Health Information Technology Oversight Council

June 9, 2016, 12:30 – 3:45 pm
The Lincoln Building – Oak Room (off the main lobby)
421 SW Oak Street
Portland, OR 97204
Call in: (888) 808-6929, HITOC Member (Host): 514237, Public Code: 453773

Name	Organization	Title
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 Sapra	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 • Approval of Minutes – April 2016 • Update on HITOC Report to OHPB	Information Discussion	1. Agenda 2. April 2016 HITOC Meeting Minutes 3. HITOC Report to OHPB
12:40 pm	**Oregon's 1115 Waiver Renewal** Lori Coyner, State Medicaid Director	Information	
12:55 pm	**Shifting environment, MACRA, and Federal Influences –** Lisa Parker and HealthTech Solutions	Discussion	4. CPC+ Overview 5. MACRA Quality Payment Program Resources 6. MACRA Quality Payment Program Fact Sheet
1:10 pm	**Interoperability Pledge**—Kim Mounts and Susan Otter	Information Discussion Action	7. Interoperability Pledge Letter 8. Interoperability Pledge Fact Sheet
1:20 pm	**Updating Oregon's HIT Strategic Plan**—Susan Otter	Discussion	9. HIE Model Options
2:15 pm	**Break**		

2:25 pm	**HIE Onboarding Program Concept**—Lisa Parker	Discussion Action	10. HITECH HIE Funds - SMD letter Feb 2016 11. HITECH HIE Funds – Oregon Draft Approach to HIE Onboarding
2:50 pm	**Common Credentialing**—Melissa Isavoran Overview	Information Discussion	12. Common Credentialing Program Fact Sheet
3:05 pm	**Provider Directory –** Karen Hale Overview	Information Discussion	13. Provider Directory Program Fact Sheet
3:20 pm	**Updates** • ONC Site Visit Summary • OHA Comments on ONC NPRM • OHA Comments on Measuring Interoperability RFI		14. ONC Site Visit 15. RFI Comments
3:35 pm	**Public Comment**	Information Discussion	
3:40 pm	**Closing Remarks** – Chair		

Links to OHA's Comments on Federal Materials (RFIs and NPRMs)

On May 5, OHA submitted comments on ONC's Enhanced Oversight and Accountability Notice of Proposed Rulemaking (NPRM). Our feedback, which incorporated HITOC input, can be found here: https://www.regulations.gov/#!documentDetail;D=HHS-OS-2016-0007-0039	

Next Meeting: **August 4, 2016**
Transformation Center Training Room,
421 SW Oak St, Suite 775
Portland OR 97204

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 in Oregon:

June 2016 Report to the Oregon Health Policy Board

Health Information Technology Oversight Council

Oregon Health Authority, Office of Health Information Technology

June 1, 2016

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Health Information Technology in Oregon

June 2016 Report to the Oregon Health Policy Board

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.

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.

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.

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.

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Significant HIT funding, policy, and oversight 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.

Looking forward: Priority efforts for 2016-2017

OHA, HITOC, and the OHPB have identified challenges, roadblocks, and paths forward where OHA/HITOC may be able to take action. OHA and HITOC are currently exploring what actions they can take related to these areas.

- Updating Oregon's HIT strategic plan
- Establishing reporting and tracking metrics for HIT in Oregon
- Improving "real-world" interoperability
- Increasing behavioral health information sharing
- Ensuring the right HIT for alternative payment models
- Leveraging new federal funding to support Medicaid behavioral health, long-term care, and other social services providers to connect to HIT/HIE

HB 2294 (2015) requires HITOC to regularly report to the Oregon Health Policy Board on the status of the HIT environment in Oregon as well as OHA's HIT efforts, including the Oregon Health Information Technology Program.

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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.

<u>HITOC's new duties under HB 2294 include</u>:

- 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.

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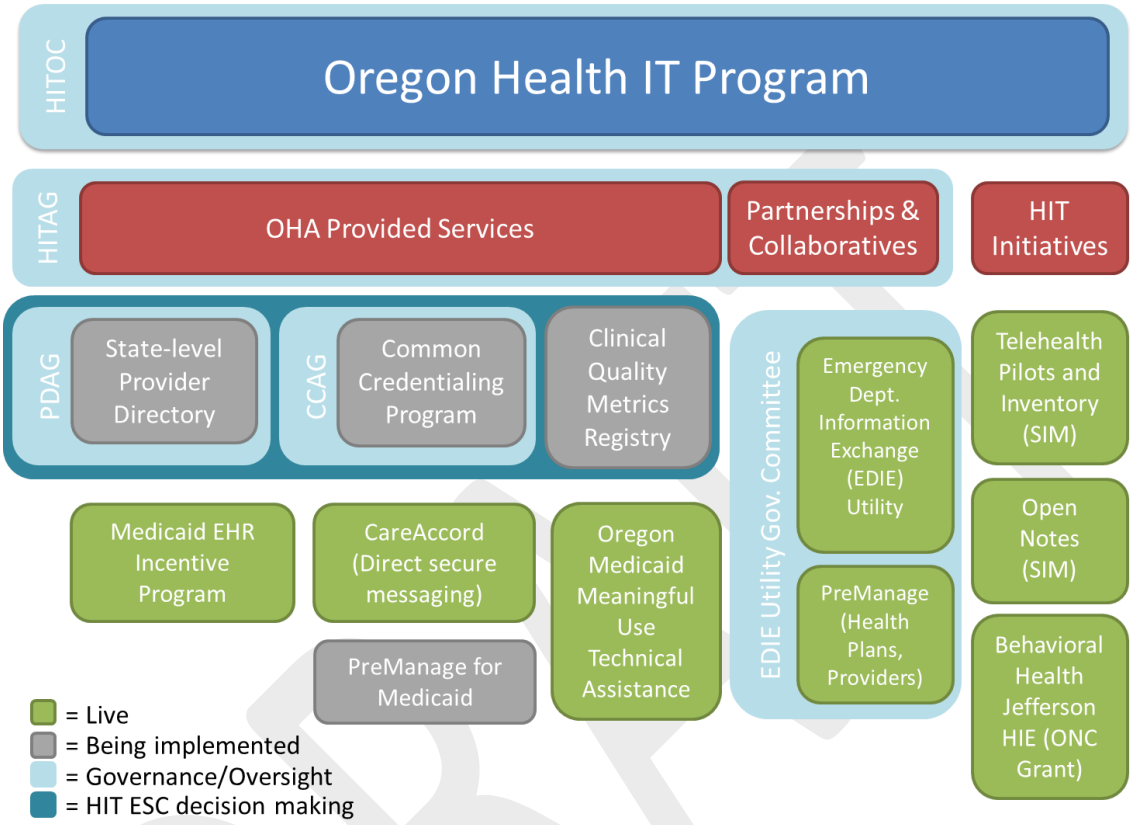
Oregon Health Information Technology Program

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

<u>Emergency Department Information Exchange (EDIE) and PreManage</u>

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.

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II. Environmental Scan of Health Information Technology in Oregon

EHR Adoption and Meaningful Use in Oregon

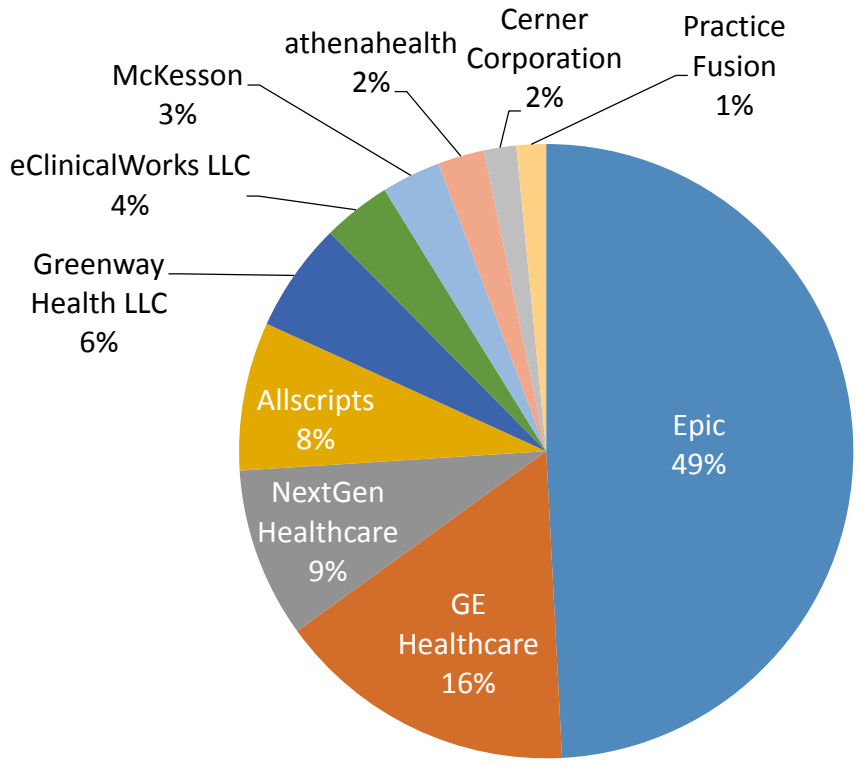
Adoption of certified EHR technology provides the foundation for optimizing Oregon's health care delivery system and supporting health information exchange, quality improvement efforts, and patient access to their health records. Federal certification of EHRs is critical for ensuring that EHRs are standards-based, 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.

