divided into five categories

- Eligible for Medicaid Incentive Payments only
- Eligible for Medicare Incentive Payments only
- Eligible for either Medicare or Medicaid Incentive Payments
- Eligible for both Medicare and Medicaid Incentive Payments (hospitals only)

- Not eligible for Medicare or Medicaid Incentive Payments

The primary focus of the Medicaid EHR Incentive Program Communications Plan will be to reach those providers who may be eligible for Medicaid incentive payments.

**TASK: Provide clear, consistent messages about the Medicare and Medicaid EHR Incentive Programs to help all Oregon providers assess if they are eligible for incentive payments, how to access their incentive payments and provide information on resources and technical assistance that are available. [Initial messaging completed; will need to regularly update; see Appendix A]**

### **3.1 Identification of individual providers**

To effectively communicate with Medicaid providers it will be necessary to communicate both directly and through communication channels that providers already depend on for information. Working closely with DMAP staff to determine the best ways to directly communicate is critical since this plan will be dependent on using existing lists of Medicaid providers available through DMAP.

Based on initial conversations, provider mailing addresses are available, but email addresses are not reliable. Additional provider data is in MMIS and can be extracted by the Client and Provider Education Unit (CaPE) if needed, although this may be a time consuming process. There are approximately 18,000 providers in the MMIS system, of which approximately 14,000 provide a medical service.

**TASK: Determine the smaller subset of providers likely to be eligible for the Medicaid EHR Incentive Program, based on categories of eligible providers as defined by CMS. [Nov/Dec]**

**TASK: Develop email and “snail” mailing lists of providers, focusing on those that are most likely to be eligible for Medicaid EHR Incentive Program. [Nov/Dec]**

## **4. Message Development**

The priority under messaging will be to develop a clean, consistent message on the “nuts and bolts” of the Medicaid EHR Incentive Program. This needs to quickly be shared with all identified partners for general use in all related communications to providers. Some of this

work has already begun with O-HITEC, Oregon Medical Association and the Oregon Association of Hospitals and Health Systems.

There are three core areas of messaging to be integrated into all communications coming out from the Medicaid HIT Program:

- Providing Oregon specific information and updates about the Medicaid EHR Incentive Program
- Connecting providers to CMS for information about Medicare and Medicaid EHR Incentive Program
- Connecting providers to O-HITEC for technical assistance to help them adopt and implement Electronic Health Record (EHR) systems to meet meaningful use in order to be eligible for incentive payments

As decisions are made about the specific elements of Oregon's Medicaid EHR Incentive Program, information will need to be quickly integrated into the core messaging.

**TASK: Develop messaging about Oregon's Medicaid EHR Incentive Program. [Initial messaging completed; will need to regularly update]**

**TASK: Develop messaging to link to CMS information on programs. [Initial messaging completed; will need to regularly update]**

**TASK: Confirm messaging on linking to O-HITEC with O-HITEC Communications staff. [Completed]**

**TASK: Integrate information on technical aspects of program as decisions are made. Patient Volume Methodology will need to include information on how to determine Medicaid recipients (CHIP, etc.) [Timing TBD as decisions are finalized]**

## **5. Key partners include, but are not limited to:**

- OHA Leadership and Communications Shop
- DMAP Staff
- O-HITEC (Oregon's Regional Extension Center)
- Medicaid Contractors (Managed Care, Mental Health and Dental Care Organizations)

- Provider associations
- County Health Departments
- HITOC (Oregon’s health information exchange governance entity)
- Tribes
- Quality Corporation

**TASK: Share core messaging (see above) with key partners. [Ongoing]**

**TASK: Explore possible partnerships with other organizations and state agencies, including Children and Family (CAF) Community Development Coordinators and Seniors and People with Disabilities (SPD) staff. [Nov/Dec]**

## 6. Communication Tools and Delivery Methods

### 6.1 Identification of Communication Tools

The Medicaid HIT project is fielding a stakeholder survey in November. The primary purpose of the survey is to gather input on the areas of state discretion in the Medicaid EHR Incentive Program. However, there will be one or two questions included to determine which communication tools providers and associations would prefer. Once the results are available in mid-November, this section of the communication plan should be updated.

#### **Communication tools to include:**

- ❖ Web Strategies
  - Medicaid HIT website postings, paired with GovDelivery notice
  - Links and information on partner websites including:
    - Other state websites (DMAP, OHA, HITOC, Public Health)
    - O-HITEC website
    - Provider association websites
    - Medicaid contractor websites (MCOs, MHOs and DCOs)
- ❖ Reaching provider audience through organizational channels:
  - Association conferences, meetings and newsletters
  - Calls or individual meetings with targeted hospitals
  - Stakeholder/provider meetings and trainings (DMAP, CAF)
- ❖ Direct mail

- ❖ Other
  - Emails to those providers for whom DMAP has addresses
  - Articles in *Provider Matters* (DMAP newsletter)
  - Establish and publicize email address and phone number for providers to contact Medicaid EHR Incentive Program (completed)
  - Develop and maintain Inquiry database to track questions and approved answers (might be integrated with internal communications and/or HITOC outreach efforts)
  - Webinars
  - Explore possibility of joint EHR focused website/newsletter with key stakeholders
  - Annual HIT Summit (timing still to be determined)

Because of the lack of reliable email addresses for providers from DMAP, communication with individual providers will need to rely heavily on direct mail. This will be augmented by email communications when possible, web postings, in-person presentations and the use of newsletters and other communication tools of partners.

### 6.1.1 Web Strategies

The existing Medicaid HITEHR incentive program webpage - <http://www.oregon.gov/DHS/mhit/incentive.shtml> - is a starting place, but is currently just a placeholder. Regular updates announced through GovDelivery notices will be one way to help move information out. However, it may be difficult to get providers to visit the site, so the webpage will need to be a secondary support to other outreach and communication tools.

A top priority is to develop an initial FAQ (Frequently Asked Questions) link on the website. This will allow one-stop service to answer many of the questions that providers will have. Any outreach materials (email and print) should include a link to the website and FAQ, so that as program decisions are finalized (Meaningful Use menu items, patient volume calculation methodology, etc.) information can be easily added to the website FAQ for easy access.

**TASK: Develop Frequently Asked Questions [Initial list developed and posted by November 15, 2010; regularly expanded and updated as needed.]**

**TASK: Enhance the information currently available on the Medicaid HIT website and send out regular updates with links to the website. [Launch site with FAQs November 15]**

**TASK: Outreach to partner organizations and arrange for shared website links.  
[Dec/Jan]**

**6.1.2 Reaching provider audience through organizational channels**

It will be important to use existing relationships through the Medicaid contractors (Managed Care Organizations (MCOs), Mental Health Organizations (MHOs), Dental Care Organizations (DCOs) or Independent Physician Associations (IPAs) to reach providers who have existing organizational affiliations.

