Health Information Technology Oversight Council

June 9, 2016

Oregon Health Authority

Agenda

12:30 pm	Welcome, Introductions & HITOC Business
12:40 pm	Oregon's 1115 Waiver Renewal
12:55 pm	Shifting Environment and Federal Influences
1:10 pm	Interoperability Pledge
1:20 pm	Updating Oregon's HIT Strategic Plan
2:15 pm	Break
2:25 pm	HIE Onboarding Program Concept
2:50 pm	Oregon Common Credentialing Program
3:05 pm	Statewide Provider Directory
3:20 pm	Updates
3:35 pm	Public Comment
3:40 pm	Closing Remarks

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Goals of HIT-Optimized Health Care

1. Sharing Patient Information Across the Care Team

- Providers have access to meaningful, timely, relevant and actionable patient information to coordinate and deliver "whole person" care.

2. Using Aggregated Data for System Improvement

- 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.

3. Patient Access to Their Own Health Information

- Individuals and their families access their clinical information and use it as a tool to improve their health and engage with their providers.

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Oregon's Waiver: Proposed renewal to Oregon's 1115 Demonstration Waiver with the Centers for Medicare & Medicaid Services

Lori Coyner
Oregon's State Medicaid Director

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Introduction

- Brief overview: Oregon's waiver with CMS
- Key components of renewal
- Oregon's waiver and Health IT

Oregon's 1115 waiver

- CMS may *waive* certain Federal regulations, or pieces of law, in order to approve experimental, pilot, or demonstration projects, outside of the parameters of State Plans.
- A Demonstration may allow the State to:
  - Test new approaches to financing & delivering Medicaid-funded services; and
  - Test new approaches to defining, and limiting benefit packages.

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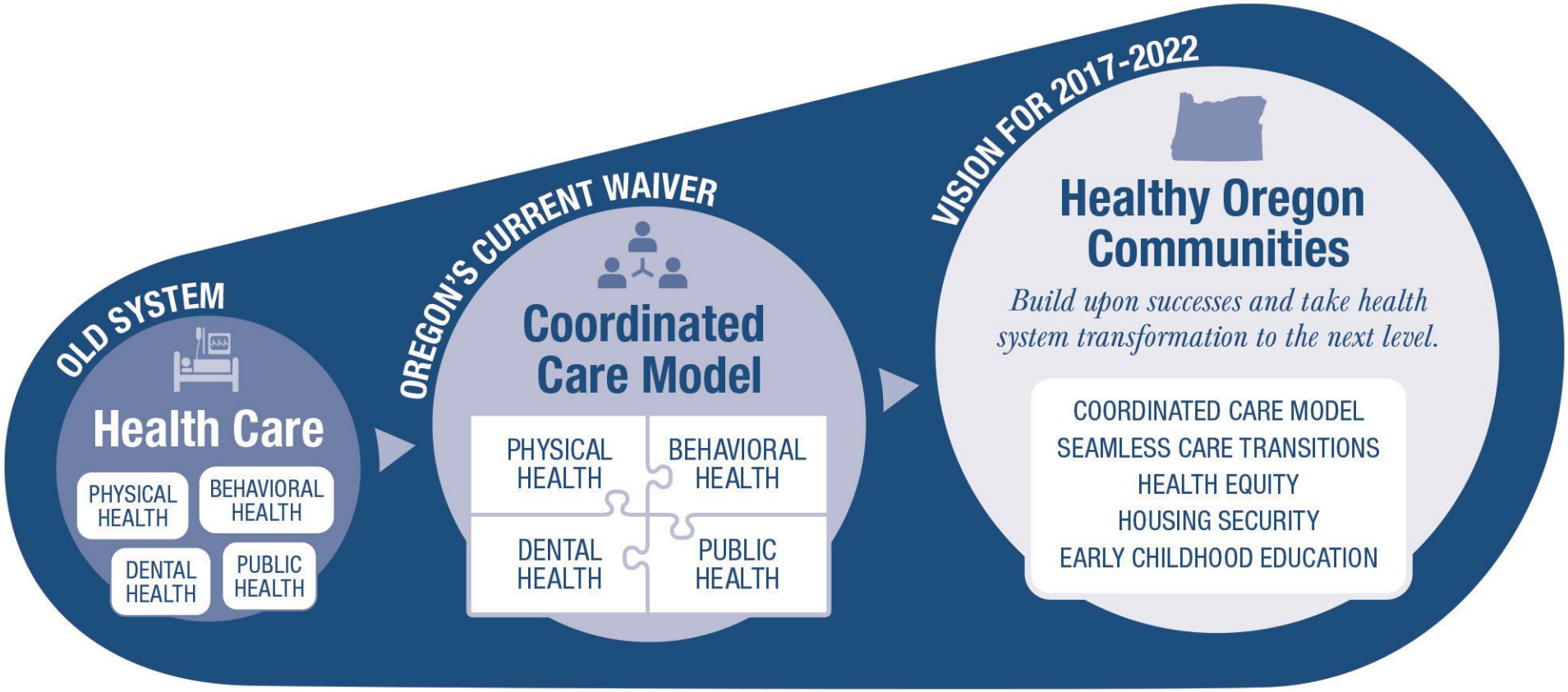
Opportunity in Oregon



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The next level of reform

1. Build on transformation with focus on integration of physical, behavioral, and oral health care through a performance driven system.

2. More deeply address social determinants of health and health equity with the goal of improving population health and health outcomes.

3. Commit to continuing to hold down costs through an integrated budget that grows at a sustainable rate.

4. Continue to expand the coordinated care model.

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Coordinated Health Partnerships (CHPs)*

Proposal to CMS: five-year grants to local pilots to increase supportive housing integration among targeted populations and develop infrastructure to ensure ongoing collaboration among the participating entities, including:

- CCOs
- County agencies
- Corrections
- Tribes
- Health providers
- Housing entities
- Local hospitals
- Other entities serving or advocating for the targeted population

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Coordinated Health Partnerships (CHPs)

Pilots will seek to address local supportive housing needs and develop solutions that fit local communities in Oregon; pilot objectives include:

- Increasing awareness of and access to housing supportive services
- Increasing coordination of housing supportive services for a targeted at-risk population. Local CHPs may identify specific sub-populations to include in pilot program based on community needs
- Reducing inappropriate emergency, inpatient and residential treatment facility utilization
- Increasing access to and use of primary care
- Improving data collection and sharing among local entities to support ongoing case management, monitoring, and improvements

CHP Pilot Domains

CHP Pilot Domains	Example: Potential Types of Services
Homelessness Prevention/ Transitions of Care Support to ensure care coordination among non-medical settings; fund services to support an individual's ability to move from institutional settings to less costly community-based care settings	• Care coordination services for pre-adjudicated criminally justice involved and Oregon State Hospital patients • Acute care transitions to less costly community-based settings • Ensuring that CCO members obtain health services necessary to maintain physical, mental, and emotional development and oral health • Ongoing assessment of medical, mental health, substance use disorder or dental needs • Case management and coordinating the access to and provision of services from multiple agencies • Establishing service linkages with community providers

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CHP Pilot Domains

CHP Pilot Domains	Example: Potential Types of Services
Housing Transition Services Invest in pre-tenancy services to decrease health care costs and reduce use of high-cost health care services	• Tenant screening and assessment • Assistance with housing searches and applications, move-in assistance, short-term expenses such as security deposits, other landlord-required rental or lease costs • Moving costs, basic furnishings, food and grocery supports • Adaptive aids and environmental modifications • Housing support crisis plan and intervention services • Care coordination services with medical homes, behavioral health and SUD providers

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CHP Pilot Domains

CHP Pilot Domains	Example: Potential Types of Services
Tenancy Sustaining Services Invest in services that support the individual in being a successful tenant in his/her housing arrangement	• Tenancy rights/responsibilities education; coaching and maintaining relationships with landlords • Eviction prevention (paying rent on time, conflict resolution, lease behavior requirements) • Utilities assistance/management (energy/gas) • Landlord relationship/maintenance • Crisis interventions and linkages with community resources to prevent eviction when housing is jeopardized • Linkages to education/job training, employment • Care coordination services with medical homes, behavioral health and SUD providers

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Waiver & HIT: Data Sharing Infrastructure

OHA proposes supporting the HIT component of Coordinated Health Partnerships (CHP) program by:

1. Ensuring data sharing infrastructure and availability of tools that support data exchange between social services and medical providers;
   - building upon the current physical health-centric health information sharing infrastructure to incorporate the needs of diverse populations, including
   - persons incarcerated in county jails, patients of the State Hospital, and persons who are transitioning housing services.
2. Enabling notification of transitions in and out of the corrections system, the State hospital, and for housing services; and
3. Support data sharing across the CHP organizations with the right policy environment.