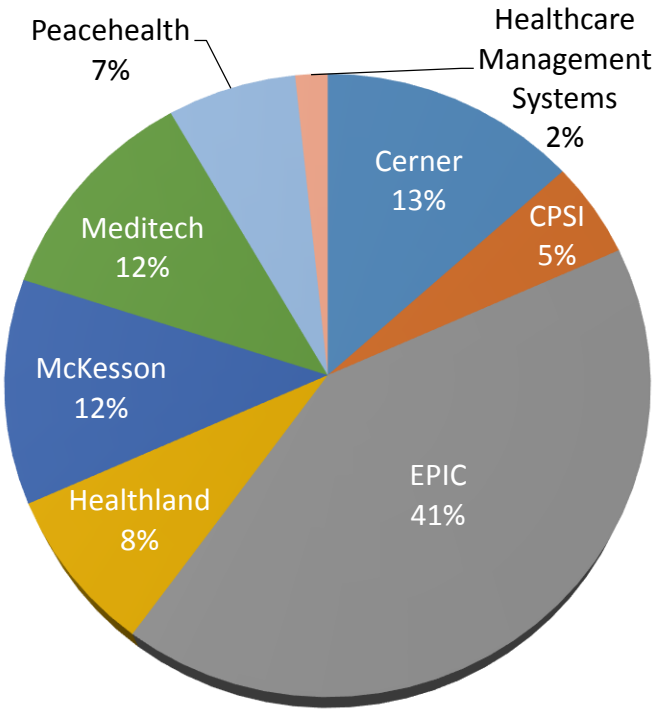
EHR Adoption in Oregon

- 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)*



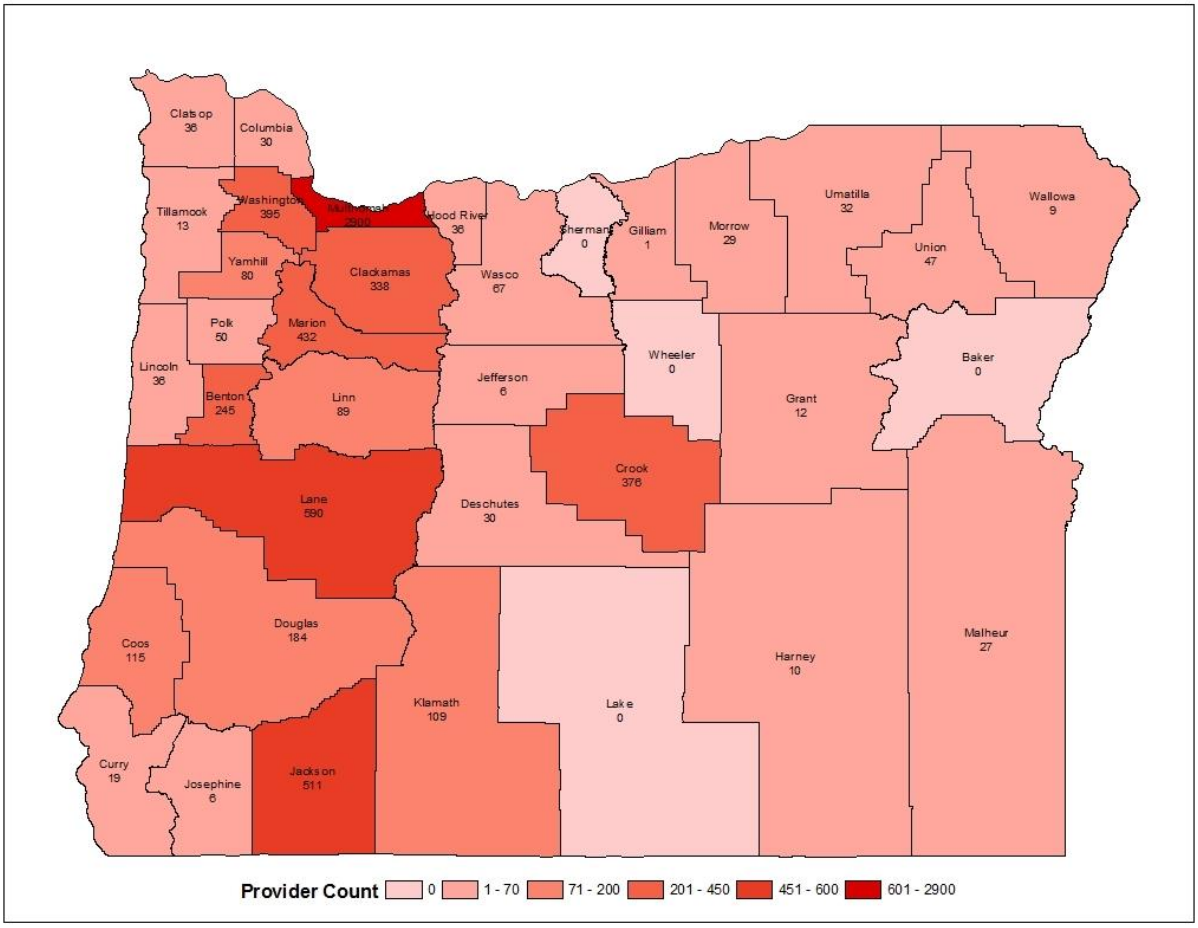
*Based on most recent EHR Incentive Payment data for a hospital from the Medicare or Medicaid EHR Incentive programs 2011- June 2015

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

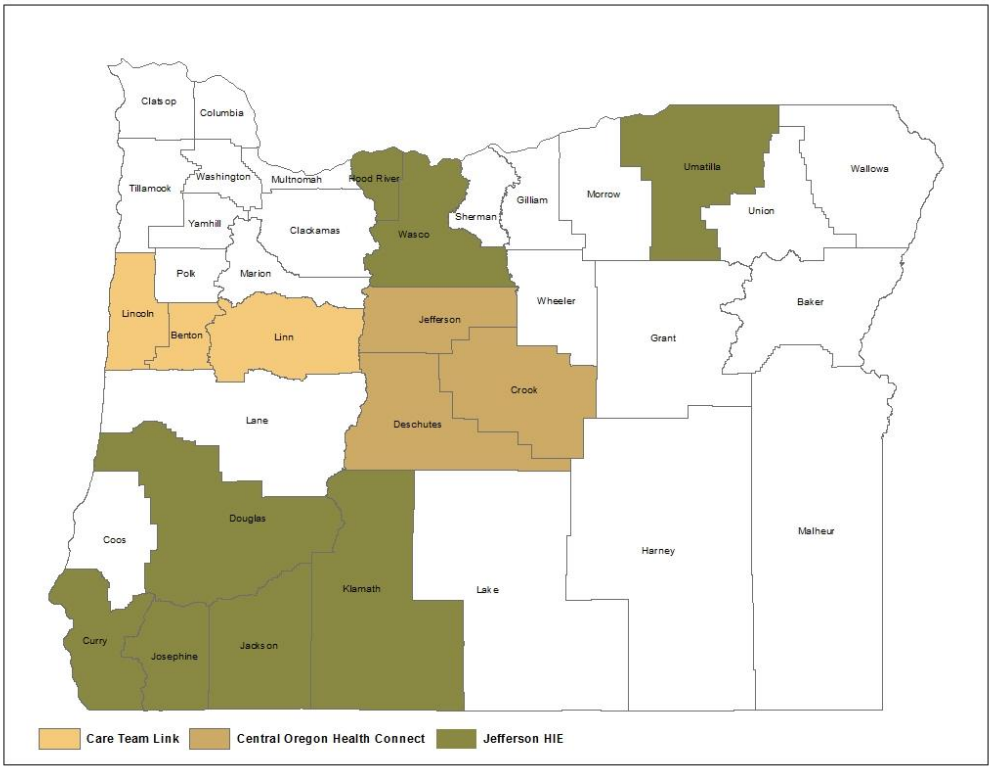
Health Information Exchange in Oregon exists is numerous forms. This section focuses on publicly-available HIE including community HIEs and statewide HIE efforts.

Regional HIEs

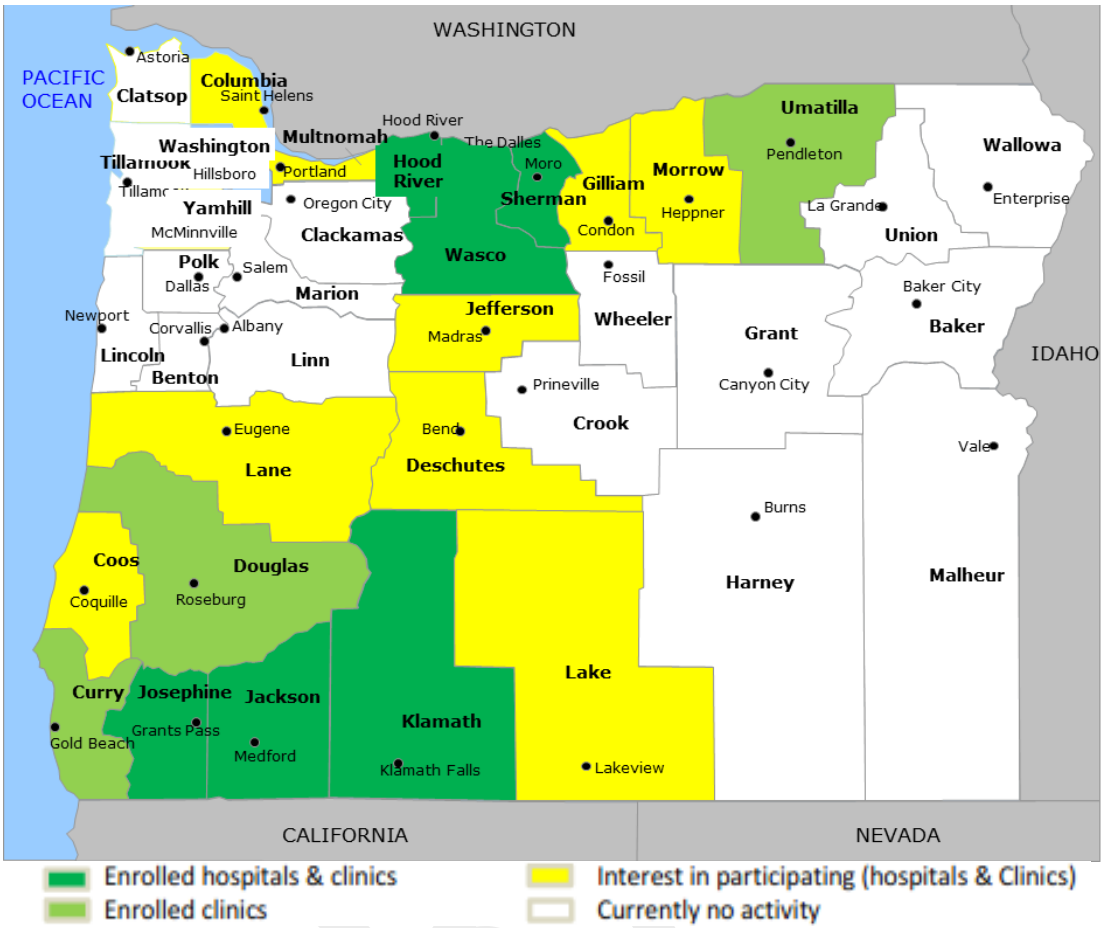
There are several regional HIEs at various stages of development and implementation. See maps on the following pages.

- 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

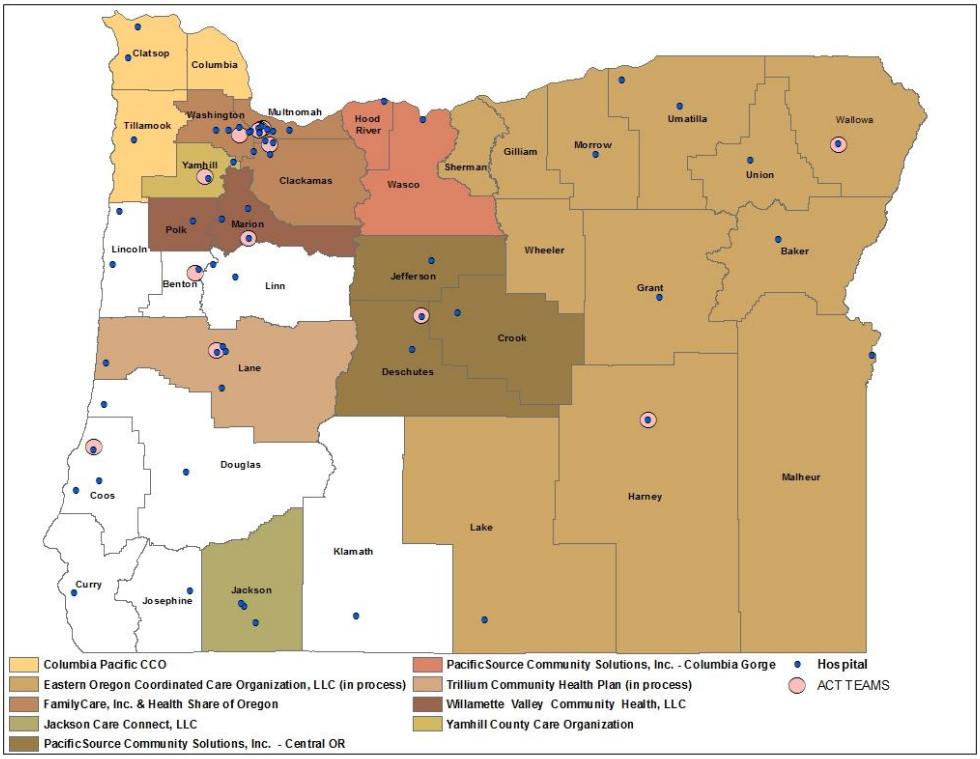
- AllCare
- Cascade Health Alliance
- Jackson Care Connect
- Primary Health
- Pacific Source

750+ Enrolled Providers at 210+ Clinics (as of 4/30/16) www.jhie.org/participants/

<u>Statewide HIE Efforts:</u>

- 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)



<u>Other HIE efforts:</u>

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)
Population Management, Metrics Tracking, Data Analytics	15	Population Management tools (9 CCOs)	Milliman: MedInsight (2 CCOs)
			Optum: Impact Intelligence
			The Big Kahuna
			Arcadia: Community Data Warehouse
			Crimson Population Risk Management
			Milliman: Patient Relationship Manager
		Business Intelligence (BI) tools (6 CCOs)	SAS BI (3 CCOs)
			IBM Cognos BI
			Microsoft BI (2 CCOs)
		Health Analytics tools (11 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
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.medicaidehrincentives.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
- Provider directory overview (2-pager): 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

What is 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. It is a 5-year program to begin on January 1, 2017 in up to 20 regions to include up to 5000 practices covering 20,000 physicians and up to 25 million patients.