Another key channel will be communicating to providers through clinics and associations, to reinforce direct communications to individual providers. These channels should include, among others:

- Oregon Academy of Family Physicians
- Oregon Association of Hospitals and Health Systems
- Oregon Dental Association
- Oregon Medical Association
- Oregon Nurses Association
- Oregon Primary Care Association
- Oregon Chapter of the American College of Nurse-Midwives
- Oregon Society of Physician Assistants
- Office of Rural Health
- OCHIN
- Provider Licensing Agencies
- County Health Departments (CLHO)

**TASK: Outreach to provider organizations has already begun, particularly with the Oregon Medical Association and the Oregon Association of Hospitals and Health Systems, but outreach to the other identified associations and organizations needs to be a top priority in Fall/Winter 2010-2011. [Focused outreach October 2010 – January 2011]**

**TASK: Determine if joint newsletter with provider associations and O-HITEC is feasible.**

**TASK: Prioritize and schedule presentations at association meetings and stakeholder events.**

**6.1.3 Direct Mail**

Series of 3 direct mail pieces to Oregon providers, tentatively scheduled for January, March and May. Each will include core messages with the following focus:

January – CMS registration; decision point on Medicare/Medicaid programs; Medicaid program details

March – Reminder of Medicare launch (link to CMS); Timing and details of Medicaid program

May – Announce launch of Medicaid program

**TASK: Develop messaging and design direct mail pieces for distribution in January, March and May 2011.**

#### **6.1.4 Other**

Although direct mail, web strategies and outreach through existing organizational channels will be the primary communication tools used to update and engage providers, there are additional communication opportunities that will be used to support the overall efforts. This list will be fine-tuned based on the results of the November, 2010 stakeholder survey being fielded by the Medicaid HIT project, but is likely to include all of the following:

- Emails to those providers for whom DMAP has addresses updating providers on the status of the Medicaid EHR Incentive Program
- Articles in *Provider Matters* (DMAP newsletter)
- Publicizing the email address and phone number for provider to contact for more information
- Develop and maintain Inquiry database to track questions and approved answers (might be integrated with internal communications and/or HITOC outreach efforts)
- Webinars scheduled to announce milestones in the Medicaid EHR Incentive Program (i.e., decisions around state discretionary items, launch of program)
- Explore possibility of joint EHR focused website/newsletter with key stakeholders
- Annual HIT Summit (timing still to be determined)

**TASK: Review the results from the November, 2010 stakeholder survey and determine which of the secondary communication tools will be most effective.**

## **6.2 Key Messengers**

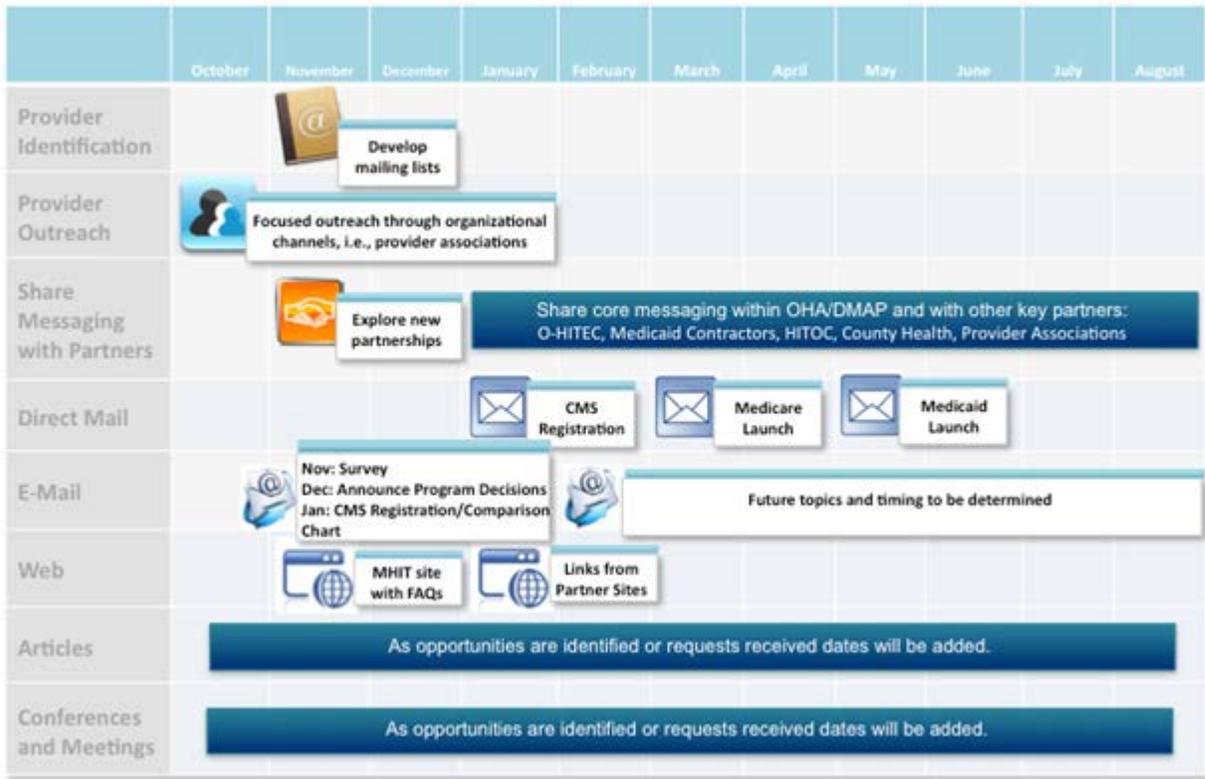
Key messengers will continue to be identified, but initial ideas include:

- Bruce Goldberg, MD
- Dr. Chuck Hofmann (OHPB)
- Judy Mohr Peterson
- Carol Robinson
- Provider Champions (OMA, OAHHS)
- Others tbd

## **7. Timeline and Deliverables**

Below is a preliminary timeline. As more information is gathered on outreach opportunities, especially the timing of key association meetings, as well as the timing of decision points for Oregon specific program decisions, then the timeline will be expanded to include that information.

### 2010-11 Medicaid Incentive Provider Communication Plan



## 7.2 Key Deliverables

Now through the program launch in the summer of 2011 all communication tools will focus on the distribution of the three core messages:

- Announce incentive payment program – link to CMS for specifics including Meaningful Use criteria and timing
- Connect providers to O-HITEC for technical assistance
- Provide updates on Oregon’s Medicaid EHR Incentive Program including any Oregon specific decisions when available

See Appendix B for the compilation of all of the tasks identified in this document.