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Waiver & HIT: Mobile/Telehealth

Oregon will support pilots to explore innovations in telehealth and mobile health for consumer and providers. Oregon is interested in these investments due to the successes seen in this rapidly changing environment:

- Mobile health (e.g., smart phone applications) has been shown to encourage increased consumer engagement in personal health and wellness, and new technology standards (FHIR) are emerging to ensure electronic health information can be accessed by mobile health applications.
- Telehealth has successfully lowered barriers to access to health services for rural and other underserved populations and can support increased capacity for behavioral health.

Results from the pilots would be shared and successful efforts may provide enough evidence to warrant sustainable funding from CCOs and other entities.

Timeline

- Waiver renewal application posted for public comment May 2, 2016
- Draft application submitted to CMS June 22
- Commitment to reach a high level agreement with CMS on the waiver renewal by this fall
- Finalize the waiver renewal in early 2017 with implementation beginning July 1, 2017
- Oregon is prepared to quickly work through the issues with CMS

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For more information on Oregon's CMS Waiver Renewal process, visit:

www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx

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Shifting Environment and Federal Influences

Lisa A. Parker

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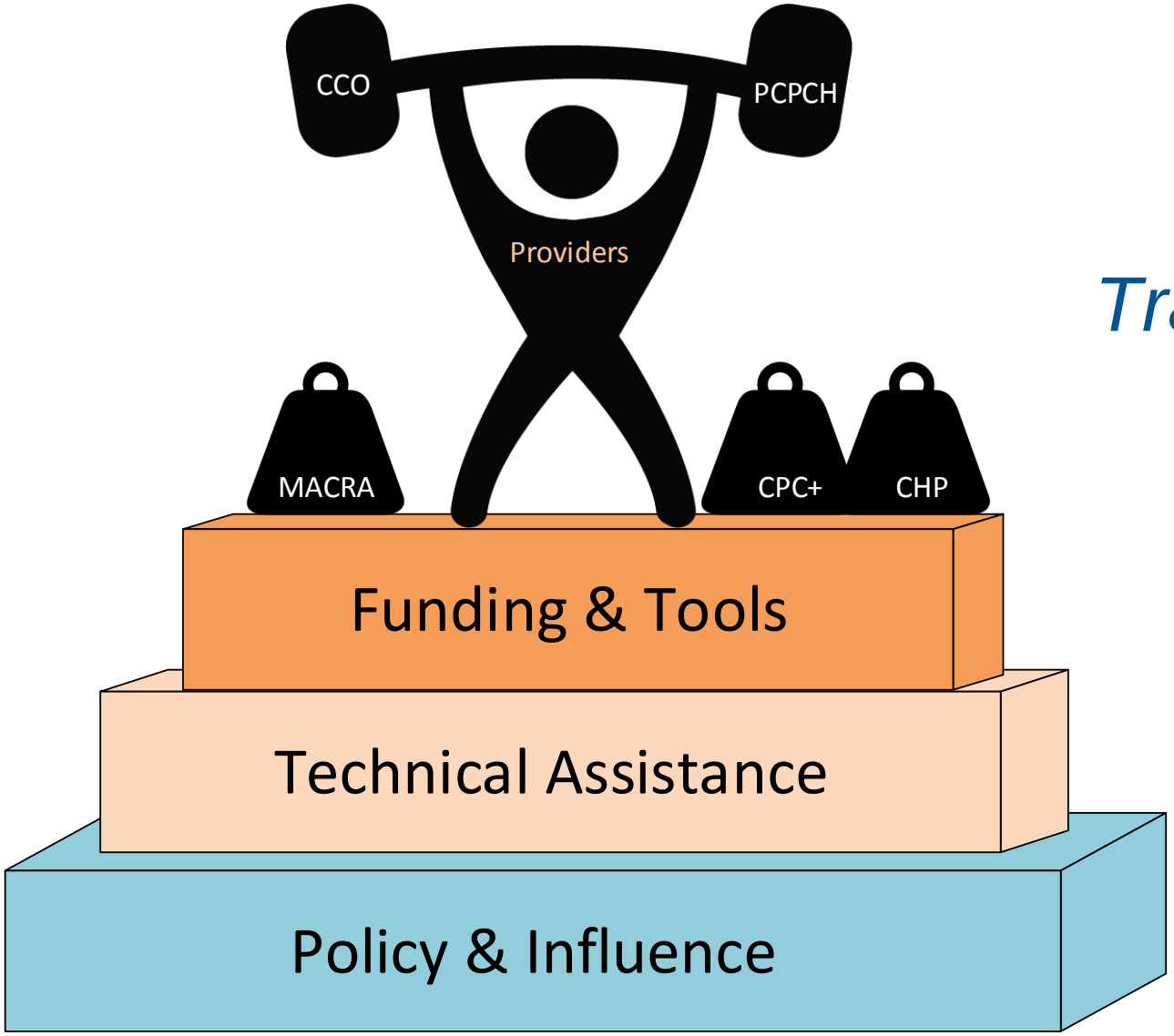
Support Needed for Upcoming Transformation



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CMS Multi-payer initiative: Comprehensive Primary Care + (CPC+)

CPC+ is a regionally based, multi-payer advanced primary care medical home model offering an innovative payment structure to improve the healthcare quality and delivery.

- Building on the Comprehensive Primary Care initiative launched in late 2012, the five-year CPC+ model will benefit patients by helping primary care practices:
- Support patients with serious or chronic diseases to achieve their health goals
- Give patients 24-hour access to care and health information
- Deliver preventive care
- Engage patients and their families in their own care
- Work together with hospitals and other clinicians, including specialists, to provide better coordinated care

- Oregon has over 600 PCPCHs
- 65 of which participate in CPCi

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CPC+: Two Tracks in each Region

Track 1: practices ready to build capabilities to deliver comprehensive primary care.

- Funding includes:
  - Care management fees and prospective incentives for quality

Track 2: practices poised to increase the comprehensiveness of care through

  - Enhanced Health IT
  - Improving care of patients with complex needs, and
  - Using supports to meet patients' psychosocial needs.
- Funding includes:
  - Larger care management fees & prospective quality incentives
  - A Comprehensive Primary Care Payment (CPCP) will be used to offset the percent of Fee for Service (FFS) income a practice receives for attributed patients

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CPC+ and Implications for HIT

Both Tracks 1 & 2:

- Each year, adopt certified health IT that meets the requirements of the EHR Incentive Programs.
- By the start of the 2017 performance year, adopt 2015 Edition certified technology to report on the CPC+ measure set
  - including technology meeting the (c)(4) filter which allows filtering of data by at least practice site address, TIN, NPI, and any combination thereof. (final measures to be determined by November 2016)

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CPC+ and Implications for HIT

Track 2: Letter of support from HIT vendor that outlines commitment to support the practice in optimizing HIT with these expected HIT capabilities:

- Risk stratify by the practice site patient population
- Empanel patients to the practice site care team
- Establish patient focused care plans to guide care management
- Screen for social and community support needs and link the identified need(s) to practice identified resources
- Produce and display electronic clinical quality metrics results at the practice level to support continuous feedback
- Document and track patient reported outcomes
- Optional: Practice site care delivery and care touch documentation

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CPC+ Resources

CMS' Comprehensive Primary Care Plus website:

https://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Plus

Payer applications were due June 8, 2016

Practice application submission July 15 to September 1, 2016

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Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) – Quality Payment Program

Signed into law on April 16, 2015

NPRM issued April 27, 2016

Changes how Medicare rewards clinicians for value over volume

Repeals the 1997 Sustainable Growth Rate Physician Fee Schedule (PFS) update

Introduces Quality Payment Program

- MIPS
- APMs

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Merit-Based Incentive Payment System (MIPS)

Streamlines three separate payment programs that will sunset December 31, 2018:

- **Physician Quality Reporting Program (PQRS)**
- **Value-Based Payment Modifier (VM)**
- **Medicare Electronic Health Record (EHR) Incentive Program**