There will be two tracks in each selected region:

- **Track 1:** Similar to the current CPC initiative; intended for practices ready to build capabilities to deliver comprehensive primary care. Funding includes Care Management Fees and Prospective Incentives for quality.
- **Track 2:** Pathway for practices poised to increase the comprehensiveness of care through enhanced Health IT, improving care of patients with complex needs, and using inventory of resources and supports to meet patients' psychosocial needs. Funding includes larger Care Management Fees & larger Prospective Incentive for quality. Additionally, 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.

Regions will be decided by the amount of payer penetration in a given region. In regions with sufficient payer penetration, payer applications will be scored to assess their alignment with the goals of the initiative. While payers in Oregon will need to submit applications, the region will be given preference as we are currently participating in CPC.

Why is this important?

Participating CPC practices have made substantial changes in how they deliver care. They have successfully decreased hospitalizations and readmissions, kept ED visits from rising, risk stratify empaneled patients, offer targeted care management, engage patients more effectively, and more comprehensive services through integrated behavioral health, medication management, and self-management support. They have also increased their QI and HIT capabilities tremendously. For many current practices, there is a fear that without further funding like CPC+ they will not be able to sustain these changes that have improved patient care and reduced utilization.

What does success look like?

Overall success for CPC+ will result in lower overall costs, a healthier patient population, improved care, and reduced utilization. Success will also result in more patient-centered, comprehensive care provided by practices coupled with enhanced capabilities in quality improvement, HIT and complex care. Progress will be monitored and assessed through regular web-based reporting.

A snapshot of CPC successes in Oregon include:

- 65% of practices have a Patient Family Advisory Council
- 35% Improvement in overall PCMH-A scores from 2012-2015
- 77% increase in Risk-stratified care management PCMH-A domain from 2012-2015
- 7.4% Decrease in hospital admissions*
- 1.5% Increase in Outpatient ED visits*
- 3.8% Decrease in 30-day readmissions*
- 94% of Oregon practices risk stratify ≥75% of empaneled patients
- 83% of OR practices use their EHR to track continuity of care – Most others track it, but not through the EHR

CPC itself has produced gross savings, but when care management fees are added back into the equation, it has not produced net savings. With that said, improvements in quality, utilization, and potential savings over the course of the initiative are performing sooner than expected. Comprehensive changes take time for practices to implement and also take time to have an effect.

What we need

- Serious consideration for participation in this model
- Talk to practices to hear their experiences and how CPC has affected their care delivery and patient populations
- Continued dialogue with us and others
- Submit an application if interested

Date/Time	Significance	Notes
June 1, 2016 11:59 pm ET	**Payer solicitations due**	**Via email using form from CMMI website**
July 15, 2016	Practice Application Open	Via Web Portal
September 1, 2016	Practice Applications due	--
October 1, 2016	Practices notified of selections	--
By October 15, 2016	CMS & HIT Vendors for Track 2 practices enter into MOU	--

	Payer Partners	Practices
Current CPC Initiative	• Pay a Per Member Per Month (PMPM) "Care management fee" (amount set by individual payers) plus build in a "shared savings" component that practices can receive if total cost of care is reduced and practices meet quality benchmarks • Participate in collaborative and data sharing activities	• Transform care and provide expanded services across their entire patient population, regardless of payer • Submit a budget for the upfront (PMPM) investment they expect to receive • Participate in collaborative learning activities • Meet multiple "Milestones" to guide their transformation activities, which are aligned with Oregon's Patient-Centered Primary Care Home Program standards
CPC+	• Alignment with CMS payment approach. CMS encourages payer partners to support practices in both tracks, including PBPM payments and consider upside • Encouraged to collaborate around data-sharing and alignment for cost and utilization, quality, and patient experience metrics and aggregating data reports • Provide attribution lists and encouraged to share attribution methodologies • Encouraged to regularly provide CMS with data for model evaluation and monitoring • Encouraged to align quality and patient experience measures with Medicare and other payers in the region • Encouraged to share their monitoring and evaluation strategy for tracking practice progress (for application) • Encouraged to describe their involvement in multi-payer/stakeholder and primary care transformation initiatives (for application)	• Both tracks will be required to implement a Patient Family Advisory Council; Document use of funds and care delivery work, Build analytic capability and perform budgeting exercises, measure quality at the practice and panel/care team level, Use certified HIT and have remote access to EHR, and submit electronic Clinical Quality Measures • Track 1 will deliver the Five Primary Care Functions (Care Management, Access & Continuity, Planned Care for Population Health, Patient and Family Caregiver Engagement, Comprehensiveness and Coordination), adding services to visit-based, FFS care • Track 2 builds on capabilities by: - Providing more intensive care management for patients with complex needs, including cognitive impairment, frailty, functional disabilities or multiple chronic conditions - Exploring alternatives for enhanced access such as e-visits, phone visits, group visits, etc. - Potentially more directly involving patient/families in QI initiatives - Work with partner HIT vendors and implement enhanced HIT tools to support care - Meet quality and utilization benchmarks to receive CPCP enhanced payments

CMS Notice of Proposed Rule Making (NPRM) on the "Quality Payment Program" aka MACRA

NPRM for the CMS *"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"*

CMS Resources and Materials:
Federal Register version can be found here: https://www.gpo.gov/fdsys/pkg/FR-2016-05-09/pdf/2016-10032.pdf Comments are due by 5pm EDT on June 27, 2016.

MACRA website:
http://links.govdelivery.com/track?type=click&enid=ZWFzPTEmbXNpZD0mYXVpZD0mbWFpbGluZ2lkPTIwMTYwNTAyLjU4NTI2NjExJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE2MDUwMi41ODUyNjYxMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3Njg4MDY5JmVtYWlsaWQ9bGlzYS5hLnBhcmtlckBzdGF0ZS5vci51cyZ1c2VyaWQ9bGlzYS5hLnBhcmtlckBzdGF0ZS5vci51cyZ0YXJnZXRpZD0mZmw9JmV4dHJhPU11bHRpdmFyaWF0ZUlkPSYmJg==&&&106&&&https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html

press release:
http://links.govdelivery.com/track?type=click&enid=ZWFzPTEmbXNpZD0mYXVpZD0mbWFpbGluZ2lkPTIwMTYwNTAyLjU4NTI2NjExJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE2MDUwMi41ODUyNjYxMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3Njg4MDY5JmVtYWlsaWQ9bGlzYS5hLnBhcmtlckBzdGF0ZS5vci51cyZ1c2VyaWQ9bGlzYS5hLnBhcmtlckBzdGF0ZS5vci51cyZ0YXJnZXRpZD0mZmw9JmV4dHJhPU11bHRpdmFyaWF0ZUlkPSYmJg==&&&107&&&http://www.hhs.gov/about/news/2016/04/27/administration-takes-first-step-implement-legislation-modernizing-how-medicare-pays-physicians.html

Quality Payment Program fact sheet:
http://links.govdelivery.com/track?type=click&enid=ZWFzPTEmbXNpZD0mYXVpZD0mbWFpbGluZ2lkPTIwMTYwNTAyLjU4NTI2NjExJm1lc3NhZ2VpZD1NREItUFJELUJVTC0yMDE2MDUwMi41ODUyNjYxMSZkYXRhYmFzZWlkPTEwMDEmc2VyaWFsPTE3Njg4MDY5JmVtYWlsaWQ9bGlzYS5hLnBhcmtlckBzdGF0ZS5vci51cyZ1c2VyaWQ9bGlzYS5hLnBhcmtlckBzdGF0ZS5vci51cyZ0YXJnZXRpZD0mZmw9JmV4dHJhPU11bHRpdmFyaWF0ZUlkPSYmJg==&&&108&&&https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf.

Health IT components (aka Advancing Care Information) fact sheet:
https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Advancing-Care-Information-Fact-Sheet.pdf

Upcoming and past webinars: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-Events.html

NOTICE OF PROPOSED RULE MAKING

Medicare Access and CHIP Reauthorization Act of 2015

QUALITY PAYMENT PROGRAM

Executive Summary

On April 27, 2016, the Department of Health and Human Services issued a Notice of Proposed Rulemaking to implement key provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), bipartisan legislation that replaced the flawed Sustainable Growth Rate formula with a new approach to paying clinicians for the value and quality of care they provide.

The proposed rule would implement these changes through the unified framework called the "Quality Payment Program," which includes two paths:

The Merit-based Incentive Payment System (MIPS)

or

Advanced Alternative Payment Models (APMs)

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

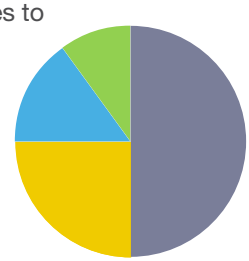
The Merit-based Incentive Payment System (MIPS)

Currently, Medicare measures the value and quality of care provided by doctors and other clinicians through a patchwork of programs, including the Physician Quality Reporting System, the Value Modifier Program, and the Medicare Electronic Health Record (EHR) Incentive Program. Through the law, Congress streamlined and improved these programs into one new Merit-based Incentive Payment System (MIPS). Most Medicare clinicians will initially participate in the Quality Payment Program through MIPS.

Consistent with the goals of the law, the proposed rule would improve the relevance and depth of Medicare's value and quality-based payments and increase clinician flexibility by allowing clinicians to choose measures and activities appropriate to the type of care they provide. MIPS allows Medicare clinicians to be paid for providing high quality, efficient care through success in four performance categories:

COST

(10 percent of total score in year 1; replaces the cost component of the Value Modifier Program, also known as Resource Use): The score would be based on Medicare claims, meaning no reporting requirements for clinicians. This category would use more than 40 episode-specific measures to account for differences among specialties.



QUALITY

(50 percent of total score in year 1; replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program): Clinicians would choose to report six measures versus the nine measures currently required under the Physician Quality Reporting System. This category gives clinicians reporting options to choose from to accommodate differences in specialty and practices.