Key Deliverables and target completion dates are listed in the table below:

Deliverable	Target Completion Date
-------------	------------------------

Initial provider messaging	Completed
List of eligible providers with email and mail addresses	November 3 (email addresses); January (mailing addresses)
Initial FAQ for MHIT website	November 15
Stakeholder Survey	In field November 4 – 19; Results November 29
Comparison chart on eligibility for Medicaid/Medicare EHR Incentive Program	December 15
#1 Mailer to Providers	January 15
#2 Mailer to Providers	March 15
#3 Mailer to Providers	May 15
Email updates and/or webinars around program development milestones	TBD
Newsletter articles for partner organizations	As requested

## 8. Ongoing Communications Needs, to be Determined

Ongoing communications with partner organizations and through the web strategies will continue. An assessment will need to be done to determine if there needs to continue to be ongoing direct mail efforts.

Decisions as to whether and if so, how, to report out a list of providers who have achieved meaningful use and received Medicaid EHR incentive payments has not been made yet. This activity would need to be coordinated with CMS if a complete list of Oregon providers under either Medicare or Medicaid was to be compiled.

## APPENDIX A: Example of Initial Provider Messages

### Electronic Health Records and the Medicare and Medicaid EHR Incentive Programs

Electronic patient health and medical history records are important components of both federal and state health reform efforts, focusing on enhancing quality of care and containing costs.

**Under the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, eligible health care professionals and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt certified EHR technology and use it to achieve specified health objectives.**

In mid-July, the U.S. Department of Health and Human Services Secretary Kathleen Sebelius announced final rules on the meaningful use of electronic records to help improve Americans' health, increase safety and reduce health care costs through expanded and effective use of electronic health records (EHR).

The Oregon Health Authority (OHA) is working to ensure the technical infrastructure is in place across Oregon so that every time a patient sees a doctor, his or her medical history will be easily accessed and up-to-date. The Department of Medical Assistance Programs (DMAP) within the OHA has responsibility for implementing and running the Medicaid incentive payment program for eligible Oregon providers. Planning has already started and the **Center for Medicaid and Medicare Services (CMS) expects that the majority of states will have launched their Medicaid programs by the summer of 2011. Oregon is on track to meet that timing.**

The Office of the National Coordinator (ONC) is providing support to assist providers across the country in adopting and using in a meaningful way certified EHR technology through a nationwide network of Regional Extension Centers. Oregon is working hard to support providers, consumers and OHA programs so that data can be exchanged in meaningful ways.

**In Oregon, those providers who need help with meeting meaningful use, beginning with the selection of an EHR system or the assessment of whether a current system needs to be upgraded, should contact O-HITEC, Oregon's Regional Extension Center, by visiting [www.o-hitec.org](http://www.o-hitec.org).**

#### **For more information:**

More information on Oregon's Medicaid incentive payment program is available at <http://www.oregon.gov/DHS/mhit/incentive.shtml>. Questions may be directed to (503) 947-5280 or [medicaid-hit.project@state.or.us](mailto:medicaid-hit.project@state.or.us).

CMS/ONC fact sheets on the Medicare and Medicaid incentive payment program, including who is eligible for incentive payments, how to qualify, when payments will start, meaningful use rules and other important information can be found at [www.cms.gov/EHRIncentivePrograms/](http://www.cms.gov/EHRIncentivePrograms/).

## **Appendix B: Identified Tasks as Listed in the Communication Plan (see page listed below for more complete information)**

### **Page 4:**

TASK: Provide clear, consistent messages about the Medicare and Medicaid EHR Incentive Programs to help all Oregon providers assess if they are eligible for incentive payments, how to access their incentive payments and provide information on resources and technical assistance that are available. [Initial messaging completed; will need to regularly update; see Appendix A]

### **Page 5:**

TASK: Determine the smaller subset of providers likely to be eligible for the Medicaid EHR Incentive Program, based on categories of eligible providers as defined by CMS. [Nov/Dec]

TASK: Develop email and “snail” mailing lists of providers, focusing on those that are most likely to be eligible for Medicaid EHR Incentive Program. [Nov/Dec]

### **Page 6:**

TASK: Develop messaging about Oregon’s Medicaid EHR Incentive Program. [Initial messaging completed; will need to regularly update]

TASK: Develop messaging to link to CMS information on programs. [Initial messaging completed; will need to regularly update]

TASK: Confirm messaging on linking to O-HITEC with O-HITEC Communications staff. [Completed]

TASK: Integrate information on technical aspects of program as decisions are made. Patient Volume Methodology will need to include information on how to determine Medicaid recipients (CHIP, etc.) [Timing TBD as decisions are finalized]

### **Page 7:**

TASK: Share core messaging (see above) with key partners. [Ongoing]

TASK: Explore possible partnerships with other organizations and state agencies, including Children and Family (CAF) Community Development Coordinators and Seniors and People with Disabilities (SPD) staff. [Nov/Dec]

### **Page 9:**

TASK: Develop Frequently Asked Questions [Initial list developed and posted by November 15, 2010; regularly expanded and updated as needed.]

TASK: Enhance the information currently available on the Medicaid HIT website and send out regular updates with links to the website. [Launch site with FAQs November 15]

TASK: Outreach to partner organizations and arrange for shared website links. [Dec/Jan]

**Page 10:**

TASK: Outreach to provider organizations has already begun, particularly with the Oregon Medical Association and the Oregon Association of Hospitals and Health Systems, but outreach to the other identified associations and organizations needs to be a top priority in Fall/Winter 2010-2011. [Focused outreach October 2010 – January 2011]

TASK: Determine if joint newsletter with provider associations and O-HITEC is feasible.

TASK: Prioritize and schedule presentations at association meetings and stakeholder events.

TASK: Develop messaging and design direct mail pieces for distribution in January, March and May 2011.

**Page 11:**

TASK: Review the results from the November, 2010 stakeholder survey and determine which of the secondary communication tools will be most effective.

## Appendix E: Oregon Medicaid HIT EHR Survey

### Medicaid HIT Stakeholder Internet Survey, November 2010 Executive Summary

On Nov. 19, 2010, the Medicaid Health Information Technology (HIT) project invited Oregon stakeholders to participate in a web-based survey. The survey was sent via e-mail to 1,057 stakeholders, targeting DMAP eligible professional types, hospitals, MCOs, professional organization representatives and key stakeholder organizations. The survey closed Nov. 29<sup>th</sup>. The survey received a total of 137 responses (overall response rate of 13%); 86 completed the entire survey.