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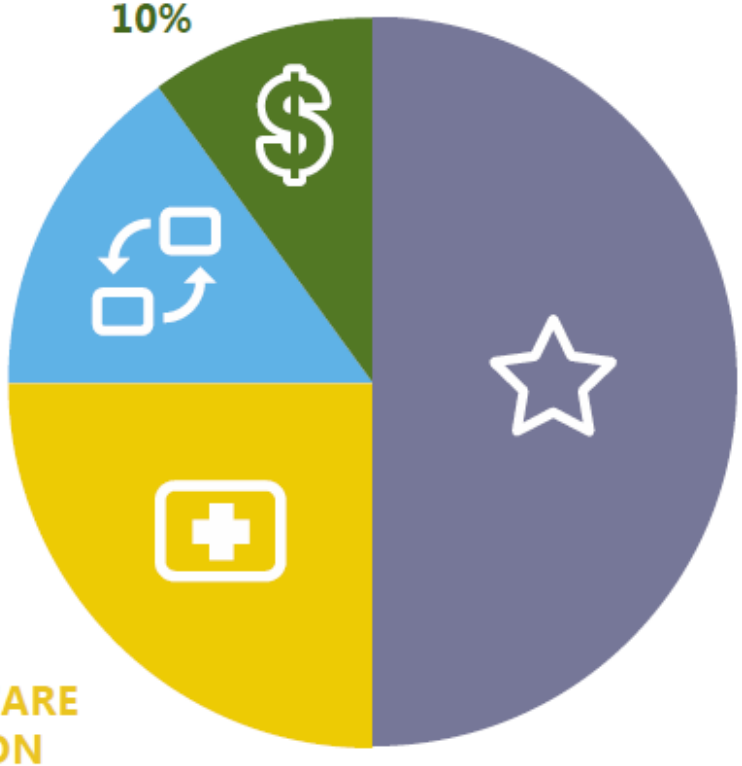
Proposed MIPS Year 1 Performance Score



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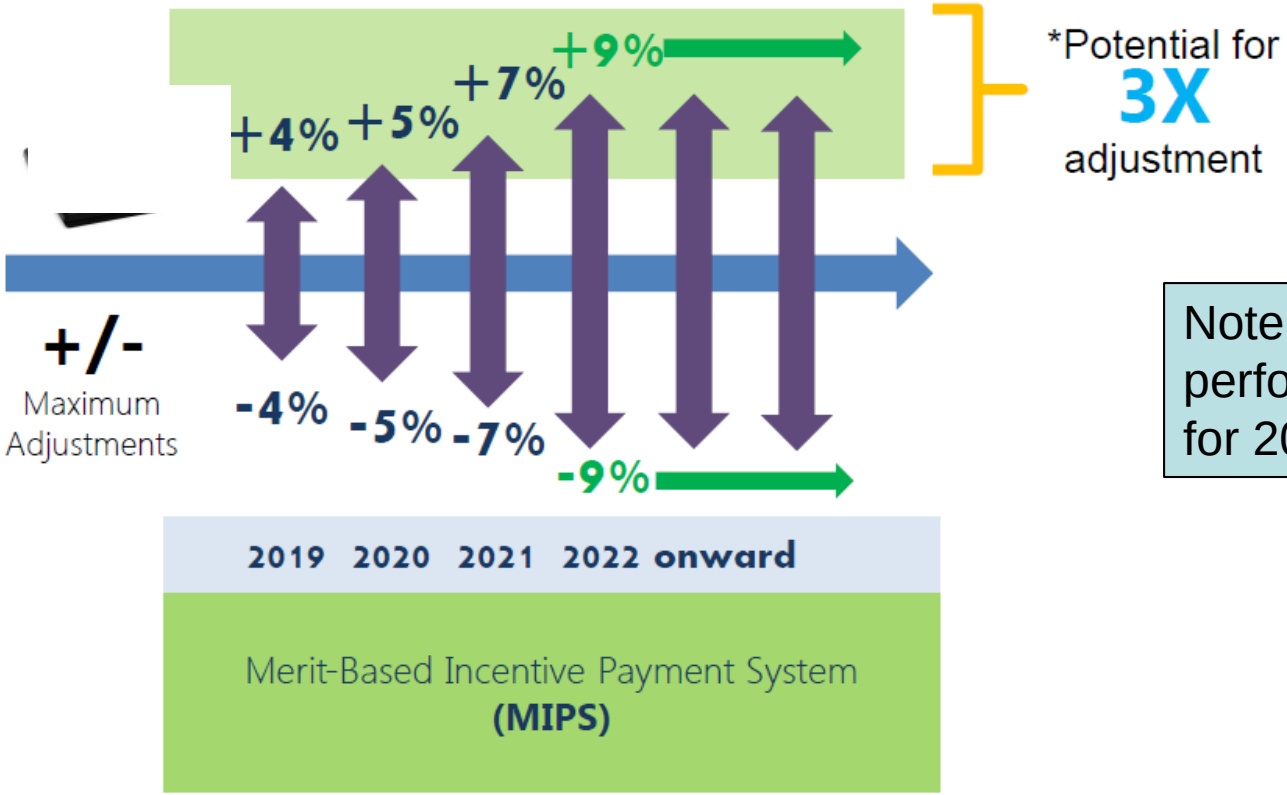
Proposed MIPS Payment Adjustments

Note: MIPS will be a **budget-neutral** program. Total upward and downward adjustments will be balanced so that the average change is 0%.



Note: 2017 is performance year for 2019 payment

Principal Changes from the Medicare EHR Incentive Program to Advancing Care Information Performance Category

Meaningful Use	Advancing Care Information
Must report on all objective and measure requirements	**Advancing Care Information streamlines measures and emphasizes interoperability, information exchange, and security measures. Clinical Decision Support and Computerized Provider Order Entry are no longer required.**
One-size-fits-all—every measure reported and weighed equally	**Customizable—Physicians or clinicians can choose which best measures fit their practice**
All-or-nothing EHR measurement and quality reporting	**Flexible—multiple paths to success**
Misaligned with other Medicare reporting programs	**Aligned with other Medicare reporting programs. No need to report quality measures as part of this category**

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MIPS & EHR Incentive Programs

Providers will be required* to attest to:

1. did not knowingly and willfully take action to limit or restrict the compatibility or interoperability of certified EHR technology;
2. implemented technologies, standards, policies, practices, and agreements to ensure that their EHR was:
    1. compliant with all standards applicable to the exchange of information,
    2. allowing for timely access by patients to their electronic health information and
    3. allows for the timely, secure, and trusted bi-directional exchange of structured electronic health information with other health care providers, including unaffiliated providers, and with disparate certified EHR technology and vendors; and
3. responded in good faith and in a timely manner to requests to retrieve or exchange electronic health information, including from patients, providers, and other persons, regardless of the requestor's affiliation or technology vendor.

*Effective April 2016 for providers participating in Medicare and Medicaid EHR Incentive Programs, and effective in future for MIPS providers

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Alternative Payment Models (APMs)

APMs are **new approaches to paying** for medical care through Medicare that **incentivize quality and value**.

As defined by MACRA, **APMs include**:

- **CMS Innovation Center model** (under section 1115A, other than a Health Care Innovation Award)
- **MSSP** (Medicare Shared Savings Program)
- **Demonstration** under the Health Care Quality Demonstration Program
- **Demonstration** required by federal law

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Proposed Rule APM Incentive Payment

Qualified Programs (QPs) will:

- Be excluded from MIPS
- Receive a 5% lump sum bonus

Bonus applies in payment years 2019-2024; then QPs receive higher fee schedule updates starting in 2026

- ✓ MACRA does NOT change how any particular APM functions or rewards value. Instead, it creates extra incentives for APM participation.
- ✓ Clinicians participating in APMs (not Advanced) will be subject to MIPS and will receive favorable scoring under MIPS.

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Oregon Takeaways on Quality Payment Program & HIT

MIPS:

- Health IT use and measurement is now referred to as “Advancing Care Information”; replaces meaningful use for Medicare
- 2017 performance measurement determines 2019 payments
- 2015 certified EHR technology optional in 2017 & required in 2018; (cannot reach full Advancing Care Information composite score with 2014 certified EHR technology)
- All providers must meet the security risk analysis measure and report to public health immunizations registry

APMs:

- Requires participants to use CEHRT & communicate clinical care information
  - 1st year at least 50% of clinicians
  - 2nd year increases to 75%

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Quality Payment Program Resources

CMS' Quality Payment Program website:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

Proposed Rule for the "Medicare Program; Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models" *(comments due 6/27/16)*:
https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-10032.pdf

CMS **Fact Sheet** on the Quality Payment Program:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf

CMS **Press Release** on the Quality Payment Program:
http://www.hhs.gov/about/news/2016/04/27/administration-takes-first-step-implement-legislation-modernizing-how-medicare-pays-physicians.html

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Interoperability Pledge

Susan Otter and Kim Mounts

Oregon Health Authority

Interoperability Pledge –
www.HealthIT.gov/commitment

90% of the companies that provide 90% of EHRs in use by hospitals nationwide, and the top 5 largest health care systems have agreed to implement 3 core commitments.