CLINICAL PRACTICE IMPROVEMENT ACTIVITIES

(15 percent of total score in year 1): Clinicians would be rewarded for clinical practice improvement activities such as activities focused on care coordination, beneficiary engagement, and patient safety. Clinicians may select activities that match their practices' goals from a list of more than 90 options. In addition, clinicians would receive credit in this category for participating in Alternative Payment Models and in Patient-Centered Medical Homes.

ADVANCING CARE INFORMATION

(25 percent of total score in year 1; replaces the Medicare EHR Incentive Program for physicians, also known as "Meaningful Use"): Clinicians would choose to report customizable measures that reflect how they use electronic health record (EHR) technology in their day-to-day practice, with a particular emphasis on interoperability and information exchange. Unlike the existing Meaningful Use program, this category would not require all-or-nothing EHR measurement or quarterly reporting.

The proposed rule seeks to streamline and reduce reporting burden across all four categories, while adding flexibility and accountability for physician practices.

The law requires MIPS to be budget neutral. Therefore, clinicians' MIPS scores would be used to compute a positive, negative, or neutral adjustment to their Medicare payments. In the first year, depending on the variation of MIPS scores, adjustments are calculated so that negative adjustments can be no more than 4 percent, and positive adjustments are generally up to 4 percent, with additional bonuses for the highest performers.

The Center for Medicare & Medicaid Services (CMS) would begin measuring performance for doctors and other clinicians through MIPS in January 2017, with payments based on those measures beginning in 2019.

Advanced Alternative Payment Models (APMs)

Clinicians who take a further step towards care transformation—participating to a sufficient extent in Advanced Alternative Payment Models—would be exempt from MIPS payment adjustments and would qualify for a 5 percent Medicare Part B incentive payment.

To qualify for incentive payments, clinicians would have to receive enough of their payments or see enough of their patients through Advanced APMs. The participation requirements are specified in statute and increase over time.

Under the new law, Advanced APMs are the CMS Innovation Center models, Shared Savings Program tracks, or statutorily-required demonstrations where clinicians accept both risk and reward for providing coordinated, high-quality, and efficient care. These models must also meet criteria for payment based on quality measurement and for the use of EHRs. The proposed rule lays out specific criteria for determining what would qualify as an Advanced APM. These include criteria designed to ensure that primary care physicians have opportunities to participate in Advanced APMs through medical home models.

The proposed rule includes a list of models that would qualify under the terms of the proposed rule as Advanced APMs. These include:

- Comprehensive ESRD Care Model (Large Dialysis Organization arrangement)
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program—Track 2
- Medicare Shared Savings Program—Track 3
- Next Generation ACO Model
- Oncology Care Model Two-Sided Risk Arrangement (available in 2018)

Under the proposed rule, CMS would update this list annually to add new payment models that qualify to be an Advanced APM. CMS will continue to modify models in coming years to help them qualify as Advanced APMs. In addition, starting in performance year 2019, clinicians could qualify for incentive payments based, in part, on participation in Advanced APMs developed by non-Medicare payers, such as private insurers or state Medicaid programs. The proposed rule also establishes the Physician-Focused Payment Technical Advisory Committee to review and assess additional physician-focused payment models suggested by stakeholders.

Intermediate Options

In order to determine whether clinicians met the requirements for the Advanced APM track, all clinicians will report through MIPS in the first year.

The proposed rule provides flexibility for participating in MIPS and makes it easy for clinicians to move between the components of the Quality Payment Program—the MIPS track or the Advanced APM track

For example:

MIPS participants who participate in APMs would receive credit toward scores in the Clinical Practice Improvement Activities category.	Certain Advanced APMs participants, who fall short of the payment or patient participation requirements for the incentive payments, but meet a lower threshold of participation, would be able to choose whether they would like to receive the MIPS payment adjustment.	Wherever possible, the proposed rule aligns standards between the two parts of the Quality Payment Program in order to make it easy for clinicians to move between them.

We expect that the number of clinicians who qualify for the incentive payments from participating in Advanced APMs will grow as the program matures and as physicians take advantage of the intermediate tracks of the Quality Payment Program to experiment with participation in APMs.

Beginning a Dialogue

In implementing the new law, we were guided by the same principles underlying the bipartisan legislation itself: streamlining and strengthening value and quality-based payments for all physicians; rewarding participation in Advanced APMs that create the strongest incentives for high-quality, coordinated, and efficient care; and giving doctors and other clinicians flexibility regarding how they participate in the new payment system.

Today's rule incorporates input received to date, but it is only a first step in an iterative process for implementing the new law. We welcome additional feedback from patients, caregivers, clinicians, health care professionals, Congress and others on how to better achieve these goals. HHS looks forward to feedback on the proposal and will accept comments until June 26, 2016.

Comments may be submitted electronically through our e-Regulation website at http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/eRulemaking/index.html?redirect=/eRulemaking

Summary of the Major Provisions

Provisions Related to the Merit-Based Incentive Payment System

Currently, Medicare measures doctors and other clinicians on how they provide patient quality and reduce costs through a patchwork of programs, with clinicians reporting through some combination of the Physician Quality Reporting System, the Value Modifier Program, and the Medicare Electronic Health Record (EHR) Incentive Program. Through the law, Congress streamlined and improved these programs into one new Merit-based Incentive Payment System (MIPS).

MIPS Score

Consistent with the goals of the law, the proposed rule would improve the relevancy of Medicare's value and quality-based payments and increase clinician flexibility by allowing clinicians to choose measures and activities appropriate to the type of care they provide. MIPS allows clinicians to be paid for providing high quality care through measured success in four performance categories.

Under MIPS, clinicians will have the option to be assessed as a group across all four MIPS performance categories. The MIPS score measures clinicians' overall care delivery. Therefore, clinicians do not need to limit their MIPS reporting to the care provided to Medicare beneficiaries.

Payment Adjustments

The law requires MIPS to be budget neutral. Therefore, clinicians' MIPS scores would be used to compute a positive, negative, or neutral adjustment to their Medicare Part B payments.

In the first year, depending on the variation of MIPS scores, adjustments are calculated so that negative adjustments can be no more than 4 percent, and positive adjustments are generally up to 4 percent. The positive adjustments will be scaled up or down to achieve budget neutrality, meaning that the maximum positive adjustment could be lower or higher than 4 percent.

Per the law, both positive and negative adjustments would increase over time. Additionally, in the first five payment years of the program, the law allows for $500 million in an additional performance bonus that is exempt from budget neutrality for exceptional performance. This exceptional performance bonus will provide high performers a gradually increasing adjustment based on their MIPS score that can be no higher than an additional 10 percent.

As specified under the statute, negative adjustments would increase over time, and positive adjustments would correspond. The maximum negative adjustments for each year are:

2019	2020	2021	2022 and after
4%	5%	7%	9%

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Participants

MIPS applies to Medicare Part B clinicians, including physicians, physician assistants, nurse practitioners, clinical nurse specialist, and certified registered nurse anesthetists. All Medicare Part B clinicians will report through MIPS during the first performance year, which begins January 2017. Medicare Part B clinicians may be exempted from the payment adjustment under MIPS if they:

Are newly enrolled in Medicare;

Have less than or equal to $10,000 in Medicare charges and less than or equal to 100 Medicare patients; or

Are significantly participating in an Advanced Alternative Payment Model (APM).

Physicians who meet the criteria for Advanced APM incentive payments do not receive a payment adjustment under MIPS and instead receive a 5 percent Medicare Part B incentive payment. Clinicians who significantly participate in an Advanced APM, but do not qualify for incentive payments can choose whether to receive a payment adjustment under MIPS.

Performance Period

The first performance period for MIPS would be from January 1, 2017 through December 31, 2017. MIPS combines the requirements of the Physician Quality Reporting System, the Value Modifier Program, and the Medicare EHR Incentive Program into a single, improved reporting program. Therefore, the last performance period for these separate reporting programs would be January 1, 2016 through December 31, 2016.

The first payment year for MIPS will be 2019, based on the first performance period of 2017.

Quality

(50 percent of total score in year 1; replaces the Physician Quality Reporting System)

The quality category accounts for 50 percent of the MIPS score in the first year. For this category, clinicians would choose six measures to report (versus the nine measures currently required under Physician Quality Reporting System). In addition, for individual clinicians and small groups (2-9 clinicians), MIPS calculates two population measures based on claims data, meaning there are no additional reporting requirements for clinicians for population measures. For groups with 10 clinicians or more, MIPS calculates three population measures. The measures would be each worth up to ten points for a total of 80 to 90 possible points depending on group size.

The proposal strives to align with the private sector and reduce the reporting burden by including the core quality measures that private payers already use for their clinicians. When choosing the six quality measures, clinicians would choose one crosscutting measure and one outcome measure (if available) or another high quality measure. High quality measures are measures related to patient outcomes, appropriate use, patient safety, efficiency, patient experience, or care coordination. There will be more than 200 measures to pick from and more than 80 percent of the quality measures proposed are tailored for specialists. Clinicians may

also choose to report a specialty measure set—which are specifically designed around certain conditions and specialty-types—instead of the six measures described above.

Advancing Care Information Category

The Advancing Care Information category (formerly Meaningful Use) would account for 25 percent of the MIPS score in the first year. For this category, clinicians must use certified EHR technology and would choose to report a customizable set of measures that reflects how they use EHR technology in their day-to-day practice, with a particular emphasis on interoperability and information exchange. This category would no longer require all-or-nothing EHR measurement or quality reporting. The measures align with the Office of the National Coordinator for Health Information Technology's 2015 Edition Health IT Certification Criteria.

The overall Advancing Care Information score would be made up of a base score and a performance score for a maximum score of 100 points. There are multiple paths to achieve the maximum score in this category.

Base Score: The base score accounts for 50 points of the total Advancing Care Information category score. To receive the base score, clinicians must provide the numerator/denominator or yes/no for each objective and measure. CMS proposes six objectives and their measures that would require reporting for the base score:

- **Protect Patient Health Information (yes/no)**
- **Patient Electronic Access (numerator/denominator)**
- **Coordination of Care Through Patient Engagement (numerator/denominator)**
- **Electronic Prescribing (numerator/denominator)**
- **Health Information Exchange (numerator/denominator)**
- **Public Health and Clinical Data Registry Reporting (yes/no)**

Because of the importance of protecting patient privacy and security, clinicians must achieve the Protect Patient Health Information objective to receive any score in the Advance Care Information performance category.

This proposal would no longer require reporting on the Clinical Decision Support and the Computerized Provider Order Entry objectives for the base score.