The purpose of the survey was to obtain quick feedback that would inform and guide the project’s analysis activities. Responses from the survey were not intended to be a representative sample from which program decisions would be based. Additional scanning work, including surveys will be completed on an ongoing, annual basis.

The general respondent make-up included a relatively balanced response rate from urban/rural providers and from those who worked in Federally Qualified Health Centers/Rural Health Centers. Survey respondents represented the following areas:

Respondent Type	Number	Proportion
Individual health care providers	36	26%
Group representatives such as clinic, managed care organization, or health care professional representatives	48	35%
Other stakeholders	41	30%
Hospital representatives	12	9%
<b>Total</b>	<b>137</b>	<b>100%</b>

Key survey areas included provider eligibility, focusing on patient volume methodologies; hospital eligibility; and project communication and outreach. The survey was also used to gain a general understanding of provider demographics and characteristics.

#### Patient Volume Methodology

Individual health care providers, group representatives, and stakeholders were asked a series of questions surrounding the patient volume methodology decision that Oregon has to make. To qualify for an incentive payment, Medicaid patient volume must be at least 30%. The decision is whether to offer a method of “Patient Encounter” or a choice between “Patient Encounter” or “Patient Panel” to calculate Medicaid patient volume. Questions surrounding which method would be chosen, rating of the difficulty or ease of calculating the patient panel method, opinion on what decision Oregon should make, as well as alternate methodologies were asked. Additional questions were asked to determine whether providers felt inclusion of out-of-state patients in the patient volume calculation would make a substantial difference in a provider qualifying for the EHR Incentive program.

While the majority (61%) of the respondents reported they would choose the Patient Encounter method compared to a small handful (9%) who chose Patient Panel, most (53%) felt that Oregon should offer the choice compared to 7% who felt that only the Patient Encounter method should be offered; 40% were not sure. The majority of respondents (45%) were also not sure whether including out of state

patients would make a difference in whether a provider would qualify for the program. The higher number of answers of “not sure” offers the project an opportunity for additional provider outreach and communication.

### **Hospital participation**

Hospitals were asked a series of questions surrounding detail of their EHR system status, eligible hospital type, Medicaid patient volume, and anticipated first year of participation. With the 12 responses, an overwhelming 92% reported that they either have or are in the process of obtaining an EHR system and 90% meet the definition of an Eligible Inpatient Acute Care Hospital. 40% of the respondents plan on participating in both the Medicare and Medicaid EHR incentives programs; the remaining 60% were not sure on program participation.

### **Communication and outreach**

The majority of respondents across all surveys (over 50%) offered to partner with the Medicaid EHR Incentive program as an either resource or communication partner. The goal of the survey was inform providers about the program and to inform the project about provider’s perspectives surrounding various program aspects.

### **Survey Overview**

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The Medicaid EHR Incentives program survey was intended to inform the project on various program areas including:

- Respondent demographics such as size of clinic, type of providers, setting of practice
- Preferences and opinions for Oregon’s Patient Volume calculation methodology
- Assessment of provider respondent’s potential eligibility for the program
- Likelihood and expected timeframe of participation in the Medicaid EHR incentives program
- Preferences for communications and education outreach

Four survey types were used within the survey:

- Individual Eligible Professional (EP)
- Clinic Rep – Almost identical content as the Individual eligible professional survey but language revised slightly for clinic representatives, health care professional association representatives and managed care organization representatives
- Hospitals
- Stakeholders – Contains limited key questions from the Individual eligible professional and Clinic Rep surveys

The responses below are a summarization of all responses from each of the various surveys. Where applicable, answers to each question have been aggregated by survey type in each of the tables. The questions have been modified slightly to accommodate minor wording variations between the four surveys.

## RESPONDENT DEMOGRAPHICS

### 1. Please identify the role that best describes you

Answer determined which of the four survey instruments would be presented to the respondent (see survey instrument key)

Answer Options	Response Count	Response Percent
A. Health care provider	36	26%
B. Clinic representative	33	24%
C. Hospital representative	12	9%
D. Health care professional association representative	6	4%
E. Hospital association representative	0	0%
F. Managed care organization representative	9	7%
G. Other stakeholder:	7	5%
Other (please specify)	34	25%
<b>Totals</b>	<b>137</b>	<b>100%</b>

Survey instrument key	
Identified Role	Survey Instrument
A. Health care provider	Individual EP
B. Clinic representative	Clinic rep
C. Hospital representative	Hospital
D. Health care professional association representative	Clinic rep
E. Hospital association representative	Stakeholder
F. Managed care organization representative	Clinic rep
G. Other stakeholder:	Stakeholder
Other (please specify)	Stakeholder

## 2. Please provide your zip code

Zip code was asked of all respondents within each of the survey instruments. Urban vs. rural designation is based on rural definitions located on the OHSU web site (<http://www.ohsu.edu/xd/outreach/oregon-rural-health/data/rural-definitions/index.cfm>)

Urban vs. Rural										
Population Density based on zip code	Indiv EP		Clinic rep		Hospital		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%	#	%
<b>Urban</b>	24	65%	30	64%	3	25%	20	50%	77	57%
<b>Rural</b>	13	35%	17	36%	9	75%	18	45%	57	42%
<b>Other* - Out of state</b>	0	0%	0	0%	0	0%	2	5%	2	1%
<b>Totals</b>	<b>37</b>	<b>27%</b>	<b>47</b>	<b>35%</b>	<b>12</b>	<b>9%</b>	<b>40</b>	<b>29%</b>	<b>136</b>	<b>100%</b>

\* Other zip codes were for Vancouver, WA and Fresno, CA

## 3. How many clinicians practice in your clinic?

Answer Options	Indiv EP		Clinic rep		Total responses	
	#	%	#	%	#	%
Solo Practice	5	14%	2	7%	7	11%
2-4 Clinicians	7	20%	1	4%	8	13%
5-9 Clinicians	6	17%	7	25%	13	21%
10-19 Clinicians	5	14%	8	29%	13	21%
20-49 Clinicians	6	17%	5	18%	11	17%
50+ Clinicians	6	17%	5	18%	11	17%
<b>Totals</b>	<b>35</b>	<b>56%</b>	<b>28</b>	<b>44%</b>	<b>63</b>	<b>100%</b>

**4. Please select which provider type best describes you or types of health care clinicians you represent.**

Note: Respondent could select as many answer options applied.