" We [name of company, organization] share the principle that to achieve an open, connected care for our communities, we all have the responsibility to take action.

To further these goals, we commit to the following principles to advance interoperability among health information systems enabling free movement of data, which are foundational to the success of delivery system reform."

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Three core principles

- **Consumer Access:** To help consumers easily and securely access their electronic health information, direct it to any desired location, learn how their information can be shared and used, and be assured that this information will be effectively and safely used to benefit their health and that of their community.
- **No Blocking/Transparency**: To help providers share individuals' health information for care with other providers and their patients whenever permitted by law, and not block electronic health information (defined as knowingly and unreasonably interfering with information sharing).
- **Standards**: Implement federally recognized, national interoperability standards, policies, guidance, and practices for electronic health information, and adopt best practices including those related to privacy and security.

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Pledge Entities with an Oregon Footprint

- Allscripts
- Athenahealth
- Cerner
- eClinicalWorks
- Epic
- GE Healthcare
- Greenway Health
- Intel
- McKesson
- Meditech
- NextGen
- SureScripts
- Wellcentive

- Healthcare Systems:
  - Catholic Health Initiatives
  - Kaiser Permanente
  - Trinity Health
- Associations
  - AAFP, ACP, AMGA, AMIA, AMA, AHIMA, AHA, CHIME, HIMSS, etc.
- Other organizations:
  - Commonwell
  - Sequoia Project

To get the full list of organizations that have pledged, visit: www.healthit.gov/commitment

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Examples of what this looks like:

- **Consumer Access:**
  - Creating or using tools and applications that support consumer access to information
  - Providing a patient portal
  - Implementing OpenNotes
- **No Blocking/Transparency**
  - HIE community access to shared record across care continuum
  - Hospitals providing data through HIEs/EDIE
  - Supporting exchange of health information though systems or interfaces
- **Standards**:
  - Adopting technology services that meet recognized standards
  - Creating new tools that meet standards
  - Foster collaboration and participate in standards and interoperability initiatives

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Stakeholder Feedback Supportive

- CCO Health Information Technology Advisory Group (HITAG)
- HIT-HIE Community and Organizational Panel (HITOC – workgroup)
  - Raised concerns about consumer access for HIEs.
- Oregon Association of Hospitals and Health Systems
  - Received positive feedback from members.
- Oregon Medical Association
  - Will pledge
- Oregon Health Leadership Council
  - If endorsed by HITOC, will share pledge information with members.

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Awareness and Promotion

- Work with associations and partners to provide awareness and encourage pledging
- Provide information and how to pledge
- National recognition:
  - ONC website: www.HealthIT.gov
- Recognition through OHA outlets
  - www.HealthIT.Oregon.gov
  - Newsletters
  - Social media
  - Outreach presentation and materials
- Office of Health IT will continually report back to HITOC

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Update on HIT Strategic planning

Susan Otter

1. Sharing Patient Information Across the Care Team

2. Using Aggregated Data for System Improvement

3. Patient Access to Their Own Health Information

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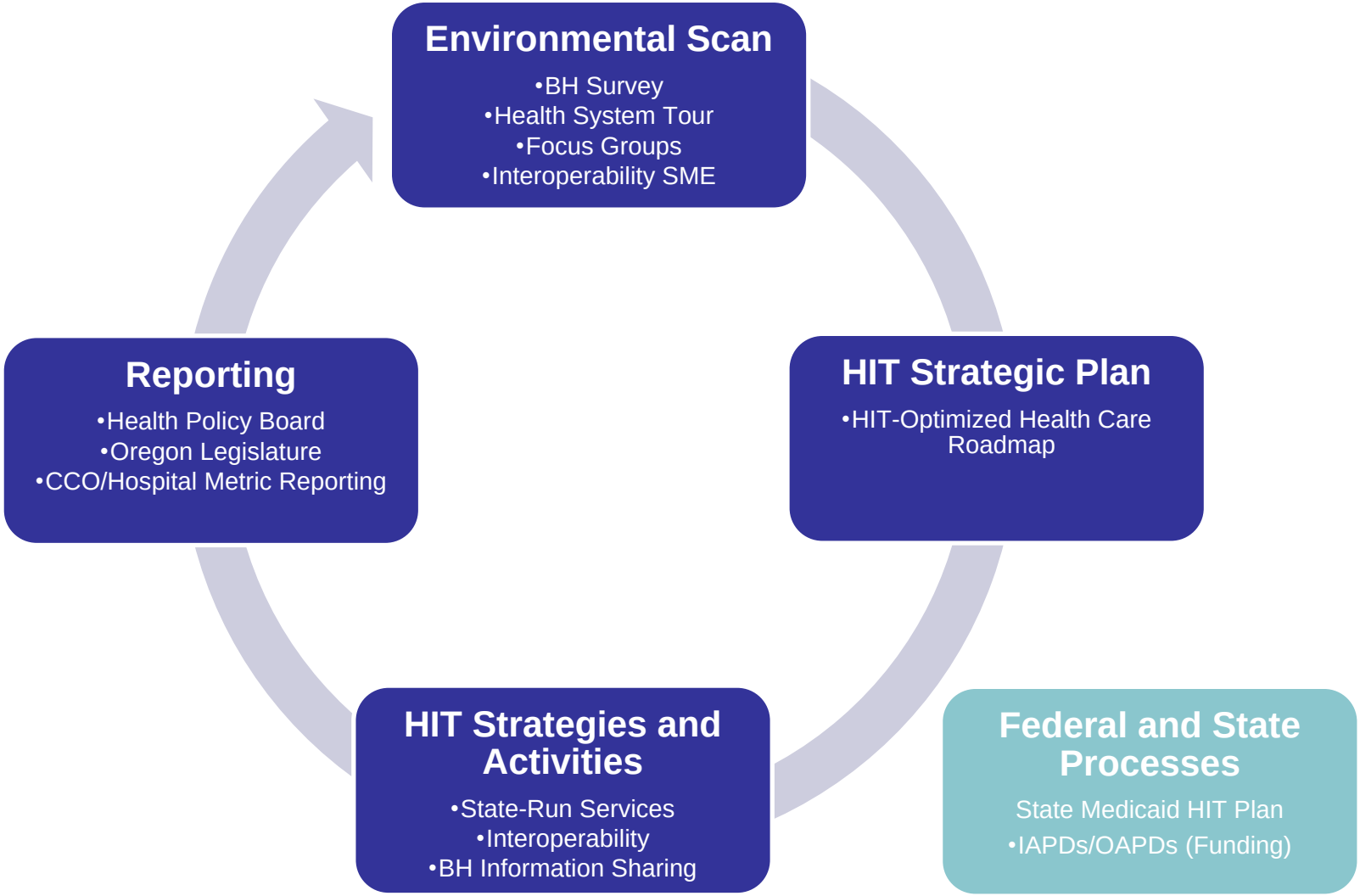

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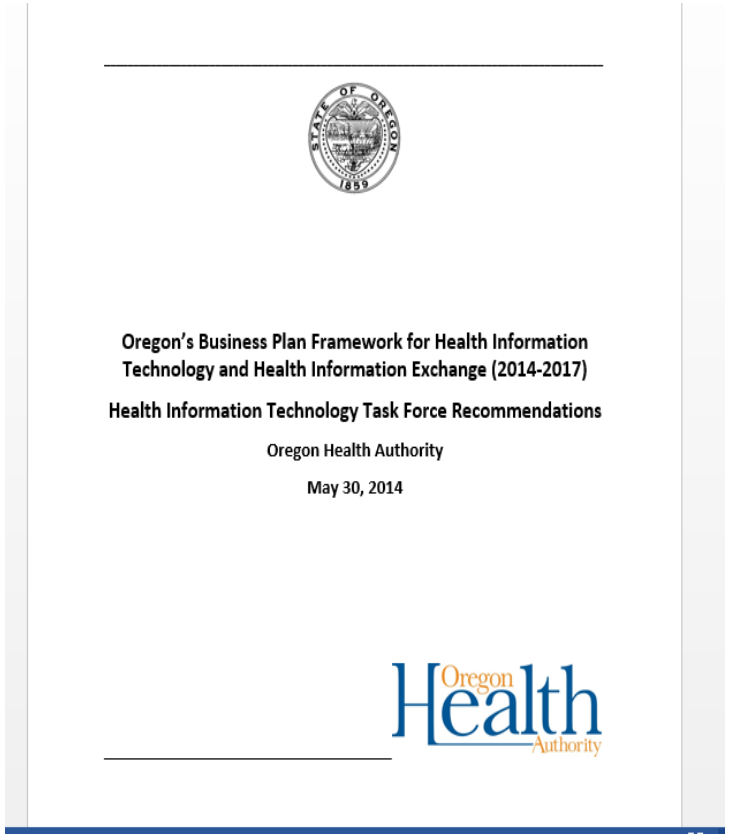
Business Plan Framework (2014-2017)