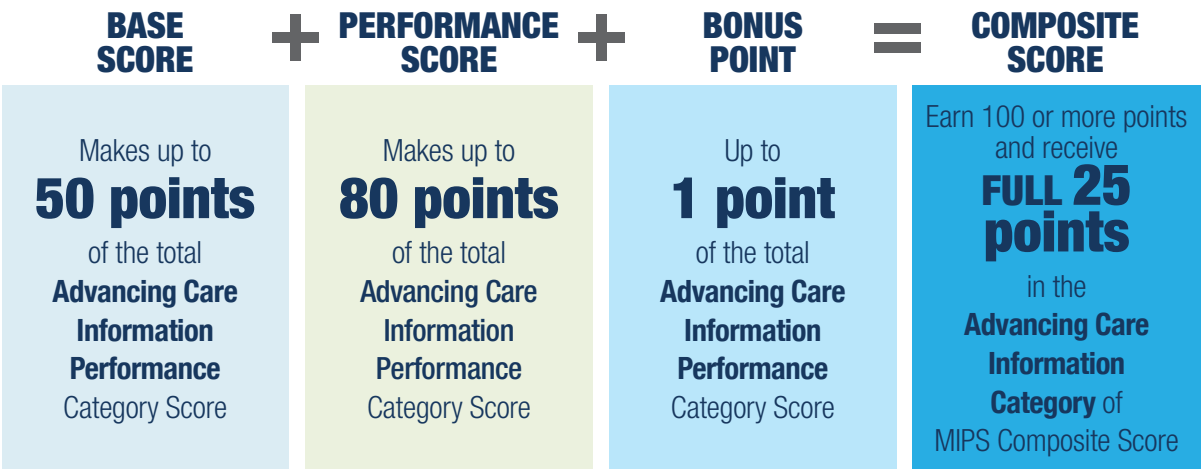
Performance Score: The performance score accounts for up to 80 points towards the total Advancing Care Information category score (note that the score can exceed 100 points, but anyone who score 100 points or above will receive the maximum 25 points towards the MIPS score). Clinicians select the measures that best fit their practice from the following objectives, which emphasize patient care and information access:

- **Patient Electronic Access**
- **Coordination of Care Through Patient Engagement**
- **Health Information Exchange**

Public Health Registry Bonus Point: Immunization registry reporting is required. In addition, clinicians may choose to report on more than one public health registry, and will receive one additional point for reporting beyond the immunization category.

The clinicians' base score, performance score, and bonus point (if applicable) are added together for a total of up to 131 points. If clinicians earn 100 points or more then they receive the full 25 points in the Advancing Care Information category. If clinicians earn less than 100 points, their overall score in MIPS declines proportionately—scoring is not all-or-nothing.

For clinicians for whom the objectives and measures are not applicable (for example, a hospital-based clinician), CMS proposes to reweight the Advancing Care Information performance category to zero, and adjust the other MIPS performance category scores to make up the difference in the MIPS score.



Clinical Practice Improvement Activities Category

(15 percent of total score in year 1)

The clinical practice improvement activities category accounts for 15 percent of the MIPS score in the first year. For this category, MIPS would reward clinical practice improvement activities such as activities focused on care coordination, beneficiary engagement, and patient safety, which clinicians would select from a list of more than 90 options. In addition, clinicians would receive credit toward scores in this category for participating in Alternative Payment Models and Patient-Centered Medical Homes.

Based on the law and the feedback received in the 2015 Request for Information, CMS proposes more than 90 activities (which will be updated annually) that clinicians may choose from in the following categories:

Expanded Practice Access	Beneficiary Engagement	Achieving Health Equity
Population Management	Patient Safety and Practice Assessment	Emergency Preparedness and Response
Care Coordination	Participation in an APM, including a medical home model	Integrated Behavioral and Mental Health

The maximum total points in this category would be 60 points. CMS proposes to determine a clinicians' score by weighting the activities on which they report. Highly weighted activities would be worth 20 points, and other activities would be worth 10 points. CMS proposes that activities that would be highly weighted would be those activities that support the patient-centered medical home, as well as activities that support the transformation of clinical practice or a public health priority. Some examples of highly weighted activities are the collection and follow-up on patient experience or seeing Medicaid patients in a timely manner. Clinicians who are not patient-facing (for example, pathologists or radiologists) will only need to report on one activity.

Cost Category

(10 percent of total score in year 1; replaces the Value Modifier Program, also known as Resource Use)

The cost category accounts for 10 percent of the MIPS score in the first year. For this category, MIPS calculates scores based on Medicare claims, meaning there are no additional reporting requirements for clinicians under the cost category. This category uses over 40 episode-specific measures to account for differences among specialties. For cost measures, clinicians that deliver more efficient, high quality care achieve better performance, so clinicians scoring the highest points would have the most efficient resource use.

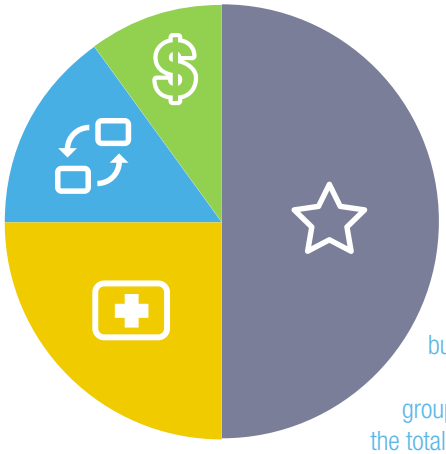
Each cost measure would be worth up to 10 points. Clinicians must see a sufficient number of patients in each cost measure to be scored, which is generally a minimum of a 20-patient sample. The clinician's cost score would be calculated based on the average score of all the cost measures that can be attributed to the clinician. For example, if a clinician only has two cost measures with sufficient patient volume to be scored, then the total number of points they could earn is 20 points. Their score will be the number of points they earned divided by the 20 possible points.

If a clinician does not have enough patient volume for any cost measures, then a cost score would not be calculated. CMS would reweight the cost category to zero, and adjust the other MIPS performance category scores to make up the difference in the MIPS score.

Table 1 below summarizes the categories of MIPS as proposed.

Table 1: Summary of MIPS Performance Categories

Performance Category	Points Need to Get a Full Score per Performance Category[1]	Maximum Possible Points per Performance Category
Quality: Clinicians choose six measures to report to CMS that best reflect their practice. One of these measures must be an outcome measure or a high quality measure and one must be a crosscutting measure. Clinicians also can choose to report a specialty measure set.	80 to 90 points depending on group size	50 percent
Advancing Care Information: Clinicians will report key measures of interoperability and information exchange. Clinicians are rewarded for their performance on measures that matter most to them.	100 points	25 percent
Clinical Practice Improvement Activities: Clinicians can choose the activities best suited for their practice; the rule proposes over 90 activities from which to choose. Clinicians participating in medical homes earn full credit in this category, and those participating in Advanced APMs will earn at least half credit.	60 points	15 percent
Cost: CMS will calculate these measures based on claims and availability of sufficient volume. Clinicians do not need to report anything.	Average score of all resource measures that can be attributed.	10 percent



[1]These total points generally apply, but possible exemptions or adjustments may apply depending on a clinician or groups' circumstances which would cause the total score for the category to be different.

Reporting

The rule proposes to allow third parties, including registries, Qualified Clinical Data Registries, health information technology developers, and certified survey vendors to act as intermediaries on behalf of clinicians and submit data for the performance categories as applicable.

Provisions Related to Advanced Alternative Payment Models

For clinicians who take a further step towards care transformation, the law creates another path. Clinicians who participate to a sufficient extent in Advanced APMs would qualify for incentive payments.

Importantly, the law does not change how any particular APM rewards value. Instead, it creates extra incentives for participation in Advanced APMs. For years 2019 through 2024, a clinician who meets the law's standards for Advanced APM participation is excluded from MIPS adjustments and receives a 5 percent Medicare Part B incentive payment. For years 2026 and later, a clinician who meets these standards is excluded from MIPS adjustments and receives a higher fee schedule update than those clinicians who do not significantly participate in an Advanced APM.

Standards for Advanced Alternative Payment Models (APMs)

Under the law, Advanced APMs are those in which clinicians accept risk for providing coordinated, high-quality care. As proposed, to be an Advanced APM, models must be a CMS Innovation Center model or a statutorily required demonstration and must generally:

1. **Require participants to bear a certain amount of financial risk.** Under our proposal, an Advanced APM would meet the financial risk requirement if CMS would withhold payment, reduce rates, or require the entity to make payments to CMS if its actual expenditures exceed expected expenditures. We propose that the amount of risk must meet the following standards:
   - Total risk (maximum amount of losses possible under the Advanced APM) must be at least 4 percent of the APM spending target.
   - Marginal risk (the percent of spending above the APM benchmark (or target price for bundles) for which the Advanced APM Entity is responsible (i.e., sharing rate) must be at least 30 percent.
   - Minimum loss rate (the amount by which spending can exceed the APM benchmark (or bundle target price) before the Advanced APM Entity has responsibility for losses) must be no greater than 4 percent.
2. **Base payments on quality measures comparable to those used in the MIPS quality performance category.** To meet this requirement, we propose that an Advanced APM must base payment on quality measures that are evidence-based, reliable, and valid. In addition, at least one such measure must be an outcome measure if an outcome measure appropriate to the Advanced APM is available on the MIPS measure list.
3. **Require participants to use certified EHR technology.** To meet this requirement, we propose that an Advanced APM must require that at least 50 percent of the clinicians use certified EHR technology to document and communicate clinical care information in the first performance year. This requirement increases to 75 percent in the second performance year.

Special Rules for Medical Home Models

Under the statute, medical home models that have been expanded under the Innovation Center authority qualify as Advanced APMs regardless of whether they meet the financial risk criteria. While medical home models have not yet been expanded, the proposed rule lays out criteria for medical home models to ensure that primary care physicians have opportunities to participate in Advanced APMs.

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The rule proposes a definition of medical home models, which focus on primary care and accountability for empaneled patients across the continuum of care. Because medical homes tend to have both less experience with financial risk than larger organizations and limited capability to sustain substantial losses, we propose unique Advanced APM financial risk standards, consistent with the statute, to accommodate medical homes that are part of organizations with 50 or fewer clinicians.

Advanced Alternative Payment Models

The proposed rule includes a list of models that qualify as Advanced APMs under the terms of the proposed rule for the first performance year. These are:

Comprehensive End Stage Renal Disease Care Model (Large Dialysis Organization arrangement)	Comprehensive Primary Care Plus	Medicare Shared Savings Program—Track 2
Medicare Shared Savings Program—Track 3	Next Generation ACO Model	Oncology Care Model Two-Sided Risk Arrangement (available in 2018)

Under the proposed rule, CMS would update this list annually to add new payment models that qualify. CMS will continue to modify models in coming years to help them qualify as Advanced APMs.

Qualifying for Incentive Payments by Significantly Participating in Advanced APMs

To qualify for incentive payments, clinicians would have to receive enough of their payments or see enough of their patients through Advanced APMs. Clinicians will have the option to be assessed as a group to qualify for incentive payments. In 2019 and 2020, the participation requirements for Advanced APMs are only for Medicare payments or patients. Starting in 2021, the participation requirements for Advanced APMs may include non-Medicare payers and patients. CMS estimates that as many as 90,000 clinicians could receive the bonus for substantially participating in Advanced APMs in the first payment year.

As shown in Table 2 below, over time, the requirements would increase to require greater commitment to Advanced APM participation.

Table 2:
Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)

Payment Year	2019	2020	2021	2022	2023	2024 and later
Percentage of Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

Physician-focused Payment Technical Advisory Committee Will Identify Future Opportunities for APM Participation

The law established the Physician-focused Payment Technical Advisory Committee (PTAC) to review and assess additional Physician-Focused Payment Models based on proposals submitted by stakeholders to the Committee. The eleven members of the Committee were appointed in October 2015 by the US Comptroller General based on their expertise in physician-focused payment models and related delivery of care. The Committee will meet on a quarterly basis, and may meet more frequently as it starts to receive payment model proposals. The rule proposes criteria for the Committee to use in making comments and recommendations on proposed Physician-focused Payment Models. The criteria require that proposed Physician-Focused Payment Models further the goals outlined by the law, as well as reduce cost, improve care or both. The law, through this committee, provides a unique opportunity for stakeholders to have a key role in the development of new models and to help determine priorities for the physician community. For more information, go to https://aspe.hhs.gov/ptac-physician-focused-payment-model-technical-advisory-committee.