Answer Options	Indiv EP		Clinic rep		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%
Physician	16	35%	31	41%	22	25%	<b>69</b>	<b>33%</b>
Pediatrician	2	4%	10	13%	7	8%	<b>19</b>	<b>9%</b>
Dentist	0	0%	4	5%	6	7%	<b>10</b>	<b>5%</b>
Nurse practitioner	7	15%	0	0%	25	28%	<b>32</b>	<b>15%</b>
Certified nurse-midwife	5	11%	5	7%	5	6%	<b>15</b>	<b>7%</b>
Physician assistant	4	9%	11	15%	9	10%	<b>24</b>	<b>11%</b>
Other (please specify)*	12	26%	14	19%	12	14%	<b>38</b>	<b>18%</b>
Not applicable	0	0%	0	0%	2	2%	<b>2</b>	<b>1%</b>
<b>Totals</b>	<b>46</b>	<b>22%</b>	<b>75</b>	<b>36%</b>	<b>88</b>	<b>42%</b>	<b>209</b>	<b>100%</b>

<b>Other Responses*</b> <b>Individual EP</b>	<b>Clinic Rep</b>	<b>Stakeholder</b>
1. Administrator	1. Behavioral health clinicians	1. All
2. Chemical dependency therapist	2. Health information management professionals	2. ASC, Laboratory, Radiology, EKG, Other ancillary services
3. Executive Management	3. LCSW	3. Long term care providers
4. Finance	4. Licensed Mental Health Professionals	4. Many of the above types of providers participate in the Telehealth Alliance of Oregon
5. Health department	5. Mental Health and Addictions	5. Nurses Mental Health Clinicians
6. Mental Health	6. Mental Health Organization	6. Nursing home, assisted living, residential care and in-home care providers
7. Mental Health Practitioner	7. Natural medicine providers, chiropractors	7. OAHN represents providers statewide in administering the \$20mm FCC Telehealth program
8. MSW	8. Nurse practitioner starting in July/Aug 2011	8. Psychiatrists
9. Peer Support Specialist	9. Psychiatrists, QMHPs, QMHA, LPCs	9. RN (2)
10. Practice Owner-Registered Nurse	10. Psychiatrist	10. We also employ public health nurses who provide communicable disease control services as well as patient care
11. Psychologist	11. QMHP	11. We represent the hospitals, clinics, community colleges as organizations.
	12. Social workers and case managers	
	13. We are an MCO	

**5. Do you or any of the clinicians you represent practice in a RuralHealthCenter or Federally QualifiedHealthCenter?**

Answer Options	Indiv EP		Clinic rep		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%
Yes	7	20%	22	51%	17	47%	<b>46</b>	<b>40%</b>
No	25	71%	18	42%	13	36%	<b>56</b>	<b>49%</b>
Not Applicable	0	0%	1	2%	3	8%	<b>4</b>	<b>4%</b>
Not sure	3	9%	2	5%	3	8%	<b>8</b>	<b>7%</b>
<b>Totals</b>	<b>35</b>	<b>31%</b>	<b>43</b>	<b>38%</b>	<b>36</b>	<b>32%</b>	<b>114</b>	<b>100%</b>

**6. Do you or any of the clinicians you represent practice in other states besides Oregon?**

Answer Options	Indiv EP		Clinic rep		Total responses	
	#	%	#	%	#	%
Yes	2	10%	6	17%	<b>8</b>	<b>15%</b>
No	18	90%	28	80%	<b>46</b>	<b>84%</b>
Not sure	0	0%	1	3%	<b>1</b>	<b>2%</b>
<b>Total</b>	<b>20</b>	<b>36%</b>	<b>35</b>	<b>64%</b>	<b>55</b>	<b>100%</b>

**7. Do you or any of the clinicians you represent serve Medicaid patients from other states besides Oregon?**

Answer Options	Indiv EP		Clinic rep		Total responses	
	#	%	#	%	#	%
Yes	10	50%	11	31%	<b>21</b>	<b>38%</b>
No	10	50%	22	63%	<b>32</b>	<b>58%</b>
Not sure	0	0%	2	6%	<b>2</b>	<b>4%</b>
<b>Total</b>	<b>20</b>	<b>36%</b>	<b>35</b>	<b>64%</b>	<b>55</b>	<b>100%</b>

## ELIGIBLE PROFESSIONALS PATIENT VOLUME METHODOLOGY

8. If given the choice, which method would you or your clinicians choose to calculate patient volume?

Answer Options	Indiv EP		Clinic rep		Total responses	
	#	%	#	%	#	%
Patient Encounter	12	55%	23	66%	35	61%
Patient Panel	2	9%	3	9%	5	9%
Not sure	8	36%	9	26%	17	30%
<b>Totals</b>	<b>22</b>	<b>39%</b>	<b>35</b>	<b>61%</b>	<b>57</b>	<b>100%</b>

***Respondent comments to this question by answer option:***

***Patient Encounter***

- Generally needy patients receive more services, so a clinician with a panel with less than 30% needy patients should not be disqualified if over 30% of the services given are for the needy patients in his/her panel – respondent answered “encounter”
- As providers of maternity services, our patient "panel" is not as stable as providers providing services over a period of years.
- RHC is an urgent care clinic.
- Easier to get
- Easiest to calculate
- Often the "needy" and Medicaid patients are seen more often.
- We do not keep a list of # of assigned patients by provider.
- Ease of gathering information from schedules.

***Not sure***

- I need to look at our office statistics more carefully before we decide. We are working on this but are in the middle of switching to an EMR and haven't had time yet.
- As of the date of this survey response, we have not calculated patient volume of our provider group under either methodology. In light of the assumption of risk of our provider group under the OHP contract, we recommend the simplified member method set forth in our comment below.

**Of the 5 respondents who chose Patient Panel:**

- 3 of the 5 represented FQHC's/RHC's; 2 of the 3 were also Managed Care Organizations
- 2 answered that more clinicians would qualify if Oregon gave providers the choice of the Patient Panel calculation and felt the calculation was manageable. 2 respondents were not sure if more would qualify and responded that the Patient Panel calculation was easy. One respondent answered that the patient encounter methodology alone would likely cover all eligible professionals but also answered that the Patient Panel methodology was burdensome to use.