Oregon's current Health IT Strategic Plan is called the Business Plan Framework (BPF)

Process:

- Review of HITOC Strategic Plan (2010)
- Listening Sessions (CCOs, others)
- HIT Task Force (Fall 2013)
- BPF Endorsed by HITOC in June 2014



Oregon's Business Plan Framework for Health Information Technology and Health Information Exchange (2014-2017)

Health Information Technology Task Force Recommendations

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May 30, 2014

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Updating Oregon's HIT Strategic Plan

- The Business Plan Framework is set through 2017
  - An update to this plan is slated for 2017
  - "Monitor and adapt" principle
- HITOC process —
  - HITOC and OHA will turn to HITAG, PDAG, CCAG, HCOP, and other groups to inform this plan
  - Stakeholder engagement planned: behavioral health scan; listening tour of health systems; interoperability workgroup
  - HITOC Strategic Planning Retreat
- Changing environment (waiver, MACRA, CPC+, etc.)
  - New funding opportunity (HIE Onboarding for Medicaid) requires more centralized role
  - Good time to re-evaluate state role and other strategic plan components

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Strategic planning process and progress

Step in the process	Status	Timeframe
Goals (confirm)	Completed	December 2015
Aims/objectives	Completed	December 2015
State's role	Initial discussion	Summer 2016
Prioritizing objectives and outcomes	Drafted	Fall 2016
Assess environment: • *Identify current state* • *Identify changing policies, etc.*	Ongoing	Ongoing
Define/refine strategies: • *Technology* • *Governance/Finance* • *Policy, legal, education, etc.* • *Pilots/initiatives*		End of 2016/2017
Roadmap/Final Plan		2017

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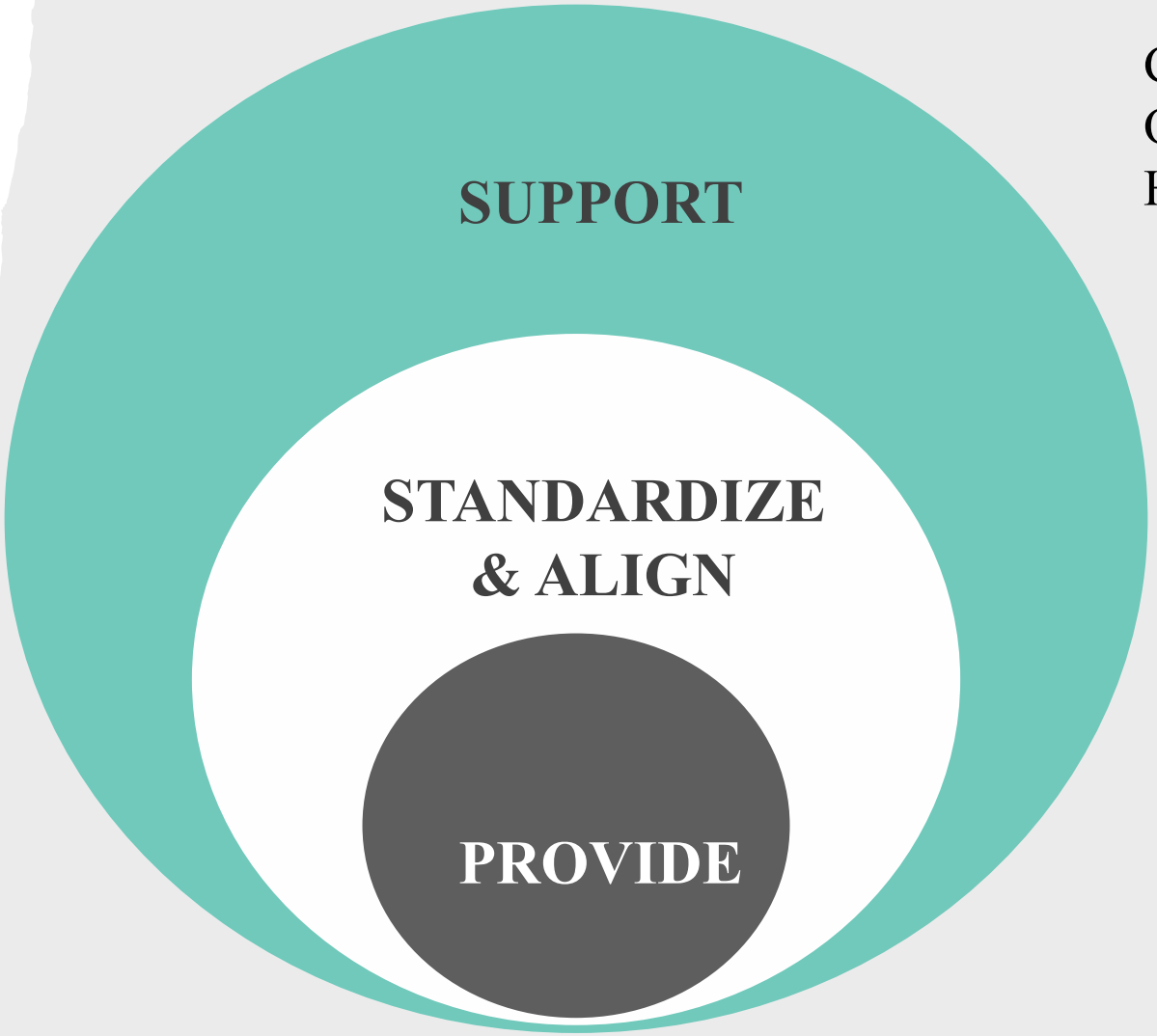
The Role of the State in Health IT



Community and Organizational HIT/HIE Efforts

OHA's HIT Priorities (a short list)

Past	• Physical health: EHR Adoption and Meaningful Use payments • Basic common exchange: Direct secure messaging

Current	• Support for care coordination (CCOs, PCPCHs, local HIE)
	  • Hospital event notifications
	  • Core infrastructure components (Provider directory, e.g.)
	• Initiatives/pilots/grants:
	  • Telehealth, OpenNotes, end of life/ePOLST
	  • Behavioral health consent, opiate prescribing/PDMP

Future	• Support for value based payment and population management
	  • CCOs/payers, PCPCHs, new HIT entities
	• New opportunities for funding and evolution of governance
	  • HIE onboarding funding
	• Advancing care coordination
	  • Interoperability and query
	  • Connecting care team: behavioral health, dental, long term care, social services, corrections, etc.
	  • Expanding notifications to other transitions of care
	• Support for consumer access/mobile health

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Approaches to Statewide HIE Coverage

Local — Central

- Community / Organizational HIEs and health systems provide HIE coverage
- No common services to provide baseline HIE capabilities to others
- No statewide enabling infrastructure tie these together

- Community / Organizational HIEs and health systems provide HIE coverage
- No common services to provide baseline HIE capabilities to others
- Statewide enabling infrastructure ties these together

- Community / Organizational HIEs and health systems provide HIE coverage to some
- Common services provide baseline HIE capabilities to others
- Statewide enabling infrastructure ties these together

- State / designated HIE entity provides HIE coverage
- All statewide, regional, and local needs are served centrally

(HITOC-approved)

Task Force Recommended

Current Approach and Activities

Oregon Approach	Current/planned activities
Private and public HIEs provide services to some entities	• Regional HIEs • Private efforts – population mgmt., care coordination tools, interfaces, hosted EHRs • Some leverage vendor driven solutions and/or national efforts
State provides enabling or connecting statewide services	• Direct secure messaging flat file directory • Statewide provider directory (planned) • Hospital event notifications/EDIE
State provides common services to fill gaps and provide high-value	• CareAccord • Common credentialing program (planned) • Clinical Quality Metrics Registry (planned)
State provides clarity around strategic direction	• *Certified HIT and recognized standards* • *Statewide Direct secure messaging* • *Clarity on state role allows investments locally*