All-Payer Combination Option

Starting in performance year 2019, clinicians could qualify for incentive payments based in part on participation in Advanced APMs developed by non-Medicare payers, such as private insurers or state Medicaid programs.

If clinicians do not meet the required percentage of payments provided or patients cared for through an Advanced APM through Medicare alone, then payments and patients under payers beside Medicare called “Other Payer Advanced APMs” will also be able to count towards their participation status. In this rule, we propose criteria for Other Payer Advanced APMs that are similar to those proposed for Advanced APMs and specify standards for Medicaid medical home models.

Intermediate Options

For clinicians that participate to some extent in APMs, but may not meet the law's criteria for sufficient participation in the most advanced models. The proposed rule provides financial rewards within MIPS, and makes it easy for clinicians to move between the components of the Quality Payment Program. In order to determine whether clinicians met the requirements for the Advanced APM track, all clinicians will report through MIPS in the first year. For example:

MIPS participants who participate in APMs would receive credit in the Clinical Practice Improvement Activities category.

Wherever possible, the proposed rule aligns standards between the two parts of the Quality Payment Program (MIPS and the Advanced APM track) in order to make it easy for clinicians to move between them.

Advanced APMs participants who fall short of the requirements for the incentive payments would be able to choose whether they would like to receive a payment adjustment through MIPS. In order to opt out of the MIPS payment adjustment for 2019 and 2020, the clinician must receive 20 percent of their Medicare payments through an Advanced APM or must see 10 percent of their Medicare patients through an Advanced APM.

We expect that the number of clinicians who qualify as participating in Advanced APMs will grow as the program matures and as physicians take advantage of the intermediate tracks of the Quality Payment Program to experiment with participation in APMs.

Provisions Related to Public Reporting and Transparency

Per the law and as part of our commitment to transparent information and patient-centered care, we propose to make publically available the results of the Quality Payment Program on the Physician Compare website to help patients make informed choices. The law requires public reporting of the following information:

- Names of clinicians in Advanced APMs
- As feasible, the names and performance of Advanced APMs
- MIPS scores for clinicians, including aggregate and individual scores for each performance category.

Consistent with current Physician Compare policies for the Physician Quality Reporting System and the Medicare EHR Incentive program, we propose a 30-day preview period in advance of the publication of any data on Physician Compare. Clinicians will be able to review and submit corrections prior to any information being made public.

Organization Name

[Organization Statement]

Begin Mandatory Language for Pledge Letter

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.

- **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.

End Mandatory Language for Pledge Letter

Optional addition: To implement these commitments we are or will [test, pilot open API/Apps on FHIR/ etc.]

CEO Name and Title

FACT SHEET

Commitments from health care industry to make electronic health records work better for patients and providers

U.S. Department of Health and Human Services Secretary Sylvia M. Burwell announced today that companies that provide 90 percent of electronic health records used by hospitals nationwide as well as the top five largest private healthcare systems in the country have agreed to implement three core commitments:

> **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 Information Blocking:** 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.

The organizations that have made commitments today represent hospitals, integrated healthcare organizations, medical groups and physician offices, academic facilities, long-term and behavioral healthcare settings, professional and advocacy organizations, and patients throughout the country, and include:

- Vendors who provide 90 percent of hospital electronic health records used nationwide;
- The top five largest private health systems in the nation and, in total, healthcare systems providing patient care in 46 states;
- More than a dozen leading healthcare provider, hospital, technology, and consumer advocacy groups.

These market leaders provided individual statements outlining how they are or will implement these shared principles in the months ahead, available at www.healthit.gov/commitment.

The full list of committed organizations is below.

Health IT Developers: The health IT developers below provide 90 percent of hospital electronic health records used nationwide. One of the products is used by 95 percent of all pharmacies. These organizations develop electronic health records, information exchange software and other

products that are used by a wide range of hospitals and providers and touch the lives of millions of healthcare consumers each year.[1]

- Aprima
- Athenahealth
- Allscripts
- Cerner
- CPSI
- CureMD
- Epic
- GE Healthcare
- Intel
- McKesson
- MedHost
- Meditech
- NextGen
- Phillips
- SureScripts
- Optum
- Greenway Health

Healthcare Systems: Among the providers below are the five largest private healthcare systems in the nation. In total, the health systems below operate in 46 states.[2]

- Ascension Health
- Carolinas Healthcare
- Catholic Health Initiatives
- Community Health Systems
- Dignity Health
- Geisinger Health System
- Hospital Corporation of America (HCA)
- John Hopkins Medical
- Intermountain Healthcare
- Kaiser Permanente
- LifePoint Health
- Mountain States Health Alliance
- Partners Healthcare
- Tenet Healthcare
- Trinity Health
- University of Utah Health Care

[1] Hospital EHR market share percentages are based off of Office of the National Coordinator for Health IT (ONC) staff analysis of products reported through participation in the EHR Incentive Program. http://dashboard.healthit.gov/datadashboard/documentation/ehr-products-mu-attestation-data-documentation.php.
[2] Size of healthcare systems is based off of ONC staff analysis of HIMSS Analytics and healthcare system websites.

Leading provider, technology, and consumer organizations: The organizations below represent a wide range of professional associations and stakeholder groups that support providers, hospitals, and consumers and provide a range of education, technical assistance and best practices to their members. Their pledges demonstrate the shared commitments among the diverse stakeholders they represent, including providers, consumers, and the technology industry.

- **American Academy of Family Physicians (AAFP)**. AAFP and its chapters represent 120,900 family physicians, residents, and medical students.
- **American College of Physicians (ACP)**. ACP is a national organization representing approximately 143,000 internists-physician specialists.
- **American Medical Association (AMA)**. AMA represents approximately 225,000 members, comprising physicians, residents, and medical students.
- **American Medical Informatics Association (AMIA)**. AMIA is an organization of more than 5,000 healthcare professionals, informatics researchers, and thought-leaders in biomedicine, healthcare, and science.
- **American Hospital Association (AHA)**. AHA is a national organization that represents and serves all types of hospitals, healthcare networks, and their patients and communities, including nearly 5,000 hospitals, healthcare systems, networks, other providers of care, and 43,000 individuals members.
- **American Health Information Management Association (AHIMA)**. AHIMA is a national, non-profit association representing 103,000 health information management professionals with component state associations in all 50 states, the District of Columbia, and Puerto Rico.
- **American Society of Clinical Oncology (ASCO).** ASCO is a leading professional organization representing more than 40,000 physicians worldwide who care for people with cancer.
- **Center for Medical Interoperability**. The Center is an organization led by large health systems to change how medical technologies work together. The Center leverages market presence and the expertise of their members to compel change and improve the safety, quality, and affordability of healthcare.
- **College of Healthcare Informatics Management Executives (CHIME)**. CHIME is an executive organization with more than 1,800 Chief Information Officer (CIO) members and 150 healthcare IT vendors and professional services firms.
- **CommonWell.** CommonWell is a not-for-profit trade association comprising nearly 40 health IT developers and organizations with a focus on the development and promotion of interoperability for its members.
- **Health Information and Management Systems Society (HIMSS)**. HIMSS North America represents 61,000 individual members, 640 corporate members, and over 450 non-profit organizations.
- **Healthcare Leadership Council (HLC)**. HLC is a coalition of chief executives from all disciplines in American healthcare. Members of HLC lead hospitals, health plans, pharmaceutical companies, medical device manufactures, biotech firms, health product distributors, pharmacies, and academic health centers.
- **Premier healthcare alliance**. Premier is a healthcare performance improvement alliance of approximately 3,600 U.S. hospitals and 120,000 other providers nationwide.

- **Sequoia Project**. The Sequoia Project, previously Healtheway, advances the implementation of secure, interoperable nationwide health exchanges and supports key interoperability initiatives such as Carequality.
- **National Partnership for Women and Families**. The Partnership is a national organization that advances policy to help women and families and advances access to quality affordable healthcare.
- **National Rural Health Association (NRHA).** NRHA is a national non-profit membership organization with more than 20,000 members that provides leadership on rural health issues through advocacy, communications, education and research.

To view the individual pledges, or to make the pledge to the commitments on behalf of your organization, visit www.healthit.gov/commitment.

Health Information Exchange: Model Options for Oregon

The market and infrastructure for health information exchange in Oregon continue to evolve and expand. This evolution is being shaped by an increasing prominence of value-based reimbursement models, related state projects underway (e.g., provider directory, common credentialing), and significant new federal funding opportunities available (including federal funding to support non-physical health providers' onboarding to HIEs). In order to best support and capitalize on this changing environment, it is appropriate for Health Information Technology Oversight Council (HITOC) and Oregon Health Authority (OHA) to reexamine the strategic model for health information exchange in Oregon.

According to a recent evaluation[1] of the State HIE Cooperative Agreement Program, the status of health information exchange in Oregon is not atypical when compared to other states. Health information exchange is occurring via a variety of technical solutions with a limited (but increasing) amount of data exchange and re-use occurring between non-affiliated entities.

For the purpose of discussion, three straw models are summarized in the attached tables. These models provide options for the role of OHA for health information exchange and their implications for finance, governance, and public policy. These options should be considered within the context of evolving needs of the marketplace, the need for coordination of new funding sources, ensuring HIE supports state goals, the needs for supporting underserved patient populations, and serving the myriad providers engaged in caring for Oregonians.