**9. In your opinion, would more clinicians qualify for the program if Oregon gave providers the choice of the Patient Panel calculation method rather than only offering the Patient Encounter calculation method?**

Answer Options	Indiv EP		Clinic rep		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%
Yes – Some providers would qualify with the Patient Panel methodology and wouldn't qualify with the Patient Encounter method	2	10%	7	20%	8	25%	17	19%
No – The Patient Encounter methodology alone would likely cover all eligible professionals	4	19%	4	11%	5	16%	13	15%
Not sure	15	71%	24	69%	19	59%	58	66%
<b>Totals</b>	<b>21</b>	<b>24%</b>	<b>35</b>	<b>40%</b>	<b>32</b>	<b>36%</b>	<b>88</b>	<b>100%</b>

***Respondent comments to this question by answer option:***

***Yes – Some providers would qualify with the Patient Panel methodology and wouldn't qualify with the Patient Encounter method***

- I think giving providers the most options is a good idea.
- Patient Encounter method appears to "favor" volume of encounters and might unfairly penalize providers that have smaller practices.
- Keep qualification criteria as broad as possible at least until details of eligibility and reimbursement are tested through simulation with a sound statistical foundation for the results

***No – The Patient Encounter methodology alone would likely cover all eligible professionals***

- We do not have Medicaid assigned patients in public health
- Over time the numbers should be almost identical anyway, yet far more cumbersome and likely more error-prone to calculate with the "panel" method
- Applied specifically to our group, acknowledge this may differ based on specialty/practice.

***Not sure***

- It would be much easier to gather data for the patient panel
- We do not base our services on patient volume

**10. Please rate how easy or difficult it would be to calculate patient volume using the Patient Panel methodology?**

Answer Options	Indiv ep		Clinic rep		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%
Easy	3	15%	2	6%	2	8%	7	9%
Manageable	5	25%	15	48%	16	62%	36	47%
Burdensome	10	50%	12	39%	4	15%	26	34%
Quite difficult	2	10%	2	6%	4	15%	8	10%
<b>Totals</b>	<b>20</b>	<b>26%</b>	<b>31</b>	<b>40%</b>	<b>26</b>	<b>34%</b>	<b>77</b>	<b>100%</b>

***Respondent comments to this question by answer option:***

**Manageable:**

- It's slightly more complicated to calculate with the Patient panel, but I imagine providers wouldn't try it unless they failed with the Patient Encounter method.
- Smaller organizations would find the Panel method more difficult than those with IT staff to assist
- Doable but not as representative for anesthesiology practice.

**Burdensome:**

- What a clinician has on record goes in and out of date, sometimes quite rapidly. Generally, it is updated at the time of an encounter.
- For some practices it might also be quite difficult. Given change in patient payment status over time, it might be difficult to get accurate data
- We have very antiquated software with limited reporting capabilities. Yet to be determined with the tools we have
- Patient Panel methodology requires a robust patient encounter logging and auditing system. Not every facility would be able to participate because of technological barriers.
- We do not have patient panels here with the tribe (most tribes don't) as we serve a smaller population and have limited staff. Thus, patients see whoever is available. If we had to take all patients and put them on panels it would be very difficult for our system. We could assign folks to a specific provider but reality is that provider would not 'truly' be that individual's sole provider.

**Quite difficult:**

- This seems like it's more applicable for Managed care providers and not Fee for Service providers like me.
- Empanelment has been hard in our practice without an electronic health record and with many different providers. We have tried.
- Being a 10 month old RHC, the report generating capability of the Practice Management software is still somewhat puzzling.

**No response:**

- NA, 100% Medicaid
- No knowledge to place opinion.
- Can't tell until run "transactions" in variety of patient/provider scenarios, especially rural where fully burdened costs are not as easily determined and sample sizes are small.

**11. In your opinion, what decision should Oregon make on patient volume calculation methodology?**

Answer Options	Indiv ep		Clinic rep		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%
Patient Encounter Only	1	5%	1	25%	2	6%	4	7%
Provider choice of Patient Panel or Patient Encounter	12	55%	3	75%	16	50%	31	53%
Not sure	9	41%	0	0%	14	44%	23	40%
<b>Totals</b>	<b>22</b>	<b>38%</b>	<b>4</b>	<b>7%</b>	<b>32</b>	<b>55%</b>	<b>58</b>	<b>100%</b>

***Respondent comments to this question by answer option:***

***Provider Choice:***

- Whatever makes more providers eligible is the best way to go.
- The meaning of "assigned to the provider" is not clear to me. Therefore I opt for a choice
- Ensures all could participate.

***Not sure***

- Per above comments
- It should be the same, so that you have the same basis to compare practices.
- Freedom
- If possible, a choice would be preferable. There are some systems (maybe Kaiser) for which the panel method would seem workable

**12. Would including patients from other states qualify more providers where they may not qualify with Oregon patients alone?**

Answer Options	Indiv EP		Clinic rep		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%
Yes	4	20%	7	20%	16	50%	<b>27</b>	<b>31%</b>
No	5	25%	14	40%	2	6%	<b>21</b>	<b>24%</b>
Not sure	11	55%	14	40%	14	44%	<b>39</b>	<b>45%</b>
<b>Totals</b>	<b>20</b>	<b>23%</b>	<b>35</b>	<b>40%</b>	<b>32</b>	<b>37%</b>	<b>87</b>	<b>100%</b>

**Respondent comments to this question by answer option:**

**Yes**

- Clinicians in border communities, such as mine, see a substantial # of residents from other states.

**Not Sure**

- Not important for my practice but will be critical for practices that practice on the border.
- I think it is possible that it could make a difference

An additional analysis was completed for the clinicians (Individual EP and Clinic Reps) who responded that they either practice (8) or see patients who reside (21) out of state to determine whether they felt including patients from other states would qualify more providers where they may not qualify with Oregon patients alone.

Answer Options	Practice out of state (8)		Serve patients who reside out of state (21)	
<b>Yes</b>	5	62.5%	8	38%
<b>No</b>	0	0%	3	14%
<b>Not sure</b>	3	38%	10	48%
<b>Totals</b>	<b>8</b>	<b>100%</b>	<b>21</b>	<b>100%</b>

**13. Oregon is seeking input from stakeholders on possible alternative methodologies given the CMS criteria. If you have any ideas or would like to assist us, please comment below?**

Indiv ep		Clinic rep		Stakeholder		Total responses	
#	%	#	%	#	%	#	%
2	22%	3	33%	4	44%	9	100%

***Respondent comments to this question:***

- 1) Choose a methodology that uses Patient Panel criteria, but allows for the provider to weight his/her volume if services are provided in a Rural areas.
- 2) Our provider group is responsible for approximately 170,000 members of which approximately 70,000 are Oregon Health Plan members (or 41% of our eligible members). We would like to qualify our provider group on this basis because of the full-risk capitat
- 3) Per wRVUs per CMS patient versus primary patient.
- 4) Please talk to a CountyFQHC like BentonCounty or LaneCounty that is fully integrated with mental health care
- 5) The encounter method seems the simplest, and that wins the day for me.
- 6) This does not relate to our type of business
- 7) We currently track our Medicaid percentage for MAC and do it based on the random survey days and tracking total number of clients seen and Medicaid clients seen that day
- 8) What about using the number of individuals covered under a provider's Mental Health Organization? For example, we are responsible for the mental health needs of all Oregon Health Plan members within our county as a result of our contract with our MHO, GO
- 9) Will discuss with fellow OHN Board members.

