

Health Information Technology Oversight Council

April 7, 2016, 12:30 – 3:45 pm

The Lincoln Building – Transformation Center Training Room

421 SW Oak Street, Suite 775

Portland, OR 97204

Call in: (888) 808-6929, Participant Code: 453773, HITOC Member (Host): 514237

Name	Organization	Title
Richard (Rich) Bodager, CPA, MBA	Southern Oregon Cardiology/Jefferson HIE	CEO/Board Chair
Maili Boynay	Legacy Health	IS Director Ambulatory Community Systems
Robert (Bob) Brown	Allies for Healthier Oregon	Retired Advocate
Erick Doolen	PacificSource	COO
Chuck Fischer	Advantage Dental	IT Director
Valerie Fong, RN	Providence Health & Services	CNIO
Charles (Bud) Garrison	Oregon Health & Science University	Director, Clinical Informatics
Brandon Gatke	Cascadia Behavioral Healthcare	CIO
Amy Henninger, MD	Multnomah County Health Department	Site Medical Director
Mark Hetz	Asante Health System	CIO
Sarah Laiosa, DO	Harney District Hospital Family Care	Physician
Sonney Saprà	Tuality Healthcare	CIO
Greg Van Pelt	Oregon Health Leadership Council	President

Time	Topic and Lead	Action	Materials
12:30 pm	Welcome, Introductions & HITOC Business – Erick Doolen (Chair), OHA Staff <ul style="list-style-type: none"> Approval of Minutes – February 2016 ONC Site Visit Endorse Provider Directory Advisory Group (PDAG) Charter Endorse Common Credentialing Advisory Group (CCAG) Charter 	Information Discussion Action	<ol style="list-style-type: none"> Agenda February 2016 HITOC Meeting Minutes PDAG Charter CCAG Charter
12:45 pm	2016 HIT Report – Marta Makarushka Draft Report to the Health Policy Board and Oregon Legislature	Information Discussion Action	<ol style="list-style-type: none"> Draft 2016 HIT Report
1:05 pm	Federal Announcements – Susan Otter & Lisa A. Parker <ul style="list-style-type: none"> ONC Announcements State Medicaid Directors Letter 	Information Discussion	<ol style="list-style-type: none"> February 2016 State Medicaid Directors Letter
1:25 pm	HITOC Work Ahead: Strategic Planning and Interoperability – Susan Otter & Justin Keller <ul style="list-style-type: none"> 2016-17 Strategic Planning Process Interoperability Next Steps 	Information Discussion	
1:45 pm	Break		

1:55 pm	Federal Policy Changes: Notices of Proposed Rulemaking <ul style="list-style-type: none"> • ONC Health IT Certification Program Proposed Rule • 42 C.F.R. Part 2 Proposed Rule, Veronica Guerra, OHA 	Information Discussion	
2:55 pm	Measuring Our Progress – Marta Makarushka & Susan Otter <ul style="list-style-type: none"> • Environmental Scan and Behavioral Health Provider HIT Survey 	Information Discussion	
3:35 pm	Public Comment	Information Discussion	
3:40 pm	Closing Remarks – Chair		

Other Materials

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Next Meeting: June 2016, TBD
Portland, OR (Location TBD)

Vision: HIT-optimized health care: A transformed health system where HIT/HIE efforts ensure that the care Oregonians receive is optimized by HIT.

Three Goals of HIT-Optimized Health Care:

- Providers have access to meaningful, timely, relevant and actionable patient information to coordinate and deliver “whole person” care.
- Systems (health systems, CCOs, health plans) effectively and efficiently collect and use aggregated clinical data for quality improvement, population management and incentivizing health and prevention. In turn, policymakers use aggregated data and metrics to provide transparency into the health and quality of care in the state, and to inform policy development.
- Individuals and their families access their clinical information and use it as a tool to improve their health and engage with their providers.

Health Information Technology Oversight Council

Thursday, February 04, 2016; Portland, Oregon

1:00 – 4:30 pm

Council and Ex-officio Members Present: Bob Brown (Vice-Chair), Chuck Fischer, Bud Garrison, Brandon Gatke, Amy Henninger, Sonney Sapra; Greg Van Pelt; Mark Hetz; Rich Bodager, Sarah Laiosa, Maili Boynay

Council and Ex-officio Members by Phone: none

Council and Ex-officio Members Absent: Erick Doolen (Chair), Valerie Fong

Staff Present: Susan Otter, Rachel Ostroy, Lisa Parker, Kristin Bork, Justin Keller, Kim Mounts, Britteny Matero, Veronica Guerra, Gary Ozanich (consultant)

Welcome – Susan Otter and Bob Brown (Vice-Chair)

Refer to HITOC 15DEC15 Minutes Final; Edited Aims & Objectives of HIT-Optimized Health Care documents

- Bob started the meeting and welcomed the group; the council members and staff introduced themselves.
- The Vice-Chair presented the December HITOC meeting minutes, and Rich Bodager moved to approve the minutes and several HITOC members seconded. All HITOC members present and on the phone were in favor of approving the minutes; no one opposed. There were no additional comments or announcements.
- Susan then reviewed the agenda for the meeting. The Vice-Chair noted that it will be an important listening meeting on Interoperability and Behavioral Health in order to get the group grounded in these topics.
- Susan reviewed the three goals of HIT-Optimized Health Care. She then went over the revised Aims and Objectives document that was discussed at the December HITOC meeting.

Discussion:

- Members suggested that Privacy and security be moved to be an overarching aim. Members also suggested adding an objective under Goal 3 around patients' access to care through HIT, which could include telehealth efforts.
- Question: Will we be looking at lag (outcome) metrics or lead (day-to-day process) metrics?
 - Answer: We will likely be looking at lag metrics because we don't have access to the day to day activities.
- Question: Are there partnerships with Public Health?
 - Answer: There are many opportunities to partner and coordinate with public health, and we can look at public health data sources for our Aims/Objectives. Some examples include - CCOs partner with Public Health. Public Health has a role to play for coordinating around events as well as service delivery. Public Health also reports on the health of the state.
- Question: Where are we with OpenNotes (referring to the Aims and Objectives around patient engagement)?
 - Answer: OHA will come back to the group with specific details (e.g., which Oregon organizations are participating). OHA does have a grant with We Can Do Better, a local organization for supporting their advocacy to spread OpenNotes in Oregon.
- Discussion continued around OpenNotes. Members commented that OpenNotes is gaining traction in Oregon and suggested monitoring and reporting out on adoption and use. It is important to socialize with the providers—OpenNotes and conversations around it are an example of a cultural shift.
- Question: is there information on consumer utilization of Open Notes?
 - Answer: Individual organizations may collect numbers on adoption by consumers, and OHA will follow up to see if We Can Do Better collects any data on this to share

Priority Policy Topics: Interoperability – Gary Ozanich, Susan Otter, Justin Keller

National Perspective, Refer to Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap document; slides 10-41

Presentation:

- Gary provided an overview of interoperability from a national perspective. In addition to clarifying the definition of interoperability, Gary's presentation focused on the context for the current state of interoperability across the country, types of barriers to interoperability (slides 25-26), and discussed the ONC Interoperability Roadmap including such topics as governance, standards, drivers, and care provider/consumer use of technology.

Discussion:

- Regarding data presented on impact of health information exchange (HIE), members commented on the challenge of evaluating and attributing clear impacts, in part because it requires speculation on what costs were saved and how to track these savings. Good control groups to conduct a study on this are rare and there are many confounding factors that bias the results.
- Regarding standards, members commented that as standards evolve, it will be important to have ways to support the various unique solutions within different communities.
- Members commented on the need for holding vendors accountable, particularly around the distinction between what vendors are certified to do and what their real-world capabilities are. This will become even more relevant as the market shifts from Stage 2 meaningful use to Stage 3.
- Discussion continued around the key issues to overcome with regard to interoperability. Susan flagged the types of barriers to interoperability (slides 25-26) as ones that we could refer back to in terms of prioritizing HITOC's work around interoperability. HITOC Members emphasized focusing on problems that HITOC and the state have the ability to address (some of the issues around standards or vendor conduct are national problems).
- Regarding transport and Direct secure messaging (DSM), members discussed needing to push vendors to be truly interoperable and integrating DSM into EHRs so providers can effectively manage workflows, including integration into in-baskets and automatic pushing of messages in some cases. Other improvements include ensuring patient matching and flagging the type of content attached to the message so the EHR or HIT system can handle the attachment in the appropriate workflow.
- Members discussed the function of standards and how they impact physicians and practices day-to-day (including how the needs of a clinician are different than the needs of data reporting and operations).
 - Needs of the end users differ depending on the group and so solutions need to be flexible. For example, comment was made that the CCD, (which can be a 40 page document), needs to be reduced in size or it needs to be broken down into multiple use cases.
 - More work needs to be done around semantics and standardization to allow usability
- Regarding APIs and FHIR – vendors appear to support these but on the ground folks are not seeing their EHRs implementing anything there yet. Interest in open APIs and/or certification/standards may be needed for APIs for small practices to manage, so these work in the specific workflow (e.g., providers' needs differ from health plans').
 - Comment: Dr. Ozanich indicated the opportunity for APIs is great, since they are able to be decentralized, granular and specific to workflows. Members agreed but are relying on vendors to buy in and support these, and ultimately, unless there is semantic interoperability these won't be useful. Interest in following how federal government will be involved in driving to these outcomes.
- Susan mentioned during the discussion on regulatory drivers, including Meaningful Use Stage 3 and the Medicare and CHIP Reauthorization Act (MACRA) that OHA will be analyzing these federal policy changes and bringing this analysis to the HITOC.

State Calls to Action and Progress, slides 42-47 (Due to time constraints, this presentation was postponed)

Interoperability SME Workgroup; slides 48-54

Presentation:

- Justin presented on barriers to interoperability that have been identified previously by stakeholders in past HITOC meetings and the HIT/HIE Community & Organizational Panel (HCOP). Discussion then turned to

the formation of an Interoperability Subject Matter Expert (SME) Workgroup. This group is proposed to advise OHA on staffing the interoperability work with HITOC, including relevance of specific topics to Oregon stakeholder experiences.

- The SME group will give OHA a better sense of the lay of the land. OHA staff will synthesize information and use it to frame discussions for HITOC. Participation in this group by HITOC members needs to be limited; a quorum of members would constitute an official HITOC meeting, and would turn the SME workgroup into a public meeting.

Discussion:

- Question: Will members be appointed, suggested, or recommended?
 - Answer: For similar groups in the past, members were identified by referral and other means and invited to participate. This group will not go through an open nomination process, but OHA is asking HITOC and HCOP for recommendations on membership.
- Question: Is the group open-ended or is there a specific goal in mind?
 - Answer: Taking action to improve real world interoperability in Oregon is complex. The SME workgroup will assist OHA and HITOC in defining the scope of the problem and actionable steps that can be taken.
- Question: How many people would be in this group?
 - Answer: OHA wants a range of perspectives on interoperability. It is most likely to fall into the range of 15-20 participants. Any more would get unmanageable and less than 12 would not be diverse enough. OHA will go back and consider the composition, then work with the Chair and Vice-Chair on membership.
- Discussion continued by the group on membership composition. Members questioned whether vendors would be an important perspective and others suggested an industry expert that knows both the vendor and consumer sides would be a compromise. Members also suggested that it would be important to include long-term care and home care representatives in the group.
- Susan concluded that the goal is to have first meeting by May. OHA will be recruiting over the next month. HITOC members were encouraged to suggest candidates for the group. OHA will update HITOC at the April meeting.

Priority Policy Topics: Behavioral Health Information Sharing – Gina Bianco (Jefferson HIE), Veronica Guerra

Jefferson Health Information Exchange (JHIE) Presentation, slides 56-79

Presentation:

- Gina presented on Jefferson Health Information Exchange (JHIE), a community based non-profit HIE based in Southern Oregon that is governed by a multi-stakeholder Board of Directors. In July, OHA was awarded Federal Advanced HIE Cooperative Agreement funds in collaboration with JHIE as the sub-awardee. JHIE and OHA are working collaboratively to break down the barriers between physical health and behavioral health data exchange. The project has defined a consent model based on a common understanding the law as it applies to substance abuse disorder and mental health information sharing. JHIE is now working with its vendor to build this model into the HIE.
- Other projects covered by the Cooperative Agreement, include: becoming eHealth Exchange certified and connecting JHIE users with the Veterans Administration to share patient data; connecting with EDIE to bring statewide ADT data into JHIE; connecting with the Prescription Drug Monitoring Program (PDMP) provided legislation passes; and implementing Notifications capabilities for JHIE users.
- JHIE's participants include over 750 providers in over 200 clinics located in 10 Oregon counties as well as Northern California; data contributors and users of JHIE are growing. JHIE offers query based exchange of JHIE's Community Health Record, comprised of clinical data from hospitals and ambulatory electronic health records (EHRs); connectivity with EHRs for data exchange; electronic closed loop referrals and Direct secure messaging.