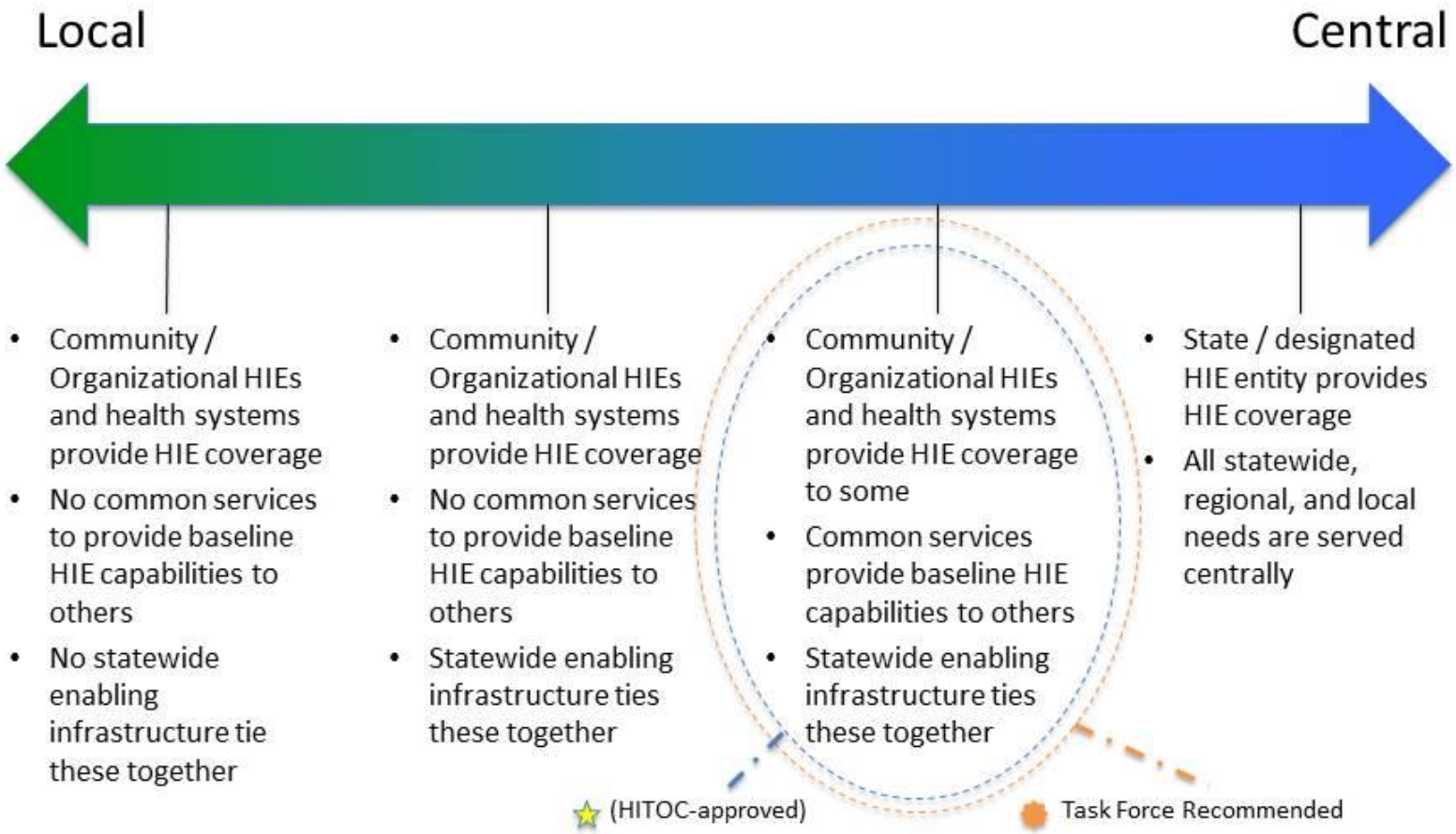
These options are:

1. **Local Models:** This relies on local community and private HIEs to meet the HIE needs of communities with little or no role for state services.
2. **Local coverage with some statewide supporting services**: In taking this approach, private and public HIEs provide services to some entities. The state plays a supporting role by providing enabling or connecting statewide services such as provider directory, as well as common services to cover gaps in local coverage (such as CareAccord) or support high-value cases that can be best served statewide (such as hospital event notifications/EDIE).
    a. Market-driven approach: This represents the status quo – HIE efforts have expanded independently with no oversight or governance role.
    b. 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.
3. **Centralized Hub Model:** This approach would designate a single entity to provide state-sanctioned HIE services and to be eligible for funding or other support.

The graphic on the next page reflects the current HIT strategic approach to HIE in Oregon as conceived in the HIT Business Plan Framework (2013-2017).

[1] NORC at the University of Chicago, *Evaluation of the State HIE Cooperative Agreement Program*. March 2016. Available at www.healthit.gov/sites/default/files/reports/finalsummativereportmarch_2016.pdf.

Approaches to Statewide HIE Coverage



Option 1: Market-Driven Model (Status Quo)*

Model Name	Distinguishing Characteristics	Implications for Finance & Governance	Technology/ Functionality	Policy/ Legislative Needs	Additional Pros	Additional Cons
Market Driven Model - Status Quo	• HIEs continue to expand independently • OHA continues to offer common services to support providers facing barriers to HIE (e.g., CareAccord) • OHA provides or enables the provision of high-value services that connect or support HIEs and HIT (e.g., EDIE, Provider Directory)	• No additional General Fund (GF) required • Entities must sustain themselves without support from the state • Some lack economies of scale • Independent governance bodies by entity or function • State participation on governance as relevant	• Will vary significantly by region/ entity • Flexible to support innovation (APIs, FHIR)	• No legislative needs – HB 2294 covers this model • Changes to State policy can remove barriers • State can convene and influence activities but has no direct role or oversight	• "Free" market (value propositions) continues to drive adoption • Flexibility in how to connect to HIE • No vendor/ product "lock in" • Leverages investments of private/public HIEs, ACOs, IDNs • Lowest risk to technology obsolescence	• Continued confusion/lack of clarity around HIT/HIE • Inconsistent services available by area or by provider type or organizational affiliation • Sustainability models may be challenging • No concentration of critical mass to achieve economies/synergies across related programs • Limited ability to leverage new federal funding for onboarding non-physical health providers to HIEs • Does not address disparities in access (technology, finance)

*Initial observations for the models

Option 2: Statewide HIE (Partnership Model)*

Model Name	Distinguishing Characteristics	Implications for Finance & Governance	Technology/ Functionality	Policy/ Legislative Needs	Additional Pros	Additional Cons
Statewide HIE Network – "Partner-ship" Model	• Network of networks model based upon meeting state-level criteria • OHA leverages federal funding to onboard providers to HIE entities that meet specific criteria • Ability for state to more directly encourage/address HIT/HIE processes & policy goals • Parallels national trend for more state involvement as orchestrator • Catalyst to support state-level goals for HIT	• New state funding may be needed to match 90% federal funds • May imply new roles for representative governance and oversight • May leverage critical mass to achieve economies/ synergies across related programs	• Regional standardization and opportunity to move toward statewide coverage of core HIE services • Support state-led goals for connectivity • Flexible to support innovation (APIs, FHIR)	Oregon Administrative Rules needed to establish criteria for HIEs and potentially for governance composition	• Greater clarity of policies and alignment with statewide HIT goals • Continued flexibility in connecting to HIE, but key ambiguities addressed • Leverage invest-ments of private/ public HIEs, ACOs, IDNs • Support for non-physical health providers	• Some increased financial risk: sustainability model • Lack of clarity of how to connect (multiple node options) • More complex, making administration and oversight more complicated • Requires potentially competitive stakeholders to be willing to work as partners

*Initial observations for the models

Option 3: Centralized Hub Model (State Designated Entity (SDE))*

Model Name	Distinguishing Characteristics	Implications for Finance & Governance	Technology/ Functionality	Policy/ Legislative Needs	Additional Pros	Additional Cons
Centralized HIE – "Hub" Model	• Designating a single entity (SDE) to provide state-sanctioned HIE services	• New state funding may be needed to match 90% federal funds • Governance & oversight roles include state participation • Full panoply of policy levers available • Accountability critical - risk of failure of SDE	• SDE solutions serve all HIT needs • Vendor/technology lock-in & priority management	• Oregon Administrative Rules (and possibly legislation) to formalize entity	• Track record of SDE • Focus – Near-term more consistency and reliability about how to connect compared to a network model • Simplicity for providers and state • Market-driven • Some increased agility, operational flexibility • Somewhat insulated from State budget • Defined state contributions and costs	• Sustainability model is critical – risk is greater with one designated entity • Unclear how stakeholders view or willing to work with SDE • Vendor/solution "lock in" • Lack of competition

*Initial observations for the models

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

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) Template[4]," 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 Use[5]. 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 needs[6]. 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 #13413[7] 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 HIPAA[8]. 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

HITECH Health Information Exchange (HIE) Federal Funds – Overview and Oregon Draft Approach to HIE Onboarding (June 2016)

State Medicaid Directors Letter 16-003 – CMS Guidance on HITECH HIE Funds
The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) on February 29, 2016 updated the guidance about how state Medicaid agencies can use the Health Information Technology for Economic and Clinical Health (HITECH) Act 90 percent federal funding to support HIE.

The guidance allows HITECH HIE funds to support all Medicaid providers to connect to health information exchange (HIE) entities or other interoperable systems.

- The guidance makes available federal funding at the 90 percent matching rate for activities to promote HIE to enable providers eligible for federal electronic health record (EHR) incentive payments ("eligible professionals") meet meaningful use requirements.
- While 90% federal HIE onboarding funding has been available to states for eligible professionals (and continues to be available), the guidance includes new flexibility to provide HIE onboarding for any Medicaid provider (including behavioral health, long term care, corrections, etc.). OHA has not leveraged any HIE federal funding for onboarding to date.
- Funds can support the costs of an HIE entity to onboard Medicaid providers who are not EHR incentive-eligible including, but not limited to: behavioral health, long-term care, home health, correctional health, substance use treatment providers, as well as laboratory, pharmacy, emergency medical services, and public health providers. Onboarding must connect the new Medicaid provider, with or without an EHR, to an eligible professional and help that eligible professional meet meaningful use.
- Possible activities include onboarding to: a statewide provider directory, care plan exchange (unidirectional or bidirectional), query exchange, encounter alerting systems, public health systems. These funds can support regional and statewide efforts related to health information exchange that help an eligible professional meet meaningful use.

How it works:
State Medicaid agencies (e.g., Oregon Health Authority (OHA)) may request a 90 percent federal funding match through 2021. OHA must cover the remaining 10 percent match.

- Fund the HIE entity's costs to onboard Medicaid providers to an HIE of a provider's choosing. Funds may not be used to support the provider's costs for onboarding (e.g., their EHR vendor costs). HIE onboarding includes technical and administrative processes "by which a provider joins an HIE and secure communications are established and all appropriate agreements, contracts, and consents are put in place."
- In addition to onboarding, these funds can 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 eligible professionals and support meeting meaningful use.

OHA approach and next steps:
Oregon intends to explore using these funds to increase Medicaid providers' capability to exchange health information by supporting the costs of an HIE entity (e.g., regional HIEs) to onboard providers, with or without an EHR. Oregon intends to support Oregon's Medicaid providers, including: behavioral health, long-term care, corrections, and other social services, to connect to HIE entities.

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.

OHA will develop a formal 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. Further definition is needed, including:

- Types of Medicaid providers to support
- Criteria for HIE entities to be eligible for onboarding funding
- Eligible HIE services and "white-space" coverage
- Avoiding unintended consequences (e.g., creating artificial markets)
- Estimates for budgeting, identifying or requesting state match, and implications for scope
- Rulemaking processes
- Oversight and governance implications for ensuring effective use of funding

The Oregon Common Credentialing Program

June 2016

What is the issue?

Credentialing organizations currently credential health care practitioners independently, resulting in a duplication of efforts. While Oregon took the first step in minimizing this administratively burdensome process by mandating the use of a common Oregon Practitioner Credentialing Application, this did not limit the number of systems and processes used to capture and verify information reported in the application. Senate Bill (SB) 604, signed into law in July 2013, requires the Oregon Health Authority (OHA) to establish a program and database to provide credentialing organizations access to information necessary to credential or re-credential all Oregon health care practitioners. New legislation introduced in 2015 (SB 594) added flexibility in the implementation date of the Oregon Common Credentialing Program (OCCP) provided the agency give six months' notice to required participants.

What are the specific legislative requirements?