**ELIGIBILITY**

**14. Do you believe that you or any of the clinicians you represent will be eligible for the Medicaid EHR Incentive Program?**

Answer Options	Indiv EP		Clinic rep		Total responses	
	#	%	#	%	#	%
Yes	12	63%	30	86%	<b>42</b>	<b>78%</b>
No	5	26%	0	0%	<b>5</b>	<b>9%</b>
Not sure	2	11%	5	14%	<b>7</b>	<b>13%</b>
<b>Totals</b>	<b>19</b>	<b>29%</b>	<b>35</b>	<b>71%</b>	<b>54</b>	<b>100%</b>

***Respondent comments to this question by answer option:***

**Yes**

- We have been exploring ways of purchasing EMR but the cost has been prohibitive. We are the only group in our hospital not using EMR.
- Our EHR will need to become certified, but they are planning to pursue this.
- They would prefer incentives come to the clinic rather than to them as individual practitioners

**No**

- My program is under development, and yet I can't pay the 38,000.00 to get it CCHIT certified

**Not Sure**

- That would be up to the SHS Administration
- I certainly hope so but it has not yet been established.
- Purchase of EHRS may be an issue due to lack of funds

The following questions (15-19) were only asked of hospitals in relation to their eligibility in particular areas.

**15. Does your hospital have an Electronic Health Record (EHR) System?**

Answer Options	Total Responses	
	#	%
Yes - We have an EHR system installed and operational	5	42%
Yes - We have an EHR system installed but not operational	0	0%
Yes - We are in the process of installing an EHR system	6	50%
No - We have no EHR system at this time	0	0%
Other (please specify)*	1	8%
<b>Totals</b>	<b>12</b>	<b>100%</b>

\*Other: Currently upgrading to certified version of Epic EMR (current version is installed and

**16. Is your Hospital's EHR system certified according to the recent ONC-ATCB certification system?**

Answer Options	Total Responses	
	#	%
Yes – Our system is a certified EHR system	8	67%
Not sure - We have an EHR system but we do not know if it is certified	0	0%
Other (please specify)*	2	33%
<b>Totals</b>	<b>12</b>	<b>100%</b>

\*Other:

- Will be upgrading to certified version in 2011 Q1
- McKesson is working to obtain certification

**17. Please provide the name of the system and the version used by your hospital**

<b>Name of system</b>	<b>Version</b>
Cerner	2007.19.12
Cerner	Millinium
CPSI	Latest
CPSI	
EPIC	
GE	Centricity
Meditech	Currently 5.4 upgrading to 6.0

<b>Answer Options</b>	<b>Total Responses</b>	
	<b>#</b>	<b>%</b>
Name of System	7	100%
Version	6	86%
<b>Totals</b>	<b>13</b>	

**18. Does it appear that your hospital will meet the 10% Medicaid patient volume requirements?**

<b>Answer Options</b>	<b>Total Responses</b>	
	<b>#</b>	<b>%</b>
Yes	7	70%
No	1	10%
Not Sure	2	20%
<b>Totals</b>	<b>10</b>	<b>100%</b>

**19. Does your hospital meet the definition of an Eligible Inpatient Acute Care Hospital?**

Answer Options	Total Responses	
	#	%
Yes	9	90%
No	0	0%
Not Sure	1	10%
<b>Totals</b>	<b>10</b>	<b>100%</b>

**PARTICIPATION**

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**20. Individual EP only: Do you plan to participate in Oregon’s Medicaid EHR Incentive Program?**

Answer Options	Indiv EP Total responses	
	#	%
Yes	5	26%
Maybe, I’m still deciding whether to participate under Medicare or Medicaid.	6	32%
No, I plan to participate in the Medicare EHR Incentive Program.	2	11%
No, I do not plan to participate in either program.	0	0%
Not eligible	2	11%
Not sure	4	20%
<b>Totals</b>	<b>19</b>	<b>100%</b>

***Respondent comments to this question by answer option:***

***Maybe, I’m still deciding whether to participate under Medicare or Medicaid***

- This will be an employer decision, not employee

***Not sure***

- I think it is likely that my institution will participate in the Medicare program. I’m not sure that my practice would qualify to participate in a different category than the larger institution.

**21. Hospital Only - Do you plan to participate in Oregon’s Medicaid EHR Incentive Program?**

Answer Options	Total Responses	
	#	%
Yes, we plan on participating in both the Medicare and Oregon’s Medicaid EHR Incentive Programs.	4	40%
Yes, we plan on participating in Oregon’s Medicaid EHR Incentive Program only.	0	0%
No, we are not participating in either program.	0	0%
Not eligible	0	0%
Not sure	6	60%
<b>Totals</b>	<b>10</b>	<b>100%</b>

**22. When would participation likely begin?**

Answer Options	Indiv EP		Clinic rep		Hospital		Total responses	
	#	%	#	%	#	%	#	%
As soon as the program is available (expected summer 2011)	5	45%	7	33%	2	50%	14	30%
Before the end of 2011	2	18%	10	48%	2	50%	14	30%
2012	2	18%	2	10%	0	0%	14	30%
Not sure	2	18%	2	10%	0	0%	4	9%
<b>Totals</b>	<b>11</b>	<b>14%</b>	<b>21</b>	<b>71%</b>	<b>4</b>	<b>20%</b>	<b>46</b>	<b>100%</b>

## COMMUNICATIONS PREFERENCES

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**23. Would your organization be willing to partner with the Medicaid HIT project to educate and communicate with hospitals/providers about the Medicaid HIT program?**

Answer Options	Clinic rep		Hospital		Total # of responses	
	#	%	#	%	#	%
Yes	23	48%	10	83%	33	55%
Not at this time	25	52%	2	17%	27	45%
<b>Totals</b>	<b>48</b>	<b>80%</b>	<b>12</b>	<b>20%</b>	<b>60</b>	<b>100%</b>

***Respondent comments to this question by answer option:***

**Yes**

- Maybe
- Depending on scope of commitment
- Should work with our CIO
- Contact director

***Not at this time***

- More information would be needed prior to making such a commitment
- Need more information about what commitments this entails.
- I am new to the position