Discussion on JHIE's model:

- Question: Clarification—does information flow in and out of JHIE’s system? What about information going between the organizations?
 - Answer (Gina): information flows in and out of the system through e-Referrals, as well as Direct secure messaging, CCD Exchange, and a query-based community health record. JHIE is technology agnostic and standards based. Information flows in and out of JHIE, with role-based access, so that all participants can access appropriate information.
- Question: Is the data that comes in just from the partners in the network?
 - Answer (Gina): yes, that’s right. A next step is to make a connection with the Emergency Department Information Exchange (EDIE) to get Admit Discharge Transfer (ADT) data statewide.
- Question: What organizations are in the pipeline for getting connected?
 - Answer (Gina): JHIE is finalizing agreements with Providence to allow them to start sending data into the HIE. We are having ongoing conversations with larger physician groups in the Portland area. There are 29 organizations in process.
- Question: What is the use case for the health plans in terms of eligibility connections/denials such as the Single Sign On service offered by One Health Port? Is this possible?
 - Answer (Gina): Our focus is getting as much clinical data to as many endpoints as possible. Eligibility is not our focus. The JHIE Board spends as much time talking about paths they don’t want to go down as they do on those they do want to go down. They are focused on getting clinics connected and getting the data and sharing it. Getting a patient-centered record.
- Question: Does it matter what plan patients are on? Do you keep that information?
 - Answer (Gina): Yes, we do and we represent that on the patient’s Face Sheet in the JHIE system, and use that information to send data to the health plan or CCO. But [in terms of collecting the information] the payer doesn’t matter. We are focused on the clinical side, not the payer side.
- Comment: Member would like to see JHIE working with Collective Medical Technologies to submit information into PreManage if possible, and seek alignment between these efforts.
- Question: How is this paid for? Who is finding value in this?
 - Answer (Gina): CCOs and hospitals are paying for this (per member per month or per bed per month). Providers pay by contributing their data and are not otherwise charged, but they do pay for their side of the EHR interface unless they fall into a group of priority provider types, then there is a pool of funds that covers these costs.
 - Comment: Finding value beyond Medicaid - CCOs are looking at using JHIE for their commercial lines of business; value is also in providing clear and concise information that fits better into providers’ workflows.
- Question: How do you get word out about the work of JHIE?
 - Answer (Gina): We typically get referrals from our users. JHIE talks to those who approach us, and we take referrals from those organizations we have trained. Colleagues and customers really drive the conversations.

Discussion on JHIE’s work on consent and behavioral health information sharing, funded under the ONC grant:

- The central objective of this work is a common consent model applied consistently across all JHIE participants.
- Question: Regarding the issue of re-disclosure (through EHR) of patient information when that patient signs a consent in JHIE—it seems like the answer to this policy issue would be to not allow re-disclosure.
 - Answer: JHIE has not fully defined the policy regarding allowing users to download protected data into a third party application (e.g., EHR). One possible solution, given the work we did to understand and interpret the relevant privacy laws, would be that a JHIE user, when they seek to access and save “protected” information, will receive an alert stating that the information cannot be re-disclosed without patient consent. The user will then agree with the statement in order to release the information. Further exploration of this issue may result in alternative solutions.
- Comment: Susan—HITOC may want to consider a role in promoting or endorsing the common consent model as an option for stakeholders across the state.

Behavioral Health Information Sharing Advisory Group, slides 80-87

Presentation:

- Veronica presented an overview of the OHA Behavioral Health Information Sharing Workgroup; the Advisory Group work plan and timeline; an overview of the webinars being offered to discuss issues in behavioral health information sharing; and outlined next steps and available resources.

Discussion:

- Question: Who has been on the webinars?
 - Answer: We have had about 300 participants, including a large mix of participants from CCOs, providers, OHA, etc.
 - Comment: Behavioral health community is excited about this work.

HITOC Work Plan – Justin Keller, Susan Otter

- In agenda, postponed to next meeting

HITOC Business – Justin Keller

- In agenda, postponed to next meeting

Public Comment – Bob Brown

- Anna Dyer, Licensed Clinical Social Worker from the Oregon State Hospital—I am very interested in the Behavioral Health Information exchange work that is going on. Has there been any thought about how the State Hospital might be incorporated into these discussions?
 - Answer: OHA will take this as an action item.

Closing Remarks – Bob Brown

- The next HITOC Meeting is on April 7th, in the Transformation Center Training Room, in the same building on the 7th floor.
- Question: Can the meeting be moved an hour earlier?
 - Response: we will follow up with the group by email.
- The Vice-Chair commented that he is looking forward to HITOC's work ahead to identify solutions to the issues discussed today. The meeting was adjourned at 4:32 p.m.

The next meeting will be held on April 7th, 2016 in Portland.

**Oregon Health Authority
 Provider Directory Advisory Group
 Draft Charter, May 2015**

Provider Directory Advisory Group Draft Charter April 2015		
Advisory group name: Oregon Provider Directory Advisory Group (PDAG)		
Objective		
The PDAG will serve as the external subject matter expert and stakeholder body that provides guidance to the Oregon Health Authority (OHA) related to statewide provider directory services.		
Advisory group members		
Name	Title	Affiliation
Gina Bianco	Acting Director	Jefferson HIE
Christopher Boyd	Data Analyst Supervisor	Women’s Healthcare Associates
MaryKay Brady	Consultant	Oregon Medical Association
Monica Clark	Business Systems Analyst	Kaiser Permanente
Mary Dallas, MD	Chief Medical Information Officer	St. Charles Health System
Liz Hubert*	Asst. Director Provider Systems & Strategy	Regence Blue Cross Blue Shield
Martin Martinez	IT VP	PacificSource
Laura McKeane	Oral Health Integration Coordinator	AllCare
Maggie Mellon	Senior Digital Product Manager	Providence Health & Services
Kelly Keith	IT Admin	Greater Oregon Behavioral Health
Jessica Perak	Manager, Provider Analytics, Underwriting & Actuarial	Moda
Robert Power *	VP-Chief Information Officer	Samaritan Health Services
Stephanie Renfro	Research Associate	OHSU Center for Health Systems Effectiveness
Nikki Vlandis	Provider Data Mgmt. and Credentialing	FamilyCare
Hongcheng Zhao	CIO	Portland IPA
*Co-chair		
OHA staffing		
<ul style="list-style-type: none"> • Karen Hale, Lead Policy Analyst, Office of Health Information Technology, OHA, karen.hale@state.or.us, 503-378-1767 • Nick Kramer, Policy Analyst, Office of Health Information Technology, OHA, nicholas.k.kramer@state.or.us, 503-373-7859 • Rachel Ostroy, Implementation Director, Office of Health Information Technology, OHA, rachel.e.ostroy@state.or.us • Susan Otter, Project Sponsor, Director of Health Information Technology, OHA, susan.otter@state.or.us 		
Project background		
Provider directory services (PDS) will allow healthcare entities access to a statewide directory of healthcare provider and practice setting information. It will seek to leverage data existing in current provider databases and add critical new information and functions. The project comprises design, development, implementation, and maintenance of the technical solution as well as operations and ongoing management and oversight of the program. It can be used by health plans, CCOs, healthcare		

practitioners including providers, clinics, hospitals, researchers, long-term care entities, social service organizations, OHA/DHS and other state programs, Health Information Exchanges (HIEs) and Health Information Services Providers (HISPs) to support operations, analytics, and the exchange of health information.

The development of the PDS will be incremental. Initially, PDS will focus on the authoritative provider directory data from the common credentialing program/database and data from provider directories that comply with new standards for healthcare directories called [Healthcare Provider Directory](#) (HPD), and data from existing healthcare provider and facility directories via file exchange/upload. It is expected that other key sources, including OHA/DHS sources will be integrated into the provider directory as well. While the provider directory is being built to support the Medicaid Enterprise, it is expected that the users of the provider directory will expand beyond the Medicaid Enterprise with enabling legislation (HB2294, 2015).

Provider Directory outcomes/success factors

- Accurate Direct secure messaging addresses for providers, as queried
- Attribution of providers to their healthcare delivery settings (clinics, practices, hospitals)
- Support of CCO, OHA and health plan analytics that rely on attributing providers to clinics
- An architecture that supports query and response across existing provider directories using the Health Provider Directory (HPD) standards
- Ingestion of the data available from the Common Credentialing solution and other designated data
- Operational processes and procedures that allow onboarding of users and data sources, user support, and data quality management

Advisory group role

The PDAG will meet regularly to provide guidance to OHA on a variety of topics surrounding the provider directory services and share information with other stakeholders. The group's role includes the following:

1) Guidance:

- The provider directory workgroup will be tasked with providing guidance on policy, program, and technical considerations, as Oregon moves forward to implement statewide provider directory services, such as:
 - Data access
 - Permitted use and network participation
 - Data quality standards
 - Onboarding
 - Security provisions
 - Ongoing monitoring of policies and procedures
 - Functionality and value of a provider directory service
 - Fees and fee structure, if OHA is granted the authority to offer services outside the Medicaid Enterprise (HB 2294)

2) Information sharing:

- PDAG members are expected to provide advisory group information to their organization to share broadly and also connect to their organization's members in other related health IT committees, such as OHLC's Administrative Simplification workgroup, Common Credentialing Advisory Group, etc.
- OHA staff will share regular reports about progress on the provider directory shared with the CCO's Health Information Technology Advisory Group (HITAG) and the [Administrative](#)

[Simplification workgroup.](#)

- OHA will publish documentation from the meetings on our website.

Duration

The PDAG is expected to meet from April 2015 through 2016.

Decision making linkage

The PDAG shall make technical, policy, and operational recommendations to OHA for the statewide PDS. Decisions by the group will be made by consensus. OHA will coordinate decision making with stakeholder members as necessary and coordinate communication with the HITAG and Administrative Simplification workgroup regarding recommendations from the PDAG.

Meetings

Expectations	Location	Date and Time
<p>Monthly 3-hour public meetings will be held throughout 2015. Staff will deliver materials the week prior to each meeting for members to review. Meeting materials and notes will be posted to the OHA’s Provider Directory website. OHA may also call for member participation outside the regularly scheduled meetings if needed.</p> <p>The PDAG is expected to meet throughout 2016 although meeting length and frequency will be evaluated for 2016. Due to the nature of the discussions, in-person attendance at the meetings is preferred. Meetings, as shown below, will be held at locations convenient for the group.</p>	Portland - Lincoln	April 15, 2015, 1:00-3:00 pm
	Wilsonville – CCC campus	May 13, 2015, 10:00-1:00 pm
	TBD	June 17, 2015, 10:00-12:00 pm
	TBD	July 15, 2015, 10:00-12:00 pm
	TBD	Aug 19, 2015, 10:00-12:00 pm
	TBD	Sept 16, 2015, 10:00-12:00 pm
	TBD	Oct 14, 2015, 10:00-12:00 pm
	TBD	Nov 18, 2015, 10:00-12:00 pm
	TBD	Dec 16, 2015, 10:00-12:00 pm
	TBD	2016 TBD

Resources

- Business Plan Framework - The state-level provider directory is one of several elements of [new state level HIT services](#) that supports new models of care under Oregon’s health system transformation efforts.
- [Provider Directory Subject Matter Expert Workgroup Summary](#) - In 2014, the OHA convened a Provider directory workgroup. Members on the committee were comprised of users or managers of provider directories, such as those working in IT, analytics, or healthcare operations. Discussions were focused on key uses, data elements, parameters, and next steps for statewide provider directory services.
- Common Credentialing - The statewide provider directory is a complimentary effort with the work of the [Common Credentialing Advisory Group](#); which will advise the agency on the implementation of a legislative requirement for OHA to establish a program and database for the purpose of providing credentialing organizations access to information necessary to credential all health care practitioners in the State. OHA staff are working closely together on both efforts.

CHARTER - Common Credentialing Advisory Group (Updated January 2016)

Authority

The passage of Senate Bill (SB) 604 (2013) requires the Oregon Health Authority (OHA) to establish a program and database for the purpose of providing credentialing organizations access to information necessary to credential all health care practitioners in the State of Oregon. Under SB 604, OHA must convene an advisory group at least annually that consists of individuals representing credentialing organizations, health care practitioners and health care regulatory boards (HCRBs), including representatives from large health care entities. This group will advise the Authority on the implementation of SB 604. In July 2015, the Oregon State Legislature passed SB 594 allowing OHA to identify an operational date via rule provided OHA notifies participants at least six months in advance. Legislative requirements are highlighted below.

Legislative Requirements

SB 604 (2013)

- Establish a program and database to provide credentialing organizations access to credentialing information
- Convene an advisory group to advise OHA
- Develop rules on submittals, verifications, and fees
- Issue an RFI to seek input from potential contractors on capabilities and cost structures associated with the scope of work required to establish and maintain the electronic system
- Report to the Legislature on implementation progress in 2014 and 2015

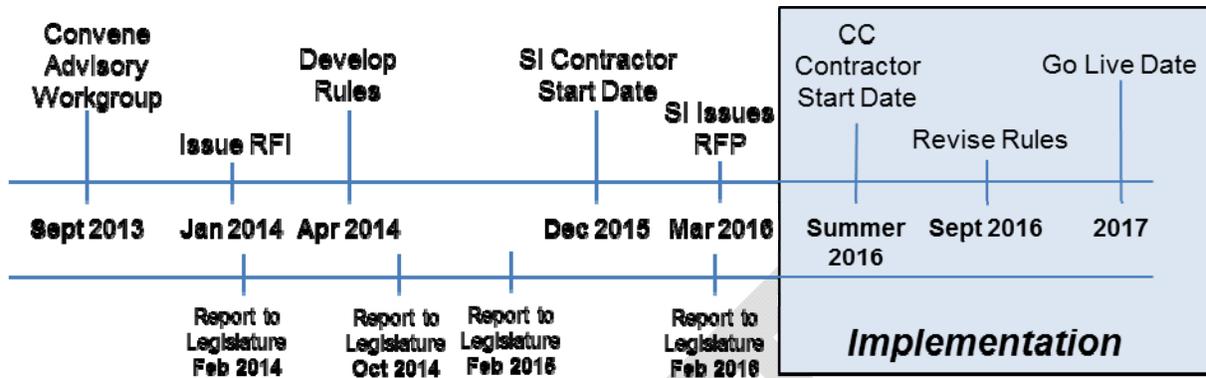
SB 594 (2015)

- OHA to establish implementation date by rule, with at least six months' notice
- Report to the Legislature on implementation progress in 2016

Advisory Group Scope

The CCAG will be responsible for advising the OHA on credentialing application and submittal requirements, the process by which credential organizations may access the system, and the imposition of fees. This includes the standards for the process of verifying credentialing information. Group membership includes individual practitioners and representatives from urban and rural credentialing organizations, large and small HCRBs, provider practices, ambulatory surgical centers, and Independent Physician Associations.

Timeline



“SI” means systems integrator, which refers the prime vendor responsible for procuring and overseeing a portfolio of OHA Health Information Technology products (e.g., common credentialing, provider directory, and clinical quality metrics registry).