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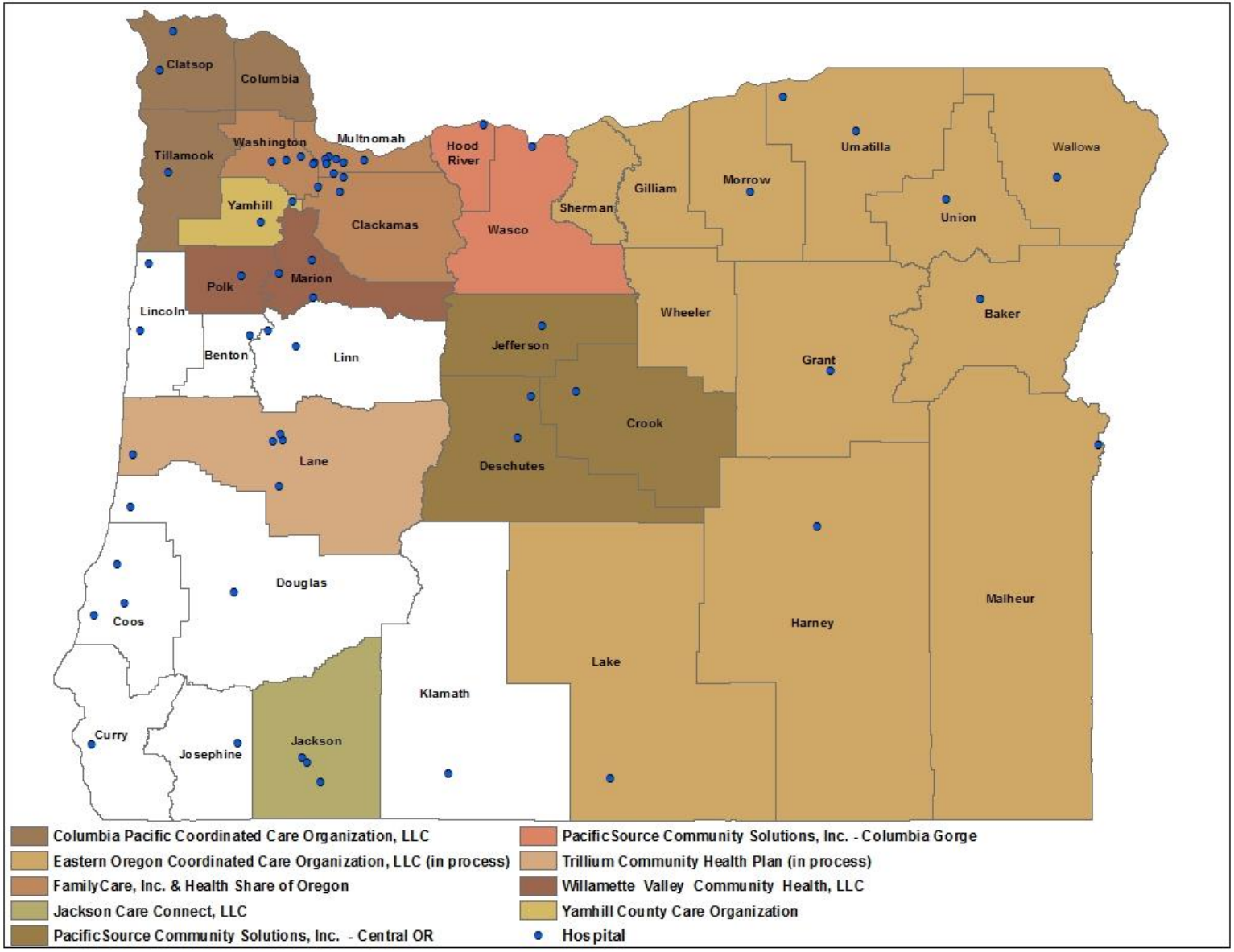
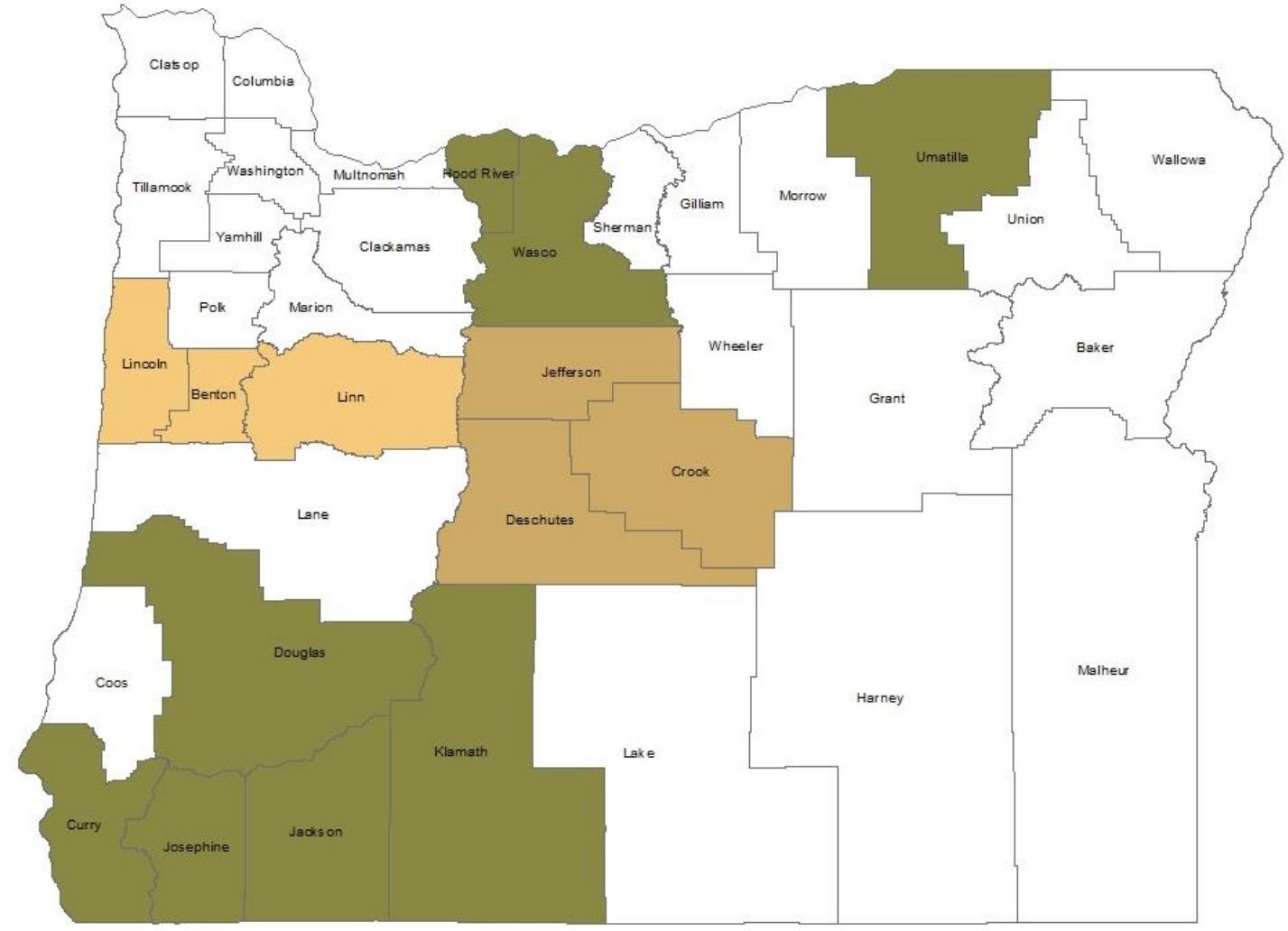
Hospital Event Data – by County

CCOs (PreManage), Hospitals (EDIE)