**24. How would you like to receive updates on Oregon’s Medicaid EHR Incentive Program?**

Answer Options	Indiv EP		Clinic rep		Hospital		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%	#	%
Regular email updates	30	45%	31	29%	11	31%	32	36%	<b>104</b>	<b>35%</b>
Webinars	12	18%	17	16%	9	25%	18	20%	<b>56</b>	<b>19%</b>
Medicaid EHR Incentive Program website, including FAQ’s (Frequently Asked Questions)	10	15%	19	18%	7	19%	19	21%	<b>55</b>	<b>18%</b>
Presentations at Association conferences or other meetings	5	8%	21	20%	4	11%	8	9%	<b>38</b>	<b>13%</b>
Brochures mailed	3	5%	9	8%	3	8%	8	9%	<b>23</b>	<b>8%</b>
Articles in Provider Matters from the Department of Medical Assistance Programs (DMAP)	6	9%	10	9%	2	6%	4	4%	<b>22</b>	<b>7%</b>
<b>Totals</b>	<b>66</b>	<b>22%</b>	<b>107</b>	<b>36%</b>	<b>36</b>	<b>12%</b>	<b>89</b>	<b>30%</b>	<b>298</b>	<b>100%</b>

***Respondent comment to this question by answer option:***

***Presentations at Association conferences or other meetings***

- Our clinicians will likely learn the most through internal meetings where the information is tailored towards how it affects our organization.

**25. Would you like to subscribe to the MHIT website?**

Answer Options	Indiv EP		Clinic rep		Hospital		Stakeholder		Total responses	
	#	%	#	%	#	%	#	%	#	%
Yes	25	68%	35	74%	11	92%	27	66%	<b>98</b>	<b>72%</b>
No	12	32%	12	26%	1	8%	14	34%	<b>39</b>	<b>28%</b>
<b>Totals</b>	<b>37</b>	<b>27%</b>	<b>47</b>	<b>34%</b>	<b>12</b>	<b>9%</b>	<b>41</b>	<b>30%</b>	<b>137</b>	<b>100%</b>

**26. Would you or someone in your organization be willing to partner with the Medicaid HIT project to provide additional input into the design of Oregon’s Medicaid EHR Incentive Program?**

Answer Options	Total Responses	
	#	%
Yes	<b>49</b>	<b>54%</b>
Please ask me later	<b>17</b>	<b>19%</b>
Not at this time	<b>24</b>	<b>27%</b>
<b>Totals</b>	<b>90</b>	<b>100%</b>

***Respondent comments to this question by survey type:***

***EP Indiv***

- Will discuss with IT volunteer committee and designate member of that committee

***Clinic rep:***

- Would need to ask my providers but I must tell you their plates are overflowing already.

***Stakeholder:***

- CountyHHS management may be interested in assigning someone to assist, depending on a number of factors. it's worth discussing.
- Swamped with FCC RHCPP deployment.
- Please contact the Board and ask for the Director. He will be able to connect you with a provider level individual who can assist and represent all Oregon Tribes. Individual Tribes may still wish to be included in this focus group but this is a more likely place to start.
- Per previous notes, will take Board

## GENERAL COMMENTS

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We received a total of 16 general comments regarding the program

### General Comments:

- 1) Plans such as Family Care should be included in the Medicaid pool for eligibility. Many of the families in the Portland Metro Area have been moved from OHP to Family Care to improve reimbursement to the providers and reduce the State's burden. However, reimbursement is almost as low as Medicaid.\*
- 2) If there is any way to broaden the definition of health care provider to include therapists and social workers, that would make the program more inclusive for community mental health agencies\*
- 3) Enterprise EHR systems for dental only have not been certified yet. We are working with vendors who assure us that certification will be attainable
- 4) For the impact that EHR has on primary care clinicians productivity (and thus the availability of health care in their community), the incentives are woefully inadequate. \$60K per year for 5 years might come close.
- 5) Continued coordination at the CMS, ONC level with the FCC and Department of Agriculture in their broadband incentive programs and how to build statewide networks (vs. silo's) to support the use of EMR and patient centered care.
- 6) We know more about the Medicare meaningful use criteria that we do the Medicaid program. We need more information before we can determine if we plan to participate
- 7) If we're not eligible, good luck getting us to go the extra reporting mile
- 8) We want to ensure that long term care providers are included.\*
- 9) Please make sure that electronic capture and transmission of reportable diseases to local health departments is included in the design
- 10) For us it is a daunting task to choose an EHR and implement it into the practice. We are a RHC with 5 MDs, 1 DO, a NP and a PA. Very busy -- difficult to take on a project of this magnitude
- 11) FQHCs should be able to get incentive payments at clinic level rather than have them paid to individual clinicians
- 12) We are on the front end of our research and plan to upgrade in early 2012. We are already in contact with someone. Thanks
- 13) Interested in seeing Behavioral Health providers being included as EPs\*
- 14) What measures are in place to ensure that the FQHC clinic receives the incentive \$ if their providers leave in the middle of the incentive cycle?
- 15) I need help!
- 16) PA's should be included since most CHC's use PA's

\*The program rules discussed in this comment are set at the federal level. Oregon does not have any flexibility to change these rules

## Appendix F: Medicaid Acronyms

Acronym	Definition
AMH	Addictions and Mental Health Division
APAC	All Payer All Claims Database
ACA	Patient Protection and Affordable Care Act
ARRA	American Recovery and Reinvestment Act
CMS	Centers for Medicare and Medicaid Services
DHS	Oregon Department of Human Services
DMAP	Division of Medical Assistance Programs
EHR	Electronic Health Record
FFP	Federal Financial Participation
HIE	Health Information Exchange
HIO	Health Information (Exchange)Organization
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HITOC	Health Information Technology Oversight Council
HP	Hewlett Packard
HRBO	Health Records Bank of Oregon
IAPD	Implementation Advanced Planning Document
IT	Information Technology
MAPIR	Medical Assistance Provider Incentive Repository
MHIN	Medicaid Health Information Network
MITA SS-A	Medicaid Information Technology Architecture State Self Assessment
MMIS	Medicaid Management Information System
NLR	National Level Repository
OHA	Oregon Health Authority
OHPR	Office for Oregon Health Policy and Research
OHIT	Office of Health Information Technology
O-HITEC	OregonHealthInformationTechnologyExtensionCenter
ONC	Office of the National Coordinator for Health Information Technology
PAPD	Planning Advance Planning Document
OPHD	Oregon Public Health Division

Acronym	Definition
REC	RegionalExtensionCenter
RFP	Request for Proposal
SMHP	State Medicaid Health Information Technology Plan
SPD	Seniors and People With Disabilities Division