Membership, Roles & Responsibilities

CCAG Co-Chairs

Erick Doolen - Chief Information Officer/SVP of Operations, Pacific Source Health Plans

Kevin Ewanchyna, MD, - Chief Medical Officer, Samaritan Health Plans/Intercommunity Health Network CCO

CCAG Members

Debra Bartel, FACMPE - Clinic Administrator, Portland Diabetes & Endocrinology Center PC

William C. Donlon, DMD, MS - Oral & Maxillo-Facial Surgeon, Retired

Larlene Dunsmuir - Family Nurse Practitioner, Oregon Nurses Association/Nurse Practitioners of Oregon

Michael Duran, MD - Psychiatrist, Oregon State Hospital

Tooba Durrani, ND, MSOM, LAc - Oregon Association of Acupuncture and Oriental Medicine (OAAOM)

Denal Everidge - Medical Staff Coordinator, Oregon Health & Sciences University

Stephen Godowski - Credentialing Coordinator, Therapeutic Associates, Inc. & NW Rehab Alliance

Kathleen Haley, JD - Executive Director, Oregon Medical Board

Joanne Jene, MD - Physician/Anesthesiologist/Retired, Oregon Medical Association/Oregon Society of Anesthesiologists

Rebecca L. Jensen, CPCS, CPMSM - Manager, Kaiser Permanente

Shannon Jones - Human Resources Manager, Dentist Relations and Recruitment, Willamette Dental Group

Kecia Norling - Administrator, Northwest Ambulatory Surgery Center

Shelley Sneed - Executive Director, Board of Optometry

Joan A. Sonnenburg, RN - Director Medical Staff Services, Mercy Medical Center

OHA Staff

Melissa Isavoran, Project Director, Office of Health Information Technology
Nick Kramer, Policy Analyst, Office of Health Information Technology
Susan Otter, Director, Office of Health Information Technology
Margie Fernando, Project Assistant, Office for Oregon Health Policy and Research

Meeting Schedule

First Meeting: October 2, 2013 from 2:30pm to 4:30pm.
Subsequent meetings conducted either monthly or bimonthly through implementation and bi-annually thereafter.

DRAFT

Health Information Technology in Oregon

June 2016 Status Report to the Oregon Health Policy Board and the Oregon Legislature – DRAFT FOR HITOC REVIEW

Oregon’s Coordinated Care Model and Health Information Technology

Oregon’s coordinated care model relies on access to patient information and the health information technology (HIT) infrastructure to share and analyze data. In fact, HIT impacts nearly every aspect of coordinated care, including care coordination; population health management; integration of physical, behavioral, and oral health; accountability, quality improvement and metrics; alternative payment methodologies; and patient engagement. New tools are needed to share information; aggregate data effectively; support telehealth; and provide patients with tools and data.

Oregon’s health care stakeholders have heavily invested in HIT and electronic health records (EHRs) when compared to other states, though many providers experience some frustration with their EHR’s functionality and interoperability. Several regions of Oregon have advanced community health information exchange infrastructure.

HIT can serve to connect all members of the care team, including physical, behavioral health, dental, and even long term care and social service providers. However, non-physical health providers experience barriers to HIT participation and challenges sharing behavioral health information remain.

Vision of “HIT-optimized” health care

A transformed health system in which HIT/HIE efforts ensure the care Oregonians receive is optimized by health IT and:

- Providers have access to meaningful, timely, relevant and actionable patient information to coordinate and deliver “whole person” care.
- Systems (health systems, CCOs, health plans) effectively and efficiently collect and use aggregated clinical data for quality improvement, population management and incentivizing health and prevention.
- Individuals and their families access their clinical information and use it as a tool to improve their health and engage with their providers.

Key Highlights for Health Information Technology in Oregon

The Oregon Health Authority (OHA) continues to make progress on state HIT initiatives. OHA is working to ensure that efforts align with and support health care provider, coordinated care organization (CCO), health plan and other stakeholder needs. OHA’s Office of Health Information Technology (OHIT) develops and supports effective health information technology policies, programs, and partnerships that support improved health for all Oregonians.

Significant HIT program and initiatives activities include:

- *Emergency Department Information Exchange (EDIE)*: Bringing real-time hospital event notifications to all eligible Oregon hospitals, and many CCOs, health plans, and provider clinics to support care coordination across the health care system around emergency and inpatient hospital events. The Emergency Department Information Exchange (EDIE) Utility launched in 2015 as a public/private partnership spearheaded by the Oregon Health Leadership Council and co-sponsored by OHA. In 2016, OHA will leverage state and federal funding to make this service available to all CCOs, long-term care local office staff, assertive community treatment teams, and care coordinators for the Medicaid fee-for-service population.
- *Technical Assistance*: Providing technical assistance for clinics serving Medicaid patients to support using EHRs in a meaningful way and meeting federal incentive program requirements. This program is operated by OCHIN and aims to serve more than 1,200 Medicaid providers and will run through May 2018.
- *New HIT Services*: Developing new HIT services scheduled to launch in 2017 that will support efficient and effective care coordination, analytics, population management and health care operations, including: common credentialing database and program, statewide provider directory, and a clinical quality metrics registry program for Medicaid.
- *Telehealth*: Supporting innovation in telehealth through pilots in five communities designed to improve care coordination and expand system capacity, and supporting a telehealth resources and inventory website to link telehealth providers and purchasers (health plans, CCOs, etc.) to each other, through the Telehealth Alliance of Oregon.
- *Behavioral Health Information Sharing*: Addressing barriers to information sharing and care coordination across settings, particularly for behavioral health data through a new \$1.6 million grant from federal The Office of the National Coordinator for Health Information Technology (ONC) to improve care coordination between behavioral and physical health care. Through the project, OHA's sub-grantee, Jefferson Health Information Exchange (JHIE), is focusing on consent management to enable coordination between primary care, behavioral health and emergency providers, by developing a common consent model that will be supported within the JHIE technology.
- *Patient access to health information*: Advocating for and supporting the expansion of patient access to health information across the state, via grant to support Open Notes spreading across Oregon, which encourages providers to make full clinician notes available through their EHR's patient portals.
- *Basic health information exchange*: Promoting basic health information exchange through statewide Direct secure messaging by offering no-cost, web-portal services through CareAccord, that connects to Direct secure messaging used in many Oregon hospitals, clinics and health information exchange entities.

Significant HIT funding, oversight, and policy activities include:

- *Federal incentive payments:* Bringing federal “meaningful use” incentive payments to Oregon hospitals and providers to support their investment in electronic health records. Since the inception of the programs in 2011, 6,925 Oregon providers and 61 hospitals have received more than \$403 million in federal incentive payments (about \$268 million under the Medicare EHR Incentive Program and \$135 million under the Medicaid EHR Incentive Program) as of February 2016.
- *HIT legislation:* Passing critical legislation (House Bill 2294 in 2015) that improves OHA’s ability to advance HIT in Oregon including establishing the Oregon HIT Program, enabling OHA participation in partnerships related to HIT, and resetting the HIT Oversight Council’s role.
- *HIT Oversight Council:* Resetting the charter and membership of Oregon’s Health Information Technology Oversight Council (HITOC), now aligned under the Oregon Health Policy Board. HITOC advises the Board on policy, strategic planning, progress, and barriers related to HIT across Oregon. In 2016-2017, HITOC will focus on updating Oregon’s HIT strategic plan, establish reporting and tracking metrics for HIT in Oregon, as well as priority efforts including improving “real-world” interoperability and behavioral health information sharing.
- *Federal funding for Oregon’s HIT/HIE efforts:* Continue exploring and leveraging federal Medicaid HIT funding to support Oregon’s providers, leveraging new federal funding to support Medicaid behavioral health, long-term care, and other social services providers to connect to HIT/HIE

This report: HB 2294 (2015) requires OHA to report to the legislature annually on the status of the Oregon HIT Program. HB 2294 also requires HITOC to report regularly to the Oregon Health Policy Board on the status of the HIT environment in Oregon as well as OHA’s HIT efforts. This report combines both reporting requirements and is the first report under HB 2294.

I. The Oregon Health Information Technology Program and OHA’s Health Information Technology efforts

Office of Health Information Technology

The Oregon Health Authority’s Office of Health IT was established in 2011 to support the adoption of electronic health records, the secure exchange of health information, and supporting the effective use of technology needed to achieve the goals of the coordinated care model.

Optimization of the health care system through the right technology tools HIT is a key part of Oregon’s efforts to create a system of better health, better care and lower cost for all Oregonians. OHIT’s work toward this seeks to leverage efforts already underway, connect to existing resources when possible, and support the development of services that fill gaps in areas where no other HIT options exist.

OHA’s Office of HIT (OHIT)

The Office of Health IT (OHIT) is a resource for both state programs and other public and private users of health information. OHIT seeks to improve the use of health information technology (HIT) in Oregon by:

- Providing planning, coordination, and policy analysis and development
- Implementing technology solutions; operating programs
- Developing public/private partnerships

Health IT Oversight Council (HITOC)

HITOC was formed in 2009 as part of House Bill 2009 as a Governor-appointed, Senate confirmed body to oversee health information technology efforts of the state. The original duties of HITOC were in part superseded by the passage of the federal Health Information Technology for Economic and Clinical Health (HITECH) Act and its health information exchange (HIE) cooperative agreement funding and EHR incentive programs as part of American Recovery and Reinvestment Act. In 2015, HITOC was reset through the passage of House Bill 2294 (HB 2294) and the council now reports directly to the Oregon Health Policy Board.

HITOC’s new duties under HB 2294 include:

- Making recommendations related to health IT to the Board to promote health system transformation (e.g. revised strategic plans for health IT in Oregon; priority health IT policy recommendations; direct responses to Board requests).
- Regularly reviewing and reporting to the Board on:
 - The status of the Oregon Health IT program and other OHA health IT efforts;
 - Efforts of local, regional, and statewide organizations to participate in health IT systems (e.g. local or regional health information exchanges);
 - Adoption and use of health IT among providers, systems, patients, and other users in Oregon (e.g. adoption of EHR among meaningful use non-eligible professionals);
- Advising the Board or the Congressional Delegation on federal law and policy changes that impact health IT efforts in Oregon (e.g. 42 CFR Part 2; Medicare Access and CHIP Reauthorization Act or “MACRA”).

- In relation to its role of providing oversight of OHA health IT efforts, other health IT advisory groups such as the Provider Directory Advisory Group (PDAG) and the Common Credentialing Advisory Group (CCAG) now have a reporting relationship to HITOC when there are issues relevant to statewide health IT efforts.

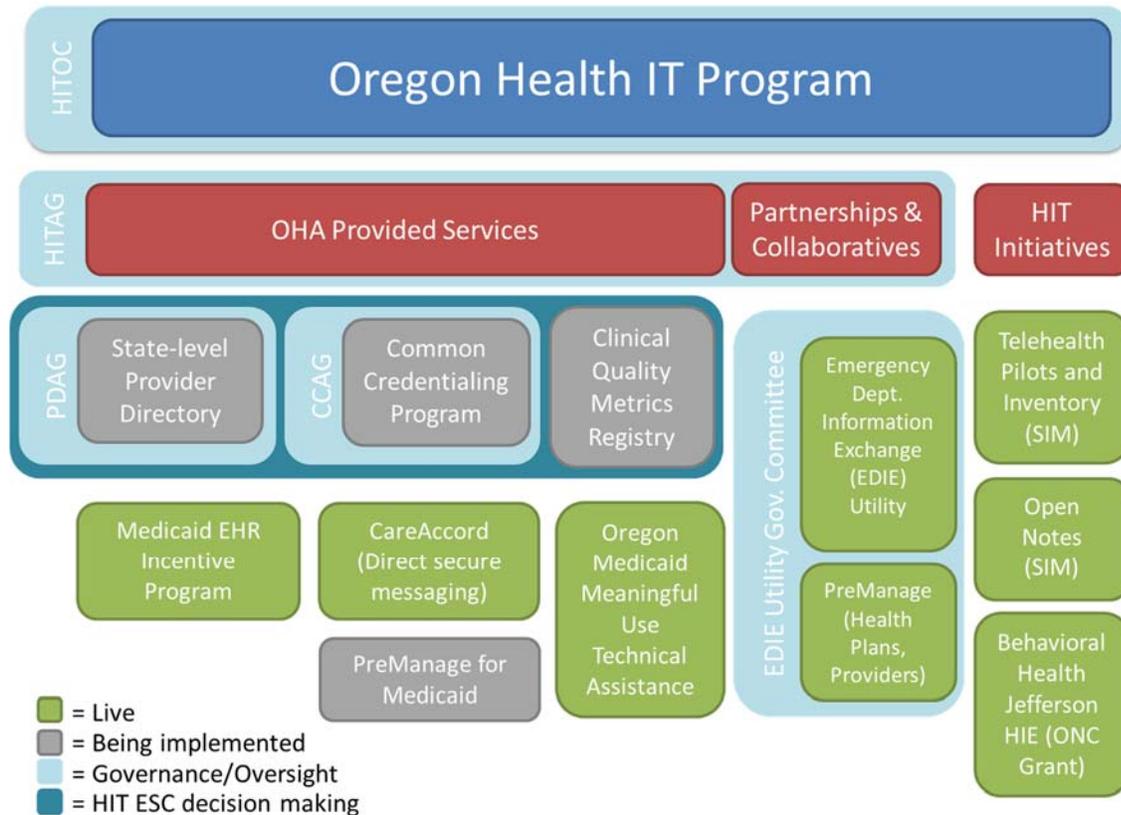
HITOC Work Plan for 2016

Based on its new charter and responsibilities as part of HB 2294, HITOC has identified the following streams of work for focus in 2016 and early 2017:

- *Policy Topics* – HITOC has identified two priority policy topics to address in 2016-2017: 1) achieving real-world interoperability; and 2) improving behavioral health information sharing broadly in Oregon;
- *Strategic Planning* – the current strategic plan for HIT in Oregon—the Business Plan Framework—concludes in 2017 and thus HITOC will engage in a strategic planning process in late 2016-early 2017 to revise and update this plan;
- *Oversight* – in addition to regular monitoring of OHA’s Oregon HIT Program efforts, HITOC will assist OHA as it seeks to develop the fee structure of key projects like the Provider Directory and the Oregon Common Credentialing Program. In addition, HITOC will review an updated CareAccord Business Plan;
- *HIT Environment and Reporting* – data collection for the strategic plan update, interoperability policy work, and reporting will occur in 2016, including a behavioral health provider HIT survey and a listening tour of health systems;
- *Federal Policy* – OHA anticipates responding via public comment opportunities to the release of proposed rules for updating 42 CFR Part 2, related to the sharing of substance use disorder information; and the Medicare Access & CHIP Reauthorization Act of 2015 (MACRA), which will have impacts to the Medicare EHR Incentive Program and HIT that supports alternative payment methodologies.