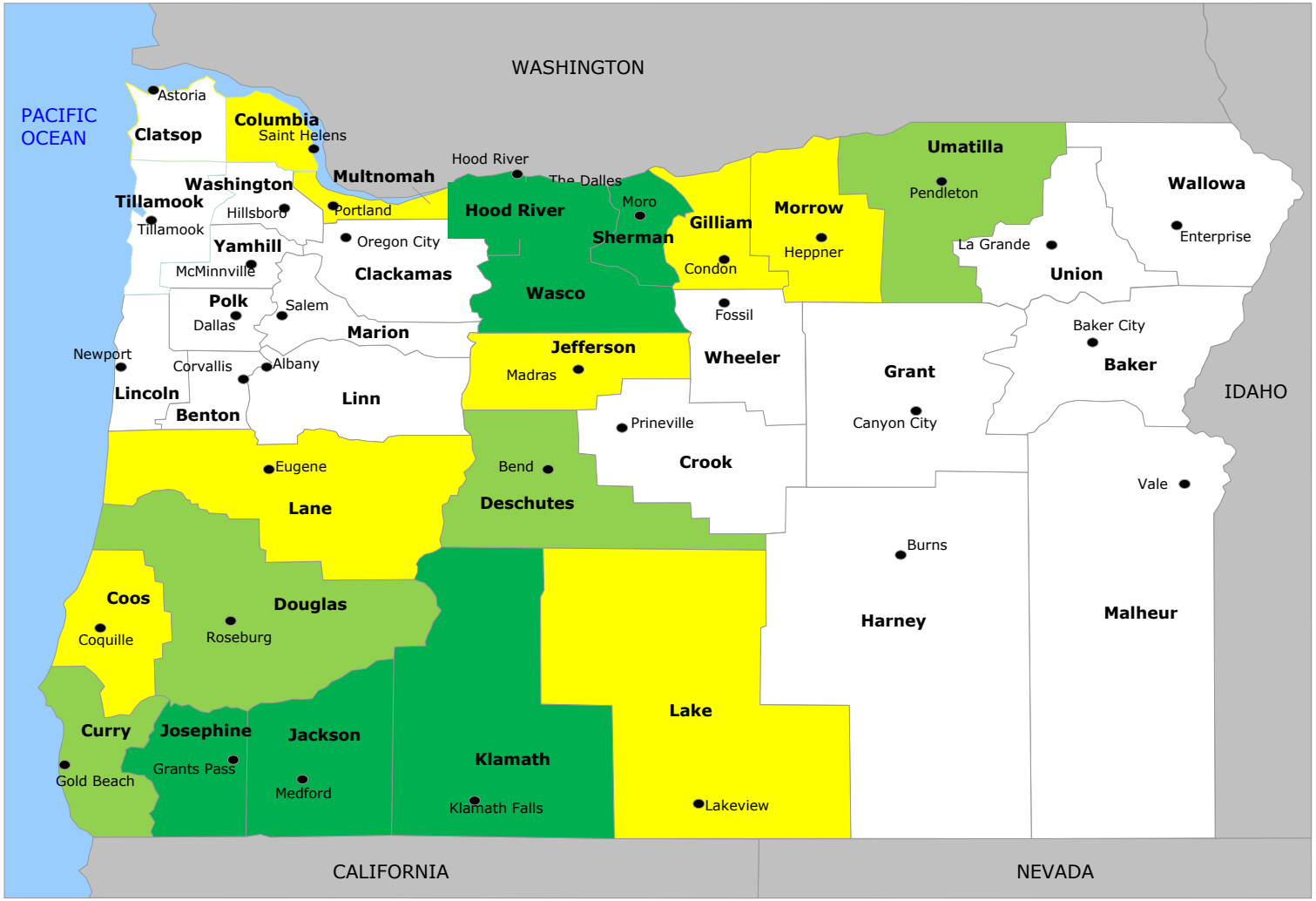


Regional HIEs – by County*



*Central Oregon piloting with JHIE

JHIE Coverage Area as of Feb 2016



Enrolled hospitals & clinics
Enrolled clinics
Some Interest in participating
Currently no activity

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Options for discussion (see handout)

- Market-driven approach: status quo –
  - HIE efforts have expanded independently with no oversight or governance role at the state level

- State-Led Partnership Model: Increases the coordination role of the state in developing a governance role over a defined "network of networks" of HIE efforts.
  - This model includes setting criteria to support statewide HIT objectives that HIE entities should meet to be eligible for funding or other support

- Centralized: A single entity is designated to provide state-sanctioned HIE services and to be eligible for funding or other support

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Break

HIE Onboarding Program Concept

Lisa A. Parker

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State Medicaid Directors Letter – HIE Funds

In early 2016, CMS and ONC updated the guidance about how state Medicaid agencies can use HITECH funding to support all Medicaid providers to connect to HIE entities or other interoperable systems:

- Federal funding at 90% matching rate for activities to promote HIE to enable eligible professionals (EPs) to meet meaningful use
- Guidance gives flexibility to provide HIE onboarding for any Medicaid provider (including behavioral health, long term care, corrections, etc.)
- Support the costs of an HIE entity to onboard Medicaid providers who are not EHR incentive-eligible. Onboarding must connect the new Medicaid provider, with or without an EHR, to an EP to help the EP meet meaningful use
- Possible activities include on-boarding to: a statewide provider directory, care plan exchange (unidirectional or bidirectional), query exchange, encounter alerting systems, public health systems

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HITECH HIE Funds – How it works

OHA may request 90% federal funding match through 2021; OHA must cover the 10% match.

- Fund the HIE entity's costs to onboard Medicaid providers to an HIE of a provider's choosing. Funding support can include technical and administrative processes, including agreements, contracts, and consents.
- Funds do not support the provider's costs for onboarding (e.g., EHR vendor costs)
- Funds can also support development and implementation of certain types of interoperable systems
- Funds cannot be used for operational costs or to purchase EHRs
- All providers or systems supported by this funding must connect to Medicaid EPs and support meaningful use

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HIE Funds – OHA Approach

Oregon intends to explore using these funds to:

1. Increase Medicaid providers' capability to exchange health information by supporting the costs of an HIE entity (e.g., regional HIEs) to onboard providers.

2. Support Oregon's Medicaid providers, with or without an EHR, including: behavioral health, long-term care, corrections, and other social services, to connect to HIE entities.

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“HIE Onboarding Program” Concept

Oregon is considering requiring HIE entities to meet minimum criteria to be eligible for support. Criteria have not yet been determined but may include that the HIE entity:

- Uses standards-based or certified health IT;
- Is interoperable and participates in statewide HIE connectivity (e.g., through Direct secure messaging);
- Participates in Oregon’s state-level provider directory (once it is available);
- Reports to OHA’s clinical quality metrics registry and public health registries as appropriate; and
- Does not engage in practices that would result in health information blocking.

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“HIE Onboarding Program” Concept

Further definition is needed, including:

- Priority types of Medicaid providers
- Criteria for HIE entities to be eligible for onboarding funding
- Eligible HIE services
- Estimates for budgeting, identifying or requesting state match, and implications for scope
- Rulemaking processes
- Oversight and governance implications for ensuring effective use of funding

Additional challenges:

- Addressing “white-space” coverage
- Avoiding unintended consequences (e.g., creating artificial markets)

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HIE Onboarding Program – Next steps

OHA's next steps:

- HITOC feedback and endorsement of HIE Onboarding concept
- Establish a process and forum to determine criteria
  - Convene small OHA work group to flesh out concept
  - Report back to HITOC and other stakeholders
- Continue to socialize concept and gather input
- Formalize strategy, in partnership with stakeholders, and submit a concept to CMS for discussion.
- Upon agreement with CMS, OHA will submit a formal request for funding and initiate the program.

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The Oregon Common Credentialing Program

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HIT Portfolio: 3 Projects Underway

Portfolio projects:

- Common Credentialing (CC)
- Provider Directory (PD)
- Clinical Quality Metrics Registry (CQMR)

Procurement of systems

Harris Corporation (systems integrator) responsible for procuring and overseeing the implementation of portfolio systems

- CC is in the selection process, vendor to be on board Sept 2016
- PD RFP in process, vendor to be on board early 2017
- CQMR in the planning/requirements refining stage, vendor in 2017

Funding sources

- State/federal Medicaid HIT funding for PD and CQMR, possible PD fees
- CC will charge fees to credentialing organizations and health care practitioners – no state/federal funding

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Background on Common Credentialing

Primary purpose of common credentialing:

- Credentialing is done to ensure qualified practitioners are treating our patients
- Process of credentialing morphed over many years into stringent standards now duplicated across organizations

Common credentialing efforts in Oregon:

- Oregon Practitioner Credentialing Application since 2000
- Oregon Health Leadership Council effort to create a solution
- Senate Bill 604 (2013) mandates common credentialing

Legislation sponsored by Senators Alan Bates and Elizabeth Steiner-Hayward supported by the Oregon Medical Association, the Oregon Association of Hospitals and Health Systems, Regence, and more.