Oregon Health Information Technology Program

In 2015, OHA launched the Oregon HIT Program, as required by HB 2294. The Oregon HIT Program consists of HIT services and programs, partnerships and collaboratives and initiatives. HITOC plays an oversight role over the Oregon HIT Program. See below for more information.



Partnerships and Collaboratives

Emergency Department Information Exchange (EDIE) and PreManage

The Emergency Department Information Exchange, known as EDIE, was spearheaded by the Oregon Health Leadership Council in partnership with OHA and in collaboration with the Oregon Association of Hospitals and Health Systems and the Oregon College of Emergency Physicians, and other stakeholders.

EDIE provides hospitals in Oregon with real-time notifications when a patient had visited the emergency department (ED) frequently. Notifications provide critical information to providers such as date and location of recent patient hospital visits, and key care recommendations to encourage care coordination and address the patient’s follow-up care needs. Timely and secure access to this information allows for better communications, improved care coordination and creates efficiencies across settings, while helping to reduce avoidable hospital visits. All of Oregon’s eligible hospitals have adopted EDIE. The EDIE network includes ED event data from Oregon and Washington State as well as inpatient admit discharge transfer (ADT) data from Oregon hospitals.

The biggest success in HIT for Oregon stakeholders in 2015, has been the increased adoption of PreManage, a companion product to EDIE which pushes hospital event data out to health care organizations outside the hospital system, including CCOs, providers, clinics and health plans, when a patient/member has a hospital event in real time. PreManage subscribers can add key care coordination information into PreManage, viewable by ED providers and other PreManage users. PreManage also includes dashboards which provide real-time population-level view of ED visits. Half of the CCOs have already subscribed to PreManage and are expanding their license to their key clinical practices. About 100 clinic sites in Oregon are live. OHA is a co-sponsor for this effort and is responsible for coordinating CCO use of the tool. CCOs, health plans, and providers can subscribe to PreManage to access EDIE data and better manage patients at high risk for hospitalization.

A September 2015 EDIE and PreManage Learning Collaborative hosted by OHA and the Oregon Health Leadership Council, included many anecdotes about the value of PreManage and EDIE, including:

- Support for emergency department doctors working with patients seeking opioids;
- CCO care coordinators better able to reach homeless members because they have the real-time information when a member is in the ED, and can intervene in-person;
- Primary care clinics who have seen incredible reductions in hospital readmissions by coordinating with hospitals through PreManage;
- Connecting behavioral health teams—including Assertive Community Treatment (ACT) teams—to physical health hospitalization information;
- Emerging efforts for community-level comprehensive care planning for high-risk patients.

In 2016, OHA will leverage state and federal funding to procure a statewide Medicaid PreManage subscription, and make this service available to all CCOs, long-term care local office staff, ACT teams, and care coordination contractors for the Medicaid fee-for-service population.

OHA-provided Services

Medicaid Electronic Health Record Incentive Program

Through the Centers for Medicare & Medicaid Services EHR Incentive Programs, eligible Oregon providers and hospitals can receive federal incentive payments to adopt, implement or upgrade and meaningfully use certified EHR technology.

2016 is the last year that eligible providers can begin participation in the Medicaid EHR Incentive Program to receive incentive payments over the course of the next six years. Program participation for all six years provides each eligible professional \$63,750.

Federal “Meaningful Use” EHR Incentive Payments to Oregon

Since the inception of the CMS Medicaid and Medicare EHR Incentive programs in 2011,

- More than \$403 million in federal incentive payments have been made to 6,925 Oregon providers and 61 hospitals including:
- About \$268 million under the Medicare EHR Incentive Program
- \$135 million under the Medicaid EHR Incentive Program

Data as of February 2016

CareAccord: Statewide Direct Secure Messaging

OHA supports health information exchange across all health care providers and promotes statewide Direct secure messaging by offering access to Direct secure messaging through its CareAccord program. CareAccord allows organizations that do not have EHRs or that are facing barriers to electronic health information sharing the ability to securely exchange health information with different care teams and across care settings. CareAccord Direct secure messaging can also help providers meet federal meaningful use requirements. CareAccord users can connect to the several thousand Oregon providers and hospitals using Direct secure messaging, as well as members of Jefferson Health Information Exchange, CCOs, and other health care coordinators.

CareAccord has been operational since May 2012, is part of the national DirectTrust, and was the first state to become accredited as a Health Information Service Provider (HISP) through the Electronic Healthcare Network Accreditation Commission (EHNAC). CareAccord serves more than 1,300 providers and other health care related users in Oregon through its web portal services, and now serves OCHIN-supported clinics through integration with OCHIN’s EHR.

Flat File Directory for Direct secure messaging addresses

Administered by CareAccord, the Flat File Directory is Oregon's combined address book for Direct secure messaging addresses. The directory allows participants throughout Oregon to find or "discover" Direct addresses outside their own organizations. The discovery of Direct addresses assists providers and hospitals with meeting Meaningful Use requirements.

As of February 2016, the Flat File Directory included 11 participant organizations, using 8 different, interoperable HISPs for Direct secure messaging, representing more than 250 Oregon health care organizations (primary care, hospital, behavioral health, dentistry, etc.), totaling more than 4,000 Direct addresses. In spring 2016, Washington Direct secure messaging addresses will be added.

Participating Organization	# Direct Addresses
Blue Mountain Health District	5
CareAccord	902
Childhood Health Associates of Salem (CHAS)	12
Hillsboro Pediatric Clinic	11
Jefferson HIE	535
Legacy	566
Lake Health District	6
OCHIN	206
OHSU	1,620
St. Charles Health System	130
Tuality	87
Total	4,080

Technical Assistance to Medicaid practices for Meaningful Use of EHRs

OHA is providing Medicaid providers contracted technical assistance from OCHIN to support the adoption of electronic health records (EHRs) and Meaningful Use of their EHRs. The Oregon Medicaid Meaningful Use Technical Assistance Program (OMMUTAP) is supported with Medicaid funding (with 90% federal matching funds). Technical assistance will help providers effectively use their EHR technology and realize the benefits of their investments, and will help support CCO efforts related to care coordination, quality improvement, and metrics and data reporting required for the CCO Quality Incentive program. OHA has contracted with OCHIN to help provide these technical assistance services.

OCHIN, OHA, and CCOs have been collaborating to discuss the needs within service areas and develop plans for meeting technical assistance needs for priority practices. Starting spring 2016, OCHIN will begin to work direct with providers for developing detailed technical assistance plans for implementation over the course of the contract. The Technical Assistance program will run through May 2018.

Leveraging Transformation Funds to Support CCOs

In 2013, Oregon's 16 coordinated care organizations (CCOs) unanimously agreed that OHA should use \$3 million of state Transformation Funds to secure federal matching dollars to invest in statewide health information technology services.

CCOs supported leveraging funds to support Medicaid providers, CCOs and health plans in their efforts to share and aggregate electronic health information. OHA received CMS approval for matching funds (most efforts have 90% federal match, although EDIE and PreManage are matched at 50% and 75% respectively).

These federal and state Transformation funds support five HIT efforts including:

- Three currently operational efforts: statewide hospital notifications (EDIE/PreManage), statewide Direct secure messaging, and technical assistance for Medicaid practices for meaningful use of EHRs; and
- Two HIT initiatives in development: the Clinical Quality Metrics Registry and Provider Directory.

CCO Health IT Advisory Group (HITAG)

HITAG members represent CCOs' HIT interests and advise OHA on the use of Transformation Funds to support the implementation of key HIT services and initiatives:

- Identify major requirements for technology, such as scope, priorities, timelines and milestones
- Represent CCO interests and participate in reporting back to CCOs

Health IT Initiatives in Development

The Common Credentialing, Provider Directory, and Clinical Quality Metrics Registry projects are being undertaken as a portfolio and leveraging a common systems integrator, Harris Corporation, to ensure desired integration between the solutions and a common entry point for end users of the systems. Implementation of the solutions will be staggered, beginning with Common Credentialing. The initial scope of work of the Harris contract includes a planning

phase, culminating in a Request for Proposal (RFP) and vendor selection for each of the three solutions. Subsequent contract amendments will cover the implementation or execution phase of each project. It is expected that each system will each go live during the 2017 calendar year. The three projects have a robust project and portfolio governance structure, including an HIT Portfolio Executive Steering Committee (HIT-ESC) made up of OHA/DHS leadership and ex-officio stakeholder representatives from the HITOC and CCO HITAG. These projects are subject to rigorous oversight by DAS Office of the State CIO, the Legislative Fiscal Office, third-party quality assurance vendor, and CMS oversight for Provider Directory and CQMR.

Oregon Common Credentialing Program

Mandated by Senate Bill 604 (2013), OHA is now in the process of implementing the Oregon Common Credentialing Program for credentialing organizations (e.g., hospitals, health plans, CCOs, Independent Physician Organizations, etc.) and practitioners. The Program will provide a secure, web-based Common Credentialing Solution for all health care practitioner information to be submitted, verified, and stored. It will help improve system efficiencies, reduce redundancies, and facilitate administrative simplification that is essential to reducing overall health system costs for Oregon. Participation in the program will be mandatory for an estimated 55,000 credentialed health care practitioners and 280 credentialing organizations. The Common Credentialing program will launch in 2017.

Stakeholders continue to be engaged in implementation activities. Over the past year, OHA has worked with the Common Credentialing Advisory Group (CCAG) and other subject matter experts to finalize program requirements, build a preferred fee structure, and prepare for procurement. All CCAG meetings are open to the public and include opportunities for public testimony.

Status:

- Project received necessary state stage gate approvals from DAS and LFO to proceed with execution of System Integrator contract for planning phase
- System integrator (Harris Corp) to release RFP in spring 2016
- Expect vendor onboard summer 2016
- Engaging stakeholders and developing rules
- Planning for outreach and marketing

Both the Provider Directory Advisory Group (PDAG) and CCAG report relevant issues or milestones related to these projects to the HITOC as part of HITOC's formal oversight role. HITOC will play a role in considering potential fee bundles, or other decisions that go beyond the scope of individual IT projects.

Provider Directory

Oregon's state-level provider directory will be a source of accurate healthcare practitioner and practice setting information that can be accessed by health care entities, such as providers, care coordinators, health plans, CCOs, health information exchange entities, and OHA/DHS programs. The Provider Directory will leverage common credentialing efforts and emerging provider directory standards. The information in the directory will be used to support and

enable efficiencies for operations, analytics, care coordination, and health information exchange. The Provider Directory will launch in 2017.

The business requirements and policy and program considerations for the provider directory project have been informed by two governance groups – the internal advisory group (IAG) comprised of internal OHA and DHS staff and the provider directory advisory group (PDAG). The IAG has been tasked with identifying authoritative state data sources that contribute to the provider directory and use cases. The PDAG has completed analysis of the external use cases for the provider directory, prioritized the uses and data elements, and provided feedback on fee structure options. All PDAG meetings are open to the public.

Status:

- Project received necessary state stage gate approvals from DAS and LFO to proceed with execution of System Integrator contract for planning phase
- CMS funding approved
- System integrator (Harris Corp) to release RFP mid-2016
- Engaging stakeholders 2016-2017
- Provider Directory vendor on board Fall 2016

Clinical Quality Metrics Registry

The Clinical Quality Metrics Registry (CQMR) will serve to collect and display clinical quality data for Oregon’s Medicaid program. Designed to inform benchmarks and other quality improvement reporting, it will produce information on CCO performance on clinical quality metrics which is part of the CCO quality incentive program. The CQMR will launch in 2017.

- CCO quality incentives include three clinical metrics: (1) Optimal diabetes care, (2) Controlling hypertension, (3) Depression screening and follow-up
- In 2017, OHA registry will capture clinical metrics electronically from providers’ EHRs, CCOs or other third parties
- Federal requirements for EHRs enable automated reporting of “Meaningful Use” clinical metrics
- Allows new insight into clinical outcomes through more efficient and aligned reporting

Status:

- Project received necessary state stage gate approvals from DAS and LFO to proceed with execution of System Integrator contract for planning phase
- CMS funding approved
- System integrator (Harris Corp) to release RFP mid-2016
- Engaging stakeholders 2016-2017
- CQMR vendor on board Fall 2016

Grant-Funded Initiatives

Integrating Behavioral Health Information and supporting regional HIE

In 2015, the Oregon Health Authority and program collaborator Jefferson Health Information Exchange (Jefferson HIE) were awarded a 2-year, \$1.6 million cooperative agreement from The Office of the National Coordinator for Health Information Technology (ONC) to improve care coordination between behavioral and physical health care.

Through the project, Jefferson HIE aims to address barriers to information sharing and care coordination across settings, particularly for behavioral health data. Jefferson HIE is focusing on consent management which is a major obstacle to electronic health information exchange across providers and care settings. The goal is to enable coordination between primary care, behavioral health, and emergency providers, by developing a common consent model that will be supported within the JHIE technology. This model will be shared with other entities across Oregon.

As a result of the work under this grant, participating providers will soon be able to use JHIE for the following:

- Provide better care with the inclusion of authorized behavioral health (BH) data
- Exchange data with the Veterans Administration (VA) and Social Security Administration (SSA)
- Connect with the Prescription Drug Monitoring Program
- Receive real-time emergency department (ED) notifications
- Receive technical assistance for workflow redesign

Telehealth Grants

Oregon's State Innovation Model (SIM) funding (from the Centers for Medicare & Medicaid Innovation) has been instrumental in moving telehealth forward in Oregon. Through a partnership with the Office of Rural Health, five SIM telehealth grants have been executed and work is under way. The five, which cover teledentistry, telepsychiatry, community paramedics, telepharmacy, and distance cognitive testing for dementia patients, have all begun recruitment of clients and participants. See <http://www.oregon.gov/oha/OHIT/Pages/Telehealth-Pilots.aspx> for more information on each project.

Telehealth: Gaps/Needs Assessment, Law/Policy Review, and Inventory

SIM funding is bringing practical information about telehealth to health plans, coordinated care organizations, and others through a new statewide inventory of telehealth services available in Oregon, and other reports. The Telehealth Alliance of Oregon (TAO) has drafted a Gaps and Opportunities Assessment around telehealth services in Oregon. Once finalized, this will be available on the TAO website (<http://www.ortelehealth.org>) and sent out to stakeholders who are interested in the status of telehealth services in Oregon. A follow-on series of focus groups will be conducted in the early summer to evaluate what progress has been made.

TAO has completed a Law and Policy Review on telehealth and published it to their website. The Law and Policy Review looks at both the national and local levels and includes information on such topics as Licensure and Credentialing; Reimbursement; and Privacy and Security among others. The first update for the Law and Policy Review has been reviewed and approved for publishing on the website. This includes a new section on Standards and Practices.

TAO has also developed a telehealth services inventory. This includes information on vendors and the types of telehealth services they provide. The information is housed on a searchable web page on TAO's website and is available to the public. The information on vendors and telehealth services available will be updated quarterly.

OpenNotes

One of Oregon's HIT goals is to ensure that Oregonians have access to their own health information electronically. OpenNotes supports healthcare organizations working with their EHR vendors to make the full clinician notes available through their EHR's patient portal. OHA has awarded a grant to We Can Do Better to advocate for, and facilitate, the implementation and dissemination of OpenNotes in healthcare organizations that are based in Oregon. The initial work plan has been approved and advocacy efforts are underway. We Can Do Better attended the recent HIMSS conference in order to speak with vendors and participants about OpenNotes.

II. Environmental Scan of Health Information Technology in Oregon

EHR Adoption and Meaningful Use in Oregon

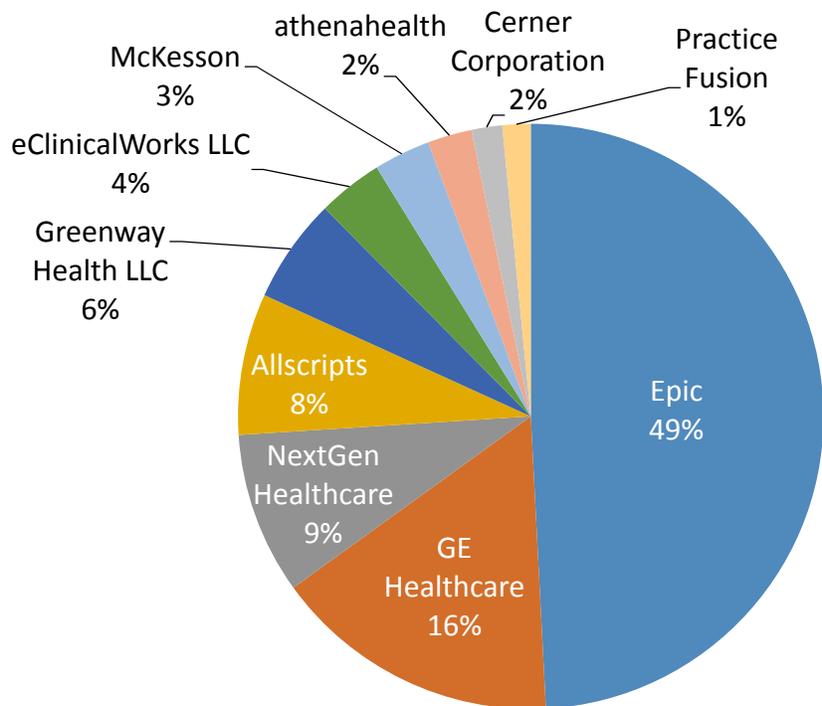
Adoption of certified EHR technology provides the foundation for optimizing Oregon’s health care delivery system and supporting health information exchange, quality improvement efforts, and patient access to their health records. Federal certification of EHRs is critical for ensuring that EHRs are standards-based, meet industry expectations, and serve providers seeking federal incentive payments.

Using data from the Medicaid and Medicaid EHR Incentive programs, OHA can identify key information about Oregon hospital and eligible professionals’ adoption and use of EHRs. However, only hospitals, physicians, dentists, nurse practitioners and select others are eligible for federal incentives, so these data are limited and do not describe the full picture of adoption and use of EHRs in Oregon.

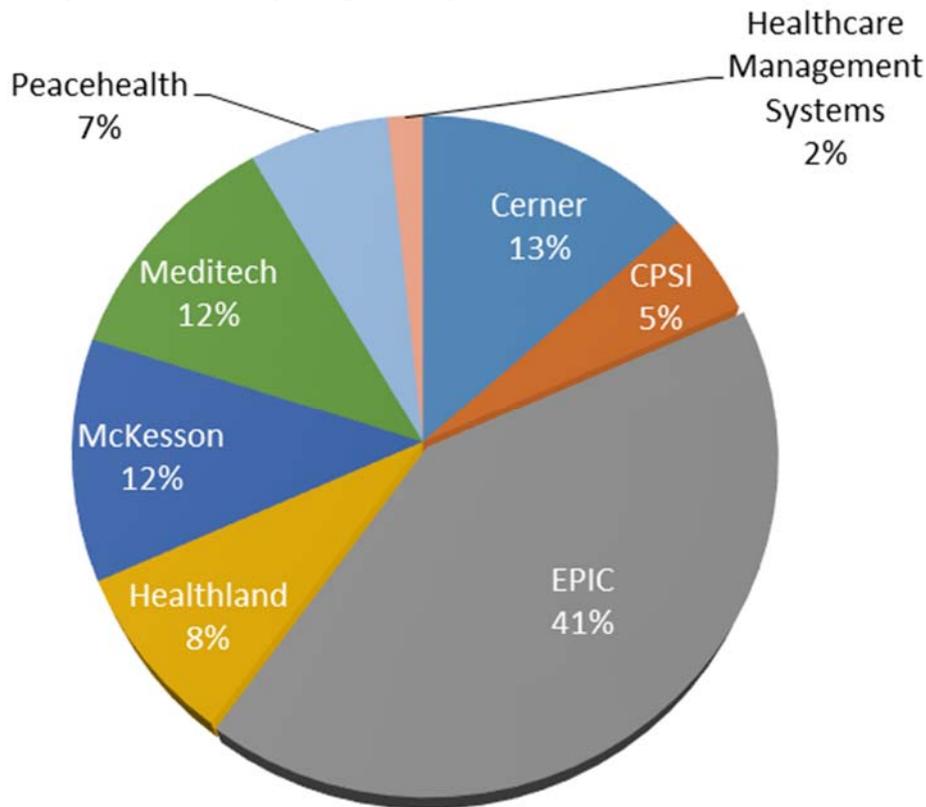
EHR Adoption in Oregon

- All Oregon hospitals have adopted a certified EHR
- More than 6,800 Oregon providers have adopted certified EHRs and received federal incentive payments
- However, over 135 different EHRs are in use by Oregon providers
- About 80% of eligible professionals use the top 10 EHRs
- Epic is the EHR vendor with the largest footprint in Oregon
- Oregon hospitals primarily use 8 different EHRs

Top 10 EHR Vendor Systems Purchased by Oregon Eligible Professionals (n=5589 out of 6886)



EHR Systems in Use by Oregon Hospitals (n=60)*



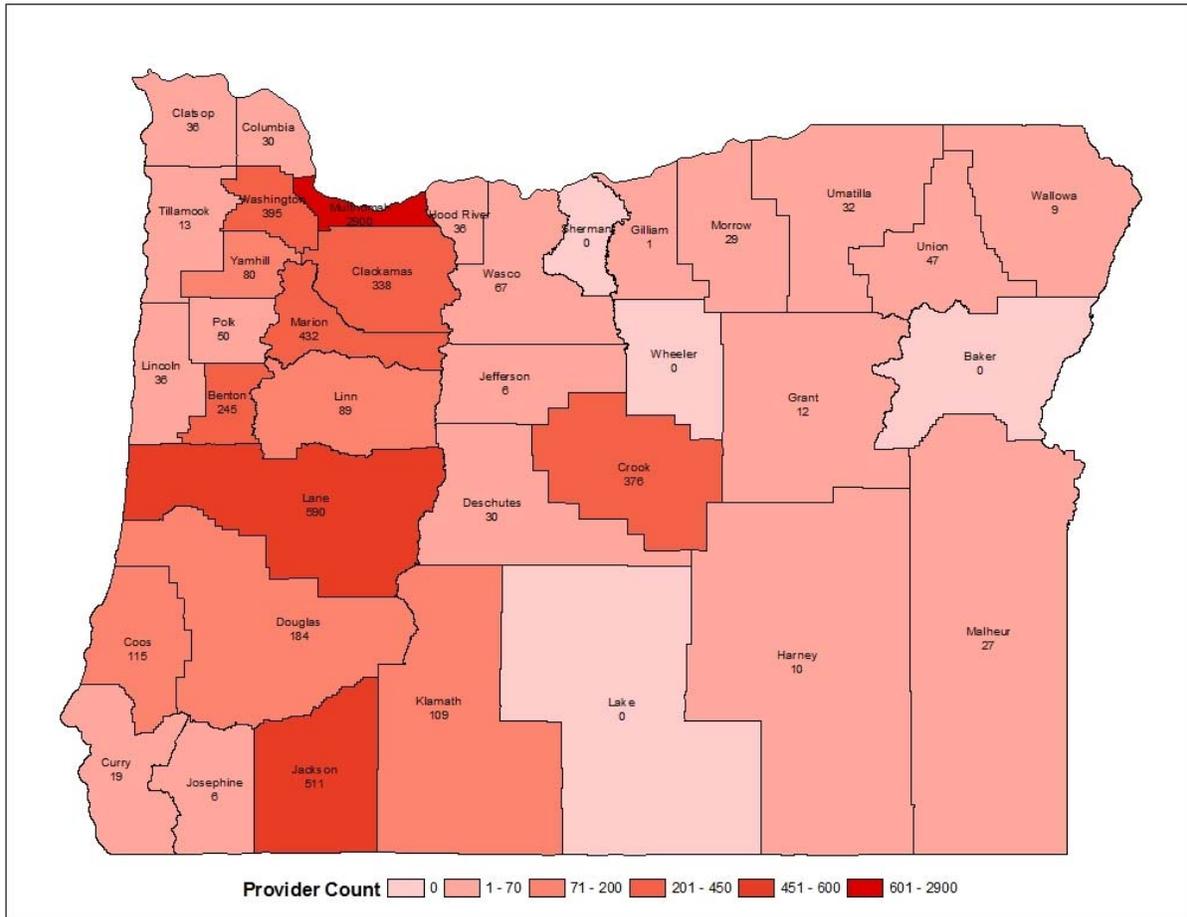
*Based on most recent EHR Incentive Payment data for a hospital from the Medicare or Medicaid EHR Incentive programs 2011- June 2015

EHR Use by Oregon Hospitals

Certification standards for EHRs change over time. Keeping up with the most recent standards is important to support interoperability and requirements for federal incentive payments.

- 53 out of 60 hospitals are using 2014 Certified EHR technology (CEHRT)
- There are 4 different 2011 CEHRT systems in use amongst the 7 hospitals that are not using 2014 CEHRT; only one does not support a 2014 CEHRT version
- Chart represents CEHRT at a high level and does not contain the details for modular CEHRT systems; many of the systems listed here are certified as modular systems and have a combination of CEHRT that is used to produce a complete certified system.

EHR Incentive Payment Map by County



Moving from adoption to meaningful use

Under the Medicaid EHR Incentive program, providers may receive their first year’s incentive payment simply by adopting, implementing or upgrading to a certified EHR. Subsequent years’ incentives require meeting federal requirements for “meaningful use” of their EHR. One concern of the program has been whether providers will move from adoption to meaningful use. See the table below for more information.