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Common Credentialing Program

The Program will include…

- A centralized web-based electronic solution that will collect, store, and maintain practitioner credentialing information
- A process for collecting and verifying credentialing information
- A process for practitioners or designees to access the Solution to submit information with 120 day attestations
- A process for credentialing organizations access and retrieve practitioner credentialing information
- A process for leveraging Health Care Regulatory Board data
- Fee collection for credentialing organizations and practitioners

The Program will *NOT* include:

- The decision to credential a practitioner
- The process of privileging a practitioner

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User Benefits and Challenges

User	Benefits	Challenges
Health Care Practitioners	• Centralized solution to enter credentialing information • One-time initial application • No recredentialing app. • Reduced overall workflow	• Workflow changes • 120-day attestations • Initial application fee • Security concerns
Credentialing Organizations	• Centralized source of verified information • Change notifications • Reduced form mailings • Reduced workflow • Economies of scale	• Workflow changes • Budget adjustments • Only Oregon practitioners • Perceived liability risks

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Fee Structure Development

Stakeholders have outlined fee structure preferences…

Credentialing Organizations	
One-Time Setup Fee	Tiered fee based on practitioner panel size
Annual Subscription Fee	
Expedited Credentialing Fee	Flat fee per expedite request/per practitioner
Health Care Practitioners	
Initial Application Fee	Flat fee (one-time)

Next steps:

- Conduct surveys to determine fee structure tiers
- Apply true cost to the fee structure, August 2016
- Rule development and public hearing, late 2016
- Legislative approval in 2017

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Activities Moving Forward

- Conducting fee development activities
- Developing an adoption plan to ensure success and value
- Formalizing a marketing and outreach strategy to inform and engage impacted stakeholders
- Revising and finalizing credentialing rules
- Focusing on quality assurance by obtaining stakeholder input, ensuring alignment with standards and HIT policy
- Continuing stakeholder engagement along the way:
  - Common Credentialing Advisory Group
  - Subject matter experts
  - Professional associations
  - General outreach efforts

"Go live" mid 2017

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Questions?

General questions and comments can be directed to:
credentialing@state.or.us

More information on the OCCP can be found at:
www.oregon.gov/oha/OHIT/occp

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Provider Directory

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Provider Directory highlights

- ✓ Directory of accurate, trusted provider data available to healthcare entities
- ✓ Authoritative data sources that are leveraged to feed the directory are matched, scrubbed, and given a quality score
- ✓ Ongoing management of the data is handled by staff that ensure data displayed in the provider directory is accurate

Correct data

↓

Complete data

↓

Current data

↓

One-stop shop for Provider data

Key uses

Efficiencies for Operations	Facilitate care coordination and health information exchange (HIE)	Resource for health care analysis
• Access to a trusted, single, complete source of provider and practice information • Validate data residing in an health care entity's own provider directory • Support entities' need to meet requirements for updated/accurate provider directories	• Find Direct secure messaging (DSM) addresses and other provider information allowing electronic clinical data to be sent to the correct recipient • Find providers for referrals and care coordination	• Source of data on where and when providers practice to support analysis of claims and other data • Support generation of metrics and data analysis for quality improvement and related payment efforts • Support research and inform policy

Provider Directory components

- Authoritative, comprehensive data sources (e.g., Common credentialing)
- Data scrubbing, matching and quality scoring
- Data stewards and ongoing data management
- Medicaid funding
- Informed by stakeholders
- Historical data
- Multiple ways to access data
- Building to national standards

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Value proposition

- ✓ Improved overall quality of data in an health care entity's own directory
- ✓ Reduced burden on providers to provide their current information and remove the duplicate and repetitious requests for their information
- ✓ Improved administrative efficiencies by streamlining current processes to reduce staff time spent on data maintenance activities
- ✓ Improved ability to meet regulations related to provider directory accuracy
- ✓ Increased use of Direct secure messaging; reduced use of fax/paper
- ✓ Better care coordination for patients
- ✓ Improves security and privacy of patient data
- ✓ Improved ability to calculate quality metrics based detailed provider and practice data
- ✓ Enables finding providers and providing outreach
- ✓ More…..

Provider Directory Services at a glance

Data services – Data leveraged from authoritative sources are scrubbed, scored, matched, and maintained

Web portal - Query the web portal and export results

Data extracts – Predefined, static extracts of data from the provider directory

Custom extracts - customizable extracts of data from the provider directory

Integrated provider directory - Integrated access to and from the provider directory via an Application Program Interface (API) or web services

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Activities

Program development activities

- Communications plan
- Funding plan, includes fees
- Governance model

Stakeholder engagement

- Provider Directory Advisory Group
- Internal OHA/DHS stakeholders
- Participate and present in national conferences

Procurement

- Request for proposal this summer
- Vendor onboard in 2017

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Questions

More information can be found at:
www.oregon.gov/oha/OHIT/Pages/Provider-Directory-Advisory.aspx

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Updates

ONC Annual Meeting

ONC JHIE Site Visit

ONC Measuring Interoperability RFI

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ONC Annual Meeting

Marta Makarushka, Lead Analyst

Oregon Health Authority

ONC Annual Meeting in DC: 5/31-6/2/2016

Priority topics included:

- Interoperability Pledge
- MACRA
- Alternative Payment Models
- Measuring Interoperability
- Privacy and Security
- Standards
- Behavioral Health Info Sharing
- Telehealth
- Patient Engagement
  - Entire third day devoted to patients
  - Patient Engagement Playbook

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ONC JHIE Site Visit

Marta Makarushka, Lead Analyst

Oregon Health Authority

ONC Site Visit to JHIE: Update

- Topics discussed included:
  - need for population health management and analytics
  - challenges facing Behavioral Health facilities
  - challenges with vendors
  - funding opportunities created by the recent SMD letter
  - other state HIT efforts related to interoperability and multi-stakeholder governance
- OHA and JHIE requested assistance from ONC for:
  - creating national standards for provider directories and other technology
  - engaging behavioral health providers in HIT/HIE
  - guidance on Alternative Payment Models (APMs)
  - working with vendors

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ONC Site Visit to JHIE: Update

Behavioral Health Workgroup Stakeholder Meeting Highlights

- Information Sharing
  - Sharing Alcohol and Drug is most challenging
- Suggested Funding Opportunities
  - Analytics
  - Provider and patient education
- Access to Patient Information Across the Care Team
  - Information exchange across and among BH providers
- Medication Information
  - PDMP data
- Behavioral Health and Other Patient Information into JHIE
  - Role of Common Consent Model

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ONC's Measuring Interoperability RFI

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Measuring Interoperability RFI

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires that HHS establishes metrics to assess the achievement of widespread interoperability

- To assist with defining the scope of measurement, ONC is soliciting feedback on the following:
  - What populations and key components of interoperability should be measured?
  - What current data sources and potential metrics should be used to measure interoperable exchange and the use of exchanged information?
  - What other data sources and metrics should HHS consider to measure interoperability more broadly?

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Measuring Interoperability RFI

Populations and Key Components

- The focus of measurement should not be limited to Meaningful EHR Users (MUsers) and their exchange partners, but rather should include behavioral health, LTC, and consumers per the Roadmap
- Measurement of interoperability should extend beyond CEHRT

Available Data Sources and Potential Measures

- Surveys only minimally contribute to the measurement of the (1) use of exchanged data, (2) facilitation of coordinated care, and (3) improvement of patient outcomes
- Suggest the inclusion of additional research approaches such as regional case studies, focus groups, structured interviews, and economic analyses (e.g., resource constraints, market structure)
- Data collected by states can also be used to identify barriers to exchange, lessons learned, and solutions

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Measuring Interoperability RFI

EHR Incentive Program Measures

- Incentive program measures do not adequately address the exchange component of interoperability
- Reconciliation activities (e.g., medication reconciliation) serve as a starting point for measuring use of exchanged information
- Data from Medicare-only eligible professionals can provide valuable insight into the development of new measures and the evaluation of exchange and data re-use

Other Data Sources

- ONC should use data from a variety of sources
- Highest priority measures are those associated with semantic interoperability and data re-use in care coordination
- Include data collected by states, technology developers, HIEs, HIOs, and other entities

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Public Comment

Next Meeting

Next Meeting: August 4, 2016

Location: **Transformation Center Training Room**
421 SW Oak St, Suite 775, Portland