Eligible Professionals Achieving Adopt/Implement/Upgrade (AIU) Followed by Meaningful Use (MU): Oregon Medicaid EHR Incentive Program

	AIU in 2011-2013	Achieved MU	Totals
Physician	882	540	61%
Pediatrician (<30% Patient volume)	272	231	85%
Nurse Practitioner	510	221	43%
Dentist	192	2	1%
Certified Nurse-Midwife	94	63	67%
Physician Assistants practicing within an FQHC or RHC that is so led by a Physician Assistant	29	16	55%
Total	1979	1073	54%

Health Information Exchange in Oregon

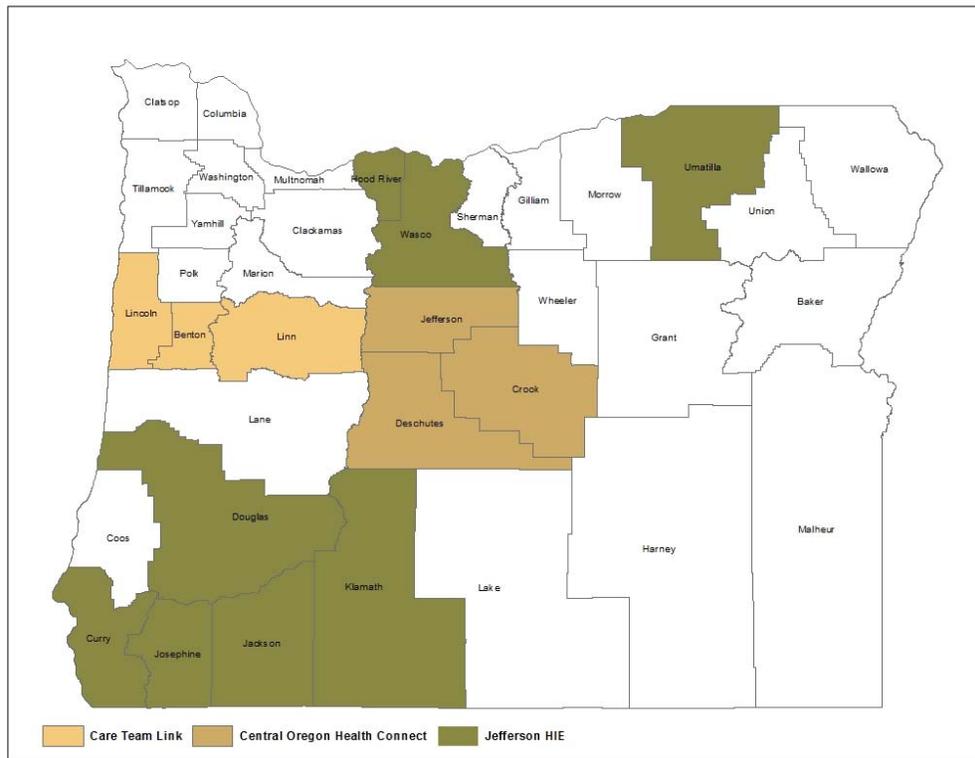
Health Information Exchange in Oregon exists in numerous forms. This section focuses on publicly-available HIE including community HIEs and statewide HIE efforts.

Regional HIEs

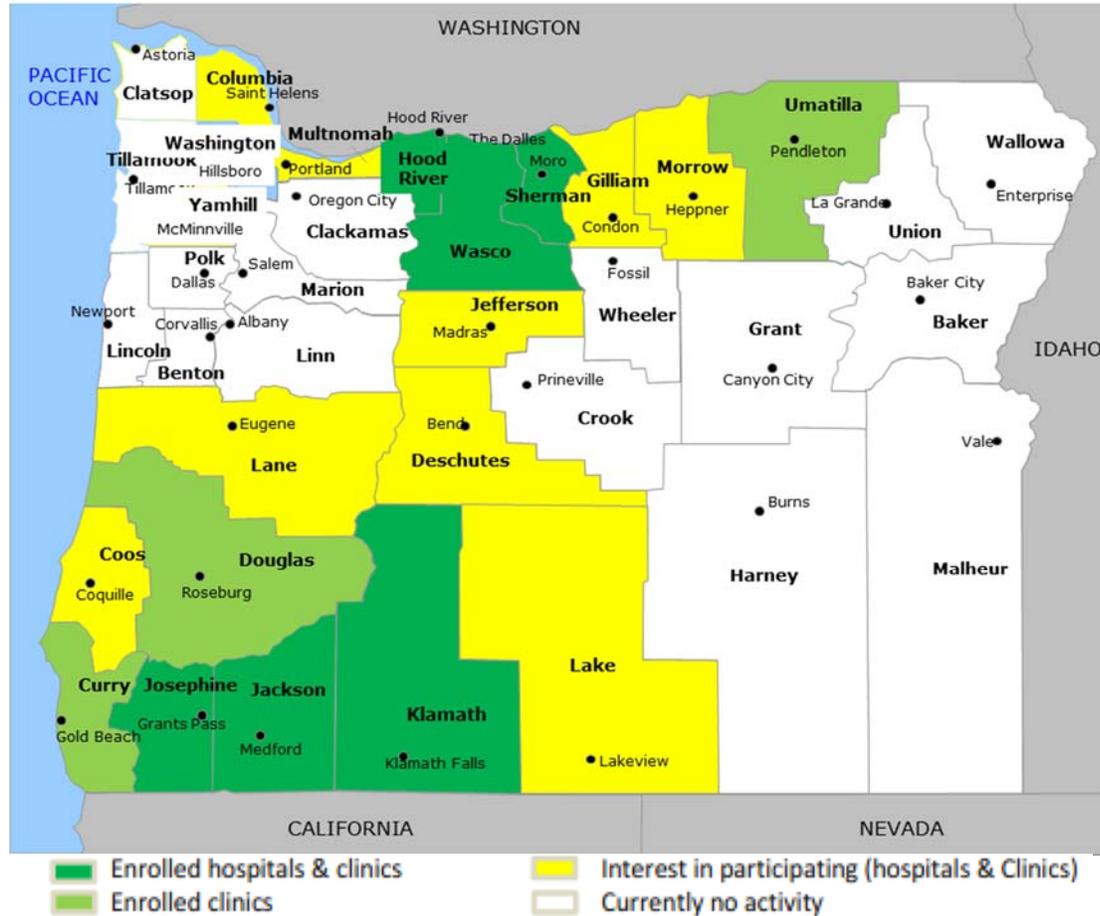
There are several regional HIEs at various stages of development and implementation. See maps on the following pages.

- Jefferson HIE currently serves Southern Oregon and the mid-Columbia River Gorge region. Jefferson HIE is the largest regional HIE currently in Oregon. See map.
- Central Oregon Health Connect in Central Oregon is currently undergoing some changes, and
- IHN-CCO's Regional Health Information Collaborative (Care Team Link) serving the Corvallis area is under development.

Regional HIEs by County



Jefferson HIE Participants



7 Hospitals in 4 Health Systems

- Asante Health System
- Providence Health & Services
- Sky Lakes Medical Center
- Mid-Columbia Medical Center

5 CCOs

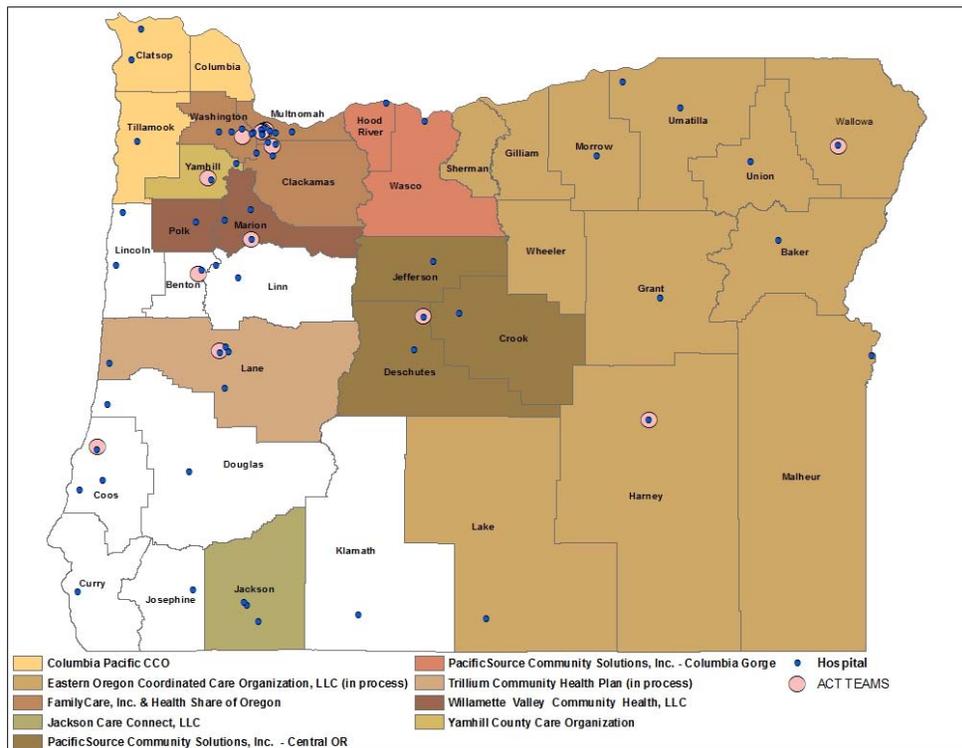
- AllCare
- Cascade Health Alliance
- Jackson Care Connect
- Primary Health
- Pacific Source

750+ Enrolled Providers at 205+ Clinics (as of 1/31/16) www.jhie.org/participants/

Statewide HIE Efforts:

- The state’s CareAccord program offers no-cost Direct secure messaging to any Oregon health care related entity, and has begun piloting Direct secure messaging within EHRs.
- In addition, all hospitals are participating in the Emergency Department Information Exchange and an increasing number of organizations are subscribing to statewide hospital event notifications through PreManage. Many CCOs have adopted PreManage and OHA has supported PreManage for Assertive Community Treatment (ACT) teams via a pilot effort. See map on the following page.

EDIE (Hospital) and PreManage (CCOs, ACT teams) Adoption in Oregon (as of March 2016)



Other HIE efforts:

Other health information exchange in use by healthcare organizations in Oregon include

- Vendor-driven solutions such as Epic Care Everywhere, Carequality and CommonWell
- Various organizational HIE efforts by CCOs, health plans, health systems, independent physician associations, and others including, hosted EHRs, etc. that support sharing information across users.
- Federal initiatives, such the eHealth Exchange which includes connection to federal agencies such as the Veteran’s Administration and Social Security Administration.

CCO Investments in Health Information Technology

In 2014, OHA visited each CCO to identify what investments they had made in HIT. Nearly every CCO used a portion of its Transformation fund grant (awarded in 2013) to invest in both a health information exchange/care coordination tools as well as a population management/data analytics tool. Even with those similarities, each of the 16 CCOs chose to invest in a different set of HIT tools. Through their implementation and use of HIT, CCOs reported early successes in achieving goals:

- Increased information exchange across providers to support care coordination
- Making new data available to assist providers with identifying patients most in need of support/services and to help providers target their care effectively
- Improved CCO population management and quality improvement activities, through better use of available claims data, while pursuing access to and use of clinical data

Summary of CCO-Specific HIT Investments (as of 2014/Spring 2015)

	# CCOs	Overview	Details		
Health Information Exchange	14	2 active HIEs (6 CCOs)	Medicity: Jefferson HIE (5 CCOs) ----- Central Oregon Health Connect (in transition)		
		2 HIEs in development	InterSystems: Care Team Link (Regional Health Information Collaborative; RHIC) ----- Bay Area Community Informatics Agency (BACIA)		
		1 Community-wide EHR	GE Centricity: Umpqua One Chart		
		Hospital Notifications (8 CCOs are live, 2 CCOs in process)	Collective Medical Technologies: PreManage		
Case Management and Care Coordination	10	1 Social Services-focused tool (2 CCOs)	VistaLogic: Community Connected Network		
		Case Management Tools (9 CCOs)	Essette: Case Management ----- PopIntel Care Coordination Registry		
			InterSystems: Care Team Link ----- McKesson: VITAL		
			The Advisory Board: Crimson CM (2 CCOs) ----- Milliman: Patient Relationship Manager		
			IMA Technologies: CaseTrakker (2 CCOs)		
			Milliman: MedInsight (2 CCOs) ----- Optum: Impact Intelligence		
			The Big Kahuna ----- Arcadia: Community Data Warehouse ----- Crimson Population Risk Management ----- Milliman: Patient Relationship Manager		
Population Management, Metrics Tracking, Data Analytics	15	Population Management tools (9 CCOs)	SAS BI (3 CCOs) ----- IBM Cognos BI ----- Microsoft BI (2 CCOs)		
		Business Intelligence (BI) tools (6 CCOs)	Inteligenz: CCO Metrics Manager (2 CCOs) ----- Truven Health Analytics (2 CCOs) ----- Inovalon Indices ----- SAS Data Store ----- IBM: SPSS ----- SAS ----- Tableau (2 CCOs) ----- IBM Cognos Query Studio ----- PopIntel		
		Health Analytics tools (11 CCOs)			
		EHR Hosting via Affiliated IPA	3		DCIPA: Umpqua One Chart ----- MVIPA: NextGen ----- MRIPA: Greenway PrimeSuite

Source: OHA Report: CCO HIT Efforts (2015),

<http://www.oregon.gov/oha/OHIT/resourceDocuments/CCO%20HIT%20Summary%20Report%20July%202015.pdf>

*Note that the categories used above are not necessarily mutually exclusive, as tools can be used to serve more than one function (and often do). The HIT tools are grouped based on their primary function.

III. Oregon Advisory Councils and Committees: Rosters

HIT Oversight Council Roster

Name	Title	Organizational Affiliation
Richard (Rich) Bodager, CPA, MBA	CEO/Board Chair	Southern Oregon Cardiology/Jefferson HIE
Maili Boynay	IS Director Ambulatory Community Systems	Legacy Health
Robert (Bob) Brown (vice-chair)	Retired Advocate	Allies for Healthier Oregon
Erick Doolen (chair)	COO	PacificSource
Chuck Fischer	IT Director	Advantage Dental
Valerie Fong, RN	CNIO	Providence Health & Services
Charles (Bud) Garrison	Director, Clinical Informatics	Oregon Health & Science University
Brandon Gatke	CIO	Cascadia Behavioral Healthcare
Amy Henninger, MD	Site Medical Director	Multnomah County Health Department
Mark Hetz	CIO	Asante Health System
Sarah Laiosa, MD	Physician	Harney District Hospital/HDH Family Care
Sonney Sapra	CIO	Tuality Healthcare
Greg Van Pelt	President	Oregon Health Leadership Council

CCO HIT Advisory Group Roster

Name	Title	Organizational Affiliation
Chris Diaz	Vice-President of Information Technology & Services	FamilyCare Health Plans
Chuck Hofmann, MD	Physician, St. Alphonsus Medical Group	Eastern Oregon CCO
Mary Kasal	Chief Information Officer	Western Oregon Advanced Health
Nancy Rickenbach	Director of Data Analytics	Willamette Valley Community Health
John Sanders	Chief Information Officer	Health Share of Oregon
Amit Shah, MD	Senior Medical Director, Care Oregon	Jackson Care Connect, Columbia Pacific CCO
Brian Wetter	Vice President - Business Intelligence and Infrastructure	PacificSource Health Plans
Justin Zesiger	Director of Information Technology	AllCare Health Plans

Common Credentialing Advisory Group Roster

Name	Title	Organization
Debra Bartel, FACMPE	Clinic Administrator	Portland Diabetes & Endocrinology Center PC
Erick Doolen (co-chair)	Chief Operations Officer	Pacific Source Health Plans
Larlene Dunsmuir	Family Nurse Practitioner	Oregon Nurses Association/Nurse Practitioners of Oregon
Michael Duran, MD	Psychiatrist	Oregon State Hospital

Tooba Durrani, ND, MSOM, LAc	Naturopathic Doctor	Oregon Association of Acupuncture and Oriental Medicine (OAAOM)
Denal Everidge	Medical Staff Coordinator	Oregon Health & Sciences University
Kevin Ewanchyna, MD (co-chair)	Chief Medical Officer	Samaritan Health Plans/ Intercommunity Health Network CCO
Stephen Godowski	Credentialing Coordinator	Therapeutic Associates, Inc. & NW Rehab Alliance
Kelli L. Fussell, BS, CPMSM, CPCS	Medical Staff Services Manager	Salem Hospital
Ruby Jason, MSN, RN, NEA-BC	Executive Director	Oregon Board of Nursing
Joanne Jene, MD	Physician/Anesthesiologist/ Retired	Oregon Medical Association/Oregon Society of Anesthesiologists
Rebecca L. Jensen, CPCS, CPMSM	Manager	Kaiser Permanente
Shannon Jones	Human Resources Manager	Willamette Dental Group
Ann Klinger, CPCS	Credentialing Supervisor	Providence Health Plans
Kecia Norling	Administrator	Northwest Ambulatory Surgery Center
Shelley Sneed	Executive Director	Board of Optometry
Joan A. Sonnenburg, RN	Director Medical Staff Services	Mercy Medical Center
Jennifer Waite, CPCS	Credentialing Manager	Central Oregon IPA
Richard Ulbricht	Credentialing Manager	Portland IPA

Provider Directory Advisory Group Roster

Name	Title	Organization
Jennifer Bradford Awa	Credentialing & Insurance Account Analyst, Privacy Officer	Metropolitan Pediatrics
Gina Bianco	Acting Director	Jefferson HIE
MaryKaye Brady	Consultant	Oregon Medical Association
Monica Clark	Business Systems Analyst	Kaiser Permanente
Mary Dallas, MD	Chief Medical Information Officer	St. Charles Health System
Liz Hubert (co-chair)	Asst. Director Provider Systems & Strategy	Regence Blue Cross Blue Shield
Kelly Keith	IT Admin	Greater Oregon Behavioral Health
Martin Martinez	Vice President IT	PacificSource
Laura McKeane	Oral Health Integration Coordinator	AllCare
Maggie Mellon	Senior Digital Product Manager	Providence Health & Services
Missy Mitchell	Director of Production	Advantage Dental Services
Jessica Perak	Manager, Provider Analytics, Underwriting & Actuarial	Moda
Robert Power (co-chair)	VP-Chief Information Officer	Samaritan Health Services
Stephanie Renfro	Research Associate	OHSU Center for Health Systems Effectiveness
Hongcheng Zhao	CIO	Portland IPA

IV. Resources and links

Oregon HIT key websites:

- OHA's Office of Health Information Technology: www.healthit.oregon.gov
- Oregon HIT Program – programs: www.oregon.gov/oha/OHIT/Pages/Programs.aspx
- Oregon HIT Program – initiatives: www.oregon.gov/oha/OHIT/Pages/Initiatives.aspx
- HIT Oversight Council (HITOC): www.oregon.gov/oha/ohpr/hitoc/Pages/index.aspx
- Common Credentialing Advisory Group (CCAG):
www.oregon.gov/oha/OHPR/occp/Pages/index.aspx
- Provider Directory Advisory Group (PDAG):
www.oregon.gov/oha/OHIT/Pages/Provider-Directory-Advisory.aspx
- Emergency Department Information Exchange (EDIE) and PreManage:
www.orhealthleadershipcouncil.org/our-current-initiatives/emergency-department-information-exchange-edie
- CareAccord: www.careaccord.org
- Oregon's Medicaid EHR Incentive Program: www.medicaidehrincentsives.oregon.gov
- The Telehealth Alliance of Oregon (TAO): www.ortelehealth.org

Reports and key HIT documents:

- Oregon HIT Business Plan Framework (2013-2017):
www.oregon.gov/oha/OHIT/resourceDocuments/Business%20Plan%20Framework.pdf
- CCO HIT Efforts Report (2015):
www.oregon.gov/oha/OHIT/resourceDocuments/CCO%20HIT%20Summary%20Report%20July%202015.pdf
- Common credentialing overview (2-pager):
[www.oregon.gov/oha/OHIT/resourceDocuments/Common%20Credentialing%20Overview%20\(2016\).pdf](http://www.oregon.gov/oha/OHIT/resourceDocuments/Common%20Credentialing%20Overview%20(2016).pdf)
- Provider directory overview (2-pager):
[www.oregon.gov/oha/OHIT/resourceDocuments/Provider%20Directory%20Overview%20\(2016\).pdf](http://www.oregon.gov/oha/OHIT/resourceDocuments/Provider%20Directory%20Overview%20(2016).pdf)
- Hospital notifications overview (2-pager):
www.oregon.gov/oha/OHIT/resourceDocuments/Hospital%20Notifications%20Overview.pdf
- Clinical quality metrics registry overview (2-pager):
www.oregon.gov/oha/OHIT/resourceDocuments/CQMR%20Overview.pdf
- Oregon telehealth inventory, law and policy review, and gaps assessment:
www.ortelehealth.org
- Oregon's five SIM-funded Telehealth Pilots:
www.oregon.gov/oha/OHIT/Pages/Telehealth-Pilots.aspx



SMD# 16-003

RE: Availability of HITECH Administrative Matching Funds to Help Professionals and Hospitals Eligible for Medicaid EHR Incentive Payments Connect to Other Medicaid Providers

February 29, 2016

Dear State Medicaid Director:

This letter updates guidance issued by the Centers for Medicare & Medicaid Services (CMS) about the availability of federal funding at the 90 percent matching rate for state expenditures on activities to promote health information exchange (HIE) and encourage the adoption of certified Electronic Health Record (EHR) technology by certain Medicaid providers. CMS previously issued guidance on this topic in State Medicaid Director (SMD) Letter #10-016 (August 17, 2010)¹, SMD Letter #11-004 (May 18, 2011)², and a 2013 guidance document, “CMS Answers to Frequently Asked Questions (9/10/2013)” (2013 guidance).

This updated guidance expands the scope of State expenditures eligible for the 90 percent matching rate, and supports the goals of, “Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap Version 1.0,”³ published by the Department of Health and Human Services, Office of the National Coordinator (ONC) for Health Information Technology, on October 6, 2015. In this letter, we are expanding our interpretation of the scope of State expenditures eligible for the 90 percent HITECH match, given the greater importance of coordination of care across providers and transitions of care in Meaningful Use modified Stage 2 and Stage 3. This letter supersedes the 2013 guidance but many of the principles of that guidance, as indicated in this letter, remain valid. We intend to issue updated, detailed guidance that integrates those principles with the interpretive changes set forth in this letter.

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5, added sections 1903(a)(3)(F) and 1903(t) to the Social Security Act. These provisions make available to States 100 percent Federal matching funding for incentive payments to eligible Medicaid providers to encourage the adoption and use of certified EHR technology through 2021, and 90 percent Federal matching funding (the 90 percent HITECH match) for State administrative expenses related to the program, including State administrative expenses related to pursuing initiatives to encourage the adoption of certified EHR technology to promote health care quality and the exchange of health care information, subject to CMS approval. CMS has implemented these

¹ Available at <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10016.pdf>

² Available at <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD11004.pdf>

³ Available at <https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf>

provisions in regulations at 42 CFR Part 495. When attesting to Meaningful Use modified Stage 2 or Stage 3, professionals and hospitals that are eligible for Medicaid EHR Incentive Payments (collectively referred to in this document as Eligible Providers) must demonstrate the ability to electronically coordinate with other providers across care settings under the CMS regulations at 42 CFR Part 495. In order to meet these Meaningful Use objectives, Eligible Providers will often need to electronically coordinate care with other Medicaid providers that are not eligible for Medicaid EHR incentive payments.

SMD Letters #10-016 and #11-004 explained that state costs related to HIE promotion may be matched at the 90 percent HITECH matching rate only if they can be directly correlated to the Medicaid EHR Incentive Program. In the 2013 guidance, we therefore explained that States' costs of facilitating connections for providers to an HIE may be matched at the 90 percent HITECH matching rate only if the providers are Eligible Providers. We now explain that State costs of facilitating connections between Eligible Providers and other Medicaid providers (for example, through an HIE or other interoperable systems), or costs of other activities that promote other Medicaid providers' use of EHR and HIE, can also be matched at the 90 percent HITECH matching rate, but only if State expenditures on these activities help Eligible Providers meet the Meaningful Use objectives. Subject to CMS prior approval, States may thus be able to claim 90 percent HITECH match for expenditures related to connecting Eligible Providers to other Medicaid providers, including behavioral health providers, substance abuse treatment providers, long-term care providers (including nursing facilities), home health providers, pharmacies, laboratories, correctional health providers, emergency medical service providers, public health providers, and other Medicaid providers, including community-based Medicaid providers.

For example, an Eligible Provider might be a physician needing to meet the modified Stage 2 or Stage 3 Meaningful Use objective for health information exchange (*see* 42 CFR 495.22(e)(5)(i) or 495.24(d)(7)(i)(A)) when transitioning patients to another Medicaid provider such as a nursing facility, or a home health care provider. Or an eligible hospital might need to meet the objective for Medication Reconciliation and compare records with other providers to confirm that the information it has on patients' medication is accurate when it admits patients into its care (*see* 42 CFR 495.22(e)(7)(i) or 495.24(d)(7)(ii)(B)(3)(i)). Subject to CMS approval, States can claim 90 percent HITECH match in the costs of developing connectivity between Eligible Providers (whether eligible professionals or eligible hospitals) and other Medicaid providers if this will help the Eligible Providers demonstrate Meaningful Use.

CMS explicitly encourages and welcomes multistate collaboratives partnering on shared solutions for HIE and interoperability, including for the activities discussed in this letter (facilitation of EHR Meaningful Use and related communications through the HIE system). CMS will aggressively support such collaboratives as potentially cost-saving opportunities to increase adoption of interoperability standards and help Eligible Providers demonstrate Meaningful Use. Such collaboratives should promote Medicaid Information Technology Architecture (MITA) principles on scalability, reusability, modularity, and interoperability. We note that ONC is a willing partner in helping States develop open source and open architecture tools for HIE that are consistent with MITA principles.

Cost controls, cost allocations, and other payers

States must ensure that any 90 percent HITECH match claimed under the guidance in this letter supports Eligible Providers' demonstration of Meaningful Use modified Stage 2 and Stage 3, and must therefore report on the extent to which the activities they are funding help Eligible Providers demonstrate Meaningful Use. CMS will require States to describe in advance which specific Meaningful Use measures they intend to support in the Implementation Advance Planning Document (IAPD) as well as to confirm such measures are indeed supported post-implementation. Under no circumstances may States claim 90 percent HITECH match in the costs of actually providing EHR technology to providers or supplementing the functionality of provider EHR systems. This funding is available, subject to CMS approval, as of the date of this letter, and will not be available retroactively.

Additionally, States should claim the 90 percent HITECH match for HIE-related costs relating to Medicaid providers that are not eligible for Medicaid EHR incentive payments only if those HIE-related costs help Eligible Providers demonstrate Meaningful Use. For example, it would not be appropriate for States to claim the 90 percent HITECH match for costs related to an HIE system that did not connect to or include Eligible Providers and therefore would not help Eligible Providers demonstrate Meaningful Use.

States should continue to adhere to the guidance in SMD Letter #11-004 detailing how Medicaid funding should be part of an overall financial plan that leverages multiple public and private funding sources to develop HIEs. Similarly, States are reminded that per SMD Letter #11-004, the 90 percent HITECH match cannot be used for ongoing operations and maintenance costs. This updated guidance makes no changes to the general cost allocation principles and fair share principles States should follow in proposing funding models to CMS for HIEs or interoperable systems, although under this updated guidance, the Medicaid portion of such cost allocations may increase to include costs associated with connecting Eligible Providers to other Medicaid providers. CMS has approved several different cost allocation methodologies for States and those various methodologies will be affected differently by this guidance. CMS will provide technical assistance on the impact of this guidance on specific States. Similarly, States should continue to complete and update the "Health Information Technology Implementation Advance Planning Document (HIT IAPD) Template⁴," developed by CMS and the Office of Management and Budget, in which States detail cost allocation models and other financial considerations. States should meet with CMS to review cost allocation models that carefully consider the extent to which the HIE or other interoperable system benefits Eligible Providers, other Medicaid providers, non-Medicaid providers, and other payers.

Medicaid Information Technology Architecture (MITA) emphasizes the importance of interoperability and industry standards. States should take an aggressive approach to HIE and interoperability governance for purposes of supporting interoperability while focusing on security and standards to keep interface costs to a minimum. The CMS final rule published on December 4, 2015, "Mechanized Claims Processing & Information Retrieval Systems (90/10)"

⁴ https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/medicaid_hit_iapd_template.pdf

requires in 42 CFR 433.112 a new focus on industry standards in MITA that support more efficient, standards-based information exchange as described in 45 CFR Part 170. Specifically, 45 CFR Part 170 defines the Common Clinical Data Set, transport standards, functional standards, content exchange standards and implementation specifications for exchanging electronic health information, and vocabulary standards for representing electronic health information. In implementing these standards, we encourage States to develop partnerships with non-profit collaboratives and other industry participants such as DirectTrust that further support Direct Secure Messaging through trust frameworks that reduce the costs and technical complexities of electronic health information exchange for providers.

The interoperable systems described in this letter are part of the MITA and interfaces to these systems should appropriately follow a Service-Oriented Architecture (SOA) as well as adhere to industry standards. States should aggressively pursue HIE and interoperability solutions for Medicaid providers that either obviate the need for costly interfaces, or utilize open architecture solutions that make such interfaces easily acquired. For example, consistent with the software ownership rights held by the state under 45 CFR § 95.617, States might require that HIE interfaces designed, developed, or installed with Federal financial participation be made available at reduced or no cost to other Medicaid providers connecting to the same HIE. Furthermore, States could require that such interfaces (or the code for such interfaces) be made publicly available. Additionally, CMS and ONC support States in sharing open source tools and interfaces with other States to further drive down the costs of HIEs, interfaces, and other interoperable systems.

States are also reminded that careful alignment and coordination with other funding sources should be thoroughly discussed with CMS and addressed in an Implementation Advance Planning Document Update (IAPD-U), specifically Appendix D. States continue to be encouraged to consult with CMS in advance of formal State Medicaid HIT Plan (SMHP) and IAPD submissions to obtain technical assistance regarding the funding options and boundaries outlined in this and the previous SMD Letters, and additional technical assistance will be provided when we release an update to the 2013 guidance that reflects the new criteria for the 90 percent HITECH match described here. States should reach out to their CMS regional office's Medicaid HIT staff lead as the initial point of contact.

Below are some examples of the types of state costs for which 90 percent HITECH match might be available, subject to CMS approval.

Federal Financial Participation (FFP) for On-boarding Medicaid providers to HIEs or interoperable systems

On-boarding is the technical and administrative process by which a provider joins an HIE or interoperable system and secure communications are established and all appropriate Business Associate Agreements, contracts and consents are put in place. State activities related to on-boarding might include the HIE's activities involved in connecting a provider to the HIE so that the provider is able to successfully exchange data and use the HIE's services. The 90 percent HITECH match is available to cover a state's reasonable costs (e.g., interfaces and testing) to on-board providers to an HIE. Subject to the parameters and cost controls described above, States

may claim 90 percent HITECH match for state costs of supporting the initial on-boarding of Medicaid providers onto an HIE, or onto any interoperable system that connects Eligible Providers to other Medicaid providers. Costs can be claimed both if they are incurred by the state to support the initial on-boarding of Eligible Providers and if they are incurred by the state to support the on-boarding of other Medicaid providers, provided that connecting the other Medicaid providers helps Eligible Providers demonstrate, and meet requirements for, Meaningful Use. States should coordinate with CMS on defining benchmarks and targets for on-boarding providers. States are reminded that, consistent with the principles described in both SMD Letter #10-016 and SMD Letter #11-004, the 90 percent HITECH match is for implementation only, and States should work with CMS on establishing an endpoint to onboarding and always ensure costs are allocated as appropriate across other payers. Also, the scope of the onboarding should be clearly defined and reviewed with CMS prior to IAPD submission to ensure that any costs claimed help Eligible Providers meet Meaningful Use and to ensure that HIE-related costs benefiting providers that are not eligible for Medicaid EHR incentive payments are claimed only if these costs help Eligible Providers demonstrate Meaningful Use. States should generally refer to SMD Letters #10-016 and #11-004 for other information about allowable onboarding costs.

Pharmacies: Similarly, subject to the parameters and cost controls described above, States may claim the 90 percent HITECH match for the costs of supporting the initial on-boarding of pharmacies to HIEs or other interoperable systems, if on-boarding the pharmacies helps Eligible Providers meet Meaningful Use objectives, such as the objectives around sending electronic prescriptions or the objectives around conducting medication reconciliations, both described in 42 CFR 495.22 and 495.24.

Clinical Laboratories: Subject to the parameters and cost controls described above, States may also claim 90 percent HITECH match for the costs of supporting the initial on-boarding of clinical laboratories to HIEs or interoperable systems, if on-boarding these laboratories helps Eligible Providers meet Meaningful Use objectives, such as the objectives for Electronic Reportable Lab Results or laboratory orders in Computerized Provider Order Entry (CPOE) described in 42 CFR 495.22 and 495.24.

Public Health Providers: Similarly, subject to the parameters and cost controls described above, States may also claim 90 percent HITECH match for the costs of on-boarding Medicaid public health providers to interoperable systems and HIEs connected to Eligible Providers so that Eligible Providers are able to meet Meaningful Use measures focused on public health reporting and the exchange of public health data, including activities such as validation and testing for reporting of public health measures described in 42 CFR 495.22 and 495.24.

FFP for interoperability and HIE architecture

As with expenses for on-boarding, States may claim 90 percent HITECH match for their costs of connecting Eligible Providers to other Medicaid providers via HIEs or other interoperable systems, if doing so helps Eligible Providers demonstrate Meaningful Use and the cost controls described above are met.

Specifically, 90 percent HITECH match would be available for States' costs related to the design, development, and implementation of infrastructure for several HIE components and interoperable systems that most directly support Eligible Providers in coordinating care with other Medicaid providers in order to demonstrate Meaningful Use. As described in SMD Letter #11-004, the 90 percent HITECH match cannot be used for ongoing operations and maintenance costs after this technology is established and functional. These components and systems include:

Provider Directories: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of provider directories that allow for the exchange of secure messages and structured data to coordinate care or calculate clinical quality measures between Eligible Providers and other Medicaid providers, so long as these costs help Eligible Providers meet Meaningful Use and the cost controls described above are met. The 90 percent HITECH match would not be appropriate for costs of developing a separate subdirectory for a class of providers that are not eligible for Medicaid EHR incentive payments and that are unlikely ever to exchange records with an Eligible Provider. CMS emphasizes the importance of dynamic provider directories with, as appropriate, bidirectional communications to public health agencies and public health registries. CMS particularly supports approaches to provider directories that provide solutions for Eligible Providers to connect to other Medicaid providers with lower EHR adoption rates, if doing so helps the Eligible Providers demonstrate Meaningful Use. Secure, web-based provider directories, for example, might help Eligible Providers coordinate care more effectively with long term care providers, behavioral health providers, substance abuse providers, etc. CMS expects that States will consider provider directories as a Medicaid enterprise asset that can also support Medicaid Management Information System (MMIS) functionality, with the reminder that, per SMD Letter #10-016, States should not claim 90 percent HITECH match for costs that could otherwise be matched with MMIS matching funds.

Secure Electronic Messaging: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of secure messaging solutions that connect Eligible Providers to other Medicaid providers and allow for the exchange of secure messages and structured data, so long as these costs help Eligible Providers meet Meaningful Use and the cost controls described above are met. States are encouraged to utilize Direct Secure Messaging as a transport standard that is secure and scalable. States should refer to the “Medicare and Medicaid Programs; Electronic Health Record Incentive Program – Stage 3 and Modifications to Meaningful Use in 2015 Through 2017” rule for guidance on meeting the Certified Electronic Health Record Technology (CEHRT) requirements for purposes of Meaningful Use⁵. States may also refer to ONC’s 2016 Interoperability Standards Advisory (ISA), a publication that provides the identification, assessment, and determination of the “best available” interoperability standards and implementation specifications for industry use to fulfill specific clinical health IT interoperability needs⁶. States should also be prescriptive in governance requirements to ensure maximal interoperability in the most secure and efficient manner possible. ONC is a willing partner with CMS in helping States deploy Direct Secure Messaging systems and developing

⁵ <https://www.federalregister.gov/articles/2015/10/16/2015-25595/medicare-and-medicaid-programs-electronic-health-record-incentive-program-stage-3-and-modifications>

⁶ <https://www.healthit.gov/sites/default/files/2016-interoperability-standards-advisory-final-508.pdf>

related governance requirements to ensure that Eligible Providers can connect to other Medicaid providers.

Query Exchange: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of query-based health information exchange, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. States may support coordination of care between Eligible Providers and other Medicaid providers by linking them into a query-based HIE that allows for secure, standards-based information exchange with thorough identity management protocols. A Query Exchange might access a state's Clinical Data Warehouse and similarly be integrated with analytic and reporting functions. These activities may support aggregate queries from providers to support population health activities performed by public health or other entities involved in population health improvement, provided that doing so helps Eligible Providers meet Meaningful Use. Given the unique data and exchange governance challenges of Query Exchange, States are encouraged to reach out to ONC to help formulate governance guidance and best practices.

Care Plan Exchange: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of interoperable systems and HIEs that facilitate the exchange of electronic care plans between Eligible Providers and other Medicaid providers, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. Medicaid providers coordinating care across multiple care settings may exchange care plans containing treatment plans and goals, as well as problem lists, medication history and other clinical and non-clinical content added and updated as appropriate by members of a patient's care team, including Medicaid social service providers. States are encouraged to consider care plan exchange for patients with multiple chronic conditions who might be coordinating care between many specialists, hospital(s), long term care facilities, rehabilitation centers, home health care providers, or other Medicaid community-based providers. Similarly, children in the foster care system might benefit from care plans shared across Medicaid providers (including Eligible Providers) to facilitate coordination of the children's care. As discussed above, costs related to exchanging care plans between Medicaid providers and other programs, such as foster care programs, may need to be allocated between benefitting programs.

Encounter Alerting: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of communications within an HIE or interoperable system connecting Eligible Providers and other Medicaid providers about the admission, discharge or transfer of Medicaid patients, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. These communications among Medicaid providers may contain structured data regarding treatment plans, medication history, drug allergies, or other secure content that aids in the coordination of patient care, including coordination of social services as appropriate.

Public Health Systems: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of public health systems and connections to public health systems, so long as the cost controls described above are met, and so long as these costs help Eligible Providers meet Meaningful Use measures focused on public health reporting and the exchange of public health data described in 42 CFR 495.22 and 495.24. It is worth

emphasizing that state costs eligible for the 90 percent HITECH match might include costs related to developing registry and system architecture for Prescription Drug Monitoring Programs (PDMPs), as per FAQ #13413⁷ PDMPs can be considered a specialized registry to which Eligible Providers may submit data in order to meet Meaningful Use objectives. States should, however, keep in mind that MMIS matching funds might in some circumstances be a more appropriate source of federal funding for costs related to developing a PDMP. Again, States should not claim 90 percent HITECH match for costs that could otherwise be matched with MMIS matching funds.

Health Information Services Provider (HISP) Services: States may claim the 90 percent HITECH match for costs related to the design, development, and implementation of HISP Services that coordinate the technical and administrative work of connecting Eligible Providers to other Medicaid providers, so long as these costs help Eligible Providers meet Meaningful Use, and the cost controls described above are met. HISP Services may coordinate encryption standards across providers, as well as coordinate contracts, Business Associate Agreements or other consents deemed appropriate for the HIEs or interoperable systems. States should be careful to distinguish between on-boarding services and HISP Services, as the scope of HISP activities overlaps with the scope of on-boarding activities, and the state should confirm that activities are only supported with federal funding once. States should clearly define the scope of HISP activities and on-boarding activities as appropriate.

This is not an exhaustive list of the types of state costs for design, development, and implementation of HIE components and interoperable systems for which 90 percent HITECH match might be claimed. Design, development, and implementation costs associated with other HIE components and interoperable systems might be supported by the 90 percent HITECH match as long as these costs help Eligible Providers achieve Meaningful Use and meet the cost controls described above, and will be considered by CMS accordingly.

Under this updated guidance, States remain able, subject to CMS approval, to claim 90 percent HITECH match for design, development, and implementation costs related to personal health records (PHRs), as utilizing a PHR through an HIE will often be the best way for many Eligible Providers to meet the Meaningful Use modified stage 2 Patient Electronic Access objective (*see* 42 CFR 495.22(e)(8)) and/or the Meaningful Use stage 3 Coordination of Care Through Patient Engagement objective (*see* 42 CFR 495.24(d)(6)). The parameters for HITECH administrative funding discussed in SMD Letters #10-016 and #11-004 continue to be relevant to PHR funding requests from States.

Conclusion

With more States utilizing or exploring the possibilities of vehicles for delivery system reform that benefit from coordination of care, such as health homes, primary care case management, managed care, home and community-based service programs, and performance-based incentive payment structures, there is an expectation that the Medicaid Enterprise infrastructure will be designed to support these efforts. These efforts therefore support the MITA principles of

⁷ <https://questions.cms.gov/faq.php?faqId=13413>

reusability, interoperability, and care management in providing a foundation for further delivery system reform.

As States enter the fifth year of the Medicaid EHR Incentive Program, CMS and ONC expect them to leverage available federal funding for tools and guidance to help Eligible Providers demonstrate Meaningful Use, which might include strengthening data exchange between Eligible Providers and other Medicaid providers. States may have questions about the Health Insurance Portability and Accountability Act (HIPAA) considerations applicable to creating more diverse HIEs and interoperable systems, so we have included links to guidance from the U.S. Department of Health and Human Services Office for Civil Rights and the Office of the National Coordinator for Health Information Technology describing uses and disclosures that are permitted under HIPAA⁸. Note that the discussion in the linked guidance only concerns the uses and disclosures that are permitted under HIPAA, and does not address when state costs related to the discussed activities would be eligible for the 90 percent HITECH match. This next phase of infrastructure development and connectivity will best position all Eligible Providers to successfully demonstrate Meaningful Use of Certified EHR Technology while solidifying a broader network of health information exchange among Medicaid providers, writ large.

Sincerely,

/s/

Vikki Wachino
Director

Enclosure

cc:

National Association of Medicaid Directors
National Academy for State Health Policy
National Governors Association
American Public Human Services Association
Association of State Territorial Health Officials
Council of State Governments
National Conference of State Legislatures

⁸ https://www.healthit.gov/sites/default/files/exchange_health_care_ops.pdf and https://www.healthit.gov/sites/default/files/exchange_treatment.pdf