Under SB 604, health care practitioners or their designees must submit necessary credentialing information into a web-based Common Credentialing Solution that will capture and store credentialing information and documentation and verifications of select credentialing information will be performed according to local and national standards. Credentialing organizations must use the Solution to obtain credentialing information to the extent that it is available. Overall, the program will reduce the considerable duplication that exists today. Program requirements are as follows:

Credentialing Organizations are required to:

- *Use the Solution to obtain health care practitioner credentialing information and verifications*
- *Not ask health care practitioners for information that is available in the Solution*
- *Pay fees to support program administration costs*

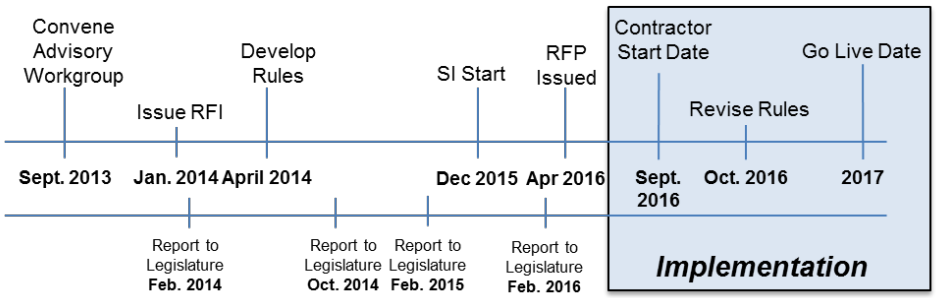
Health Care Practitioners are required to:

- *Use the Solution to enter in credentialing information (a health care practitioner's designee may be used)*
- *Attest every 120 days that information in the Solution is correct or make changes as necessary*
- *Pay fees to support program administration costs*

While practitioners must attest to the credentialing information in the Solution every 120 days – more frequently than the current process requires – attestations will only need to be done through the centralized Solution rather than with multiple credentialing organizations.

What has been done so far?

In September 2013, the OHA convened the Common Credentialing Advisory Group (CCAG) that is responsible for advising the implementation of SB 604. Meetings for the CCAG have been conducted monthly since October 2013 and have resulted in the development of a list of health care practitioners expected to participate in the program, the identification of accrediting entity requirements for credentialing, and a Request for Information (RFI) released in January 2014. OHA also published rules in July 2014 that solidified the OCCP. In 2015, Harris Corporation was chosen as a prime vendor and systems integrator for a portfolio of OHA technology projects including the OCCP, Provider Directory, and Clinical Quality Metrics Registry under the agency's Office of Health Information Technology (OHIT). A Request for Proposal (RFP) for an OCCP technology vendor was released by Harris on April 29, 2016, with responses due May 20, 2016. A vendor will be on board by September 2016.



What are the next steps?

OHA will continue to work with Harris Corporation to manage the implementation of the OCCP. Current work includes fee structure development, marketing and outreach planning, and adoption plan development to ensure successful implementation. The CCAG will continue to be consulted on programmatic aspects of the project. OHA anticipates implementation of the Solution during 2017.

What are some future stakeholder opportunities?

OHIT will be continuously conducting stakeholder outreach. A rulemaking hearing opportunity to voice concerns/support will be held in late 2016. Details will be posted on the OCCP's website (see below) once this is scheduled. Targeted marketing and outreach will begin at least six months prior to the OCCP go-live date. CCAG meetings are conducted at least bi-monthly and are open to the public. Meeting notices will be posted on the OCCP website (see below). OHA also convenes a Subject Matter Expert Workgroup related to OCCP planning and implementation. Stakeholders interested in requesting to join this group should email: credentialing@state.or.us.

Get Involved in Oregon Health IT

Visit our websites:

Office of Health Information Technology – www.HealthIT.Oregon.gov

Oregon Common Credentialing Program - www.oregon.gov/oha/OHPR/occp/

Subscribe to the OCCP listserv at the bottom of the OCCP home page

Provider Directory Services Background: Spring 2016

Overview

The Oregon Health Authority (OHA) is developing a state-level provider directory that will be operational in 2018. Healthcare entities will use the state-level provider directory to find authoritative healthcare practitioner and practice setting information. The state-level provider directory (PD) is part of our Health IT (HIT) portfolio which includes other HIT services such as the Oregon Common Credentialing Program and the Clinical Quality Metrics Registry. Harris Corporation is the system integrator and is responsible for procuring and overseeing the implementations.

The provider directory will leverage data from existing, trusted data sources, starting with the upcoming Oregon Common Credentialing Program which places a 120-day requirement for providers to update their information in a central database. Other authoritative data sources will also be included. It will also leverage national or federally recognized standards (such as the IHE-HPD standard) which supports the management of provider directories and opens the door for an interoperable solution.

The project includes design, development, implementation, and maintenance of the technical solution, data validation and management, as well as operations, ongoing management, and oversight of the program. An incremental implementation approach, driven by stakeholder endorsed use cases will be applied to ensure success out of the gate.

Purpose

Today, a single, accurate directory of health care providers and their affiliated organizations does not exist in Oregon. Instead, health care organizations use many different directories to look up providers and their clinic and network affiliations. These directories are isolated and exist within many state and non-state systems. The process for maintaining directories is burdensome for providers and healthcare organizations alike as provider data changes frequently. However, it is essential that provider directories are correct so they can be relied upon by patients and health care entities. Currently, directories are:

- Limited in scope and data accuracy
- Costly and difficult to maintain
- May not meet current and emerging provider directory national standards
- Not interoperable – limited ability to tap into outside provider directories

The implications of outdated and incorrect provider data can be costly and result in not only financial penalties but also the inability to effectively coordinate care, meet meaningful use requirements around health information exchange, and have the data to support analysis for metrics needed for quality improvement efforts.

Opportunity

- Stakeholders are asking for it
    - Oregon stakeholders, including Medicaid Coordinated Care Organizations (CCOs) expressed the need for foundational health IT services that support health transformation
    - A directory of electronic messaging addresses, such as Direct secure messaging, is not widely available; current processes to compile this information is built on manual processes
    - Meaningful use requires the ability to find providers to coordinate care
    - Knowing where and when providers practice in certain clinics and locations is essential for quality reporting
    - Health plans can face penalties for inaccurate provider directories
    - Patients need to be able to trust the information they see in a provider directory
- Reliable data sources to leverage
    - OR Senate Bill 604 established the Common Credentialing Program (operational in 2017)
- Authority to charge fees

- OR House Bill 2294 (2015) allows the OHA to expand Health IT services beyond the Medicaid program and charge fees

Goals and Objectives

1. Improve operational efficiencies – Having one trusted, single, complete source of provider and practice information, will eliminate the need to gather and find data from multiple sources. Healthcare entities' need to meet requirements for updated/accurate provider directories will be satisfied by using the state-level provider directory. Providers will not be burdened by multiple requests for the same information.
2. Improve ability to coordinate care and exchange health information – Providers will find Direct secure messaging (DSM) addresses and other provider information allowing electronic clinical data to be sent to the correct recipient for referrals and care coordination. Providers will be able to meet Health Information Exchange meaningful use requirements.
3. Improve data needed for health care analysis – There will be one source of data on where and when providers practice to support analysis of claims, generation of metrics and data analysis for quality improvement and related payment efforts.

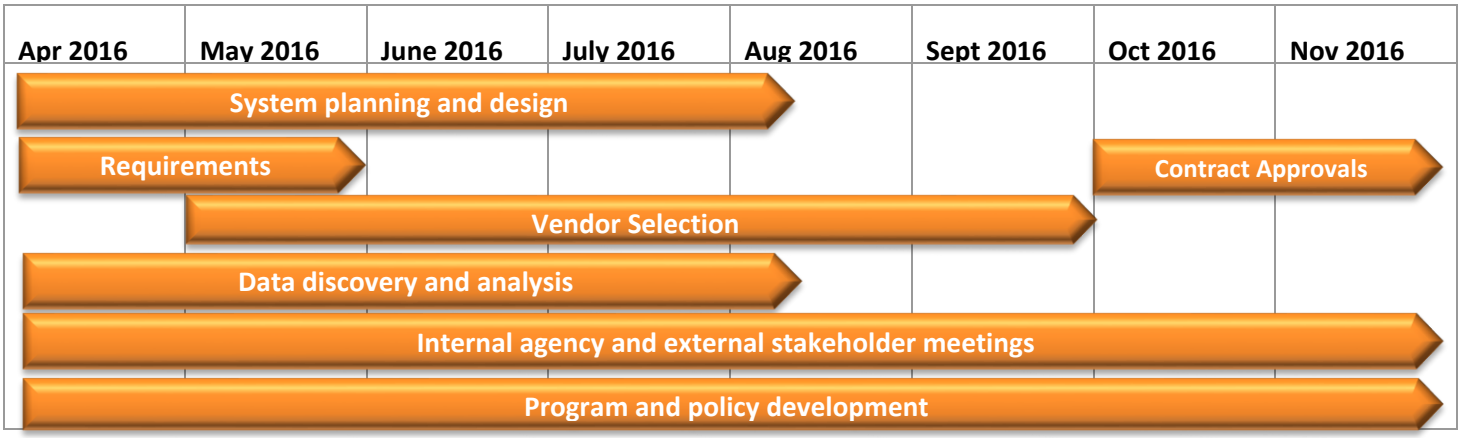
Approach

- Oregon will stand-up a set of healthcare provider directory services that will connect but not replace disparate provider directories existing today
- Access to the provider directory services will be via web portal, through an EHR/HIT, or through a flat-file exchange of data
- Leverages Oregon's Common Credentialing database which contains key trustworthy provider information such as demographics, practice locations, specialty, licensing, and other core credentialing information and requires providers to confirm the accuracy of those data every 120 days
- Built on recently adopted IHE-HPD standards that establishes requirements for how data are stored and transmitted
- Approach to development will be incremental where each successful phase will build upon the last phase

Activities

Major project milestones:

- ✓ August 2016: RFP released
- ✓ Oct/Nov 2016: Provider directory vendor selected; contract approvals begin
- ✓ Early 2017: Vendor onboard



Advance Interoperable HIE Award: ONC Site Visit to Jefferson HIE (JHIE)
May 3-4, 2016

ONC participated in three stakeholder meetings which included members/representatives from:

- ONC
- JHIE
- OHA
- JHIE Board of Directors
- HITOC
- CCO representatives
- Behavioral Health Workgroup
- HealthTech Solutions

HITOC representatives were Brandon Gatke, Erick Doolen, Mark Hetz, and Rich Bodager.

Overview

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

SUMMARY of ONC SITE VIST RECOMMENDATIONS:

Across the **three** stakeholder sessions during the site visit (JHIE Board of Directors and HITOC representatives, CCO representatives, and the Behavioral Health Workgroup), the following recommendations were made to ONC regarding needed resources and how additional funding could be utilized.

- Connect additional providers, especially behavioral health and oral health, and support on-boarding costs
- Support the exchange of high value data that is important to the community, including clinical data – PDMP, ADT, results radiology/laboratory – across broader spectrum of clinical sites
- Improve medication reconciliation
- Support the exchange of actionable clinical data and predictive analytics to address a myriad of health and social challenges for informed, coordinated and proactive patient care across the continuum
- Build modules with basic analytics and provide support to non-experienced users; and build reports that will turn people on to the value of the data
- Complete data sets to do analytical work that will be meaningful and support good decisions at the patient/clinical and population health level
- Provide access to data in the HIE for ancillary services, that have a direct impact on health outcomes and prevention (e.g., EMS/Paramedics)
- Promote broader membership in JHIE, e.g. commercial plans, additional labs/radiology facilities
- Behavioral Health connectivity is critical; need to support those providers in getting EHRs (including technical staff resources and/or additional training for staff) and implement better data systems to be able to interact with JHIE to support care management
- Support OHA's forthcoming behavioral health IT scan to inform HITOC on their strategic planning: BH Workgroup to validate the survey, respond, etc.
- Investigate how the 90/10 match for on-boarding could be applied; and estimate how many of each types of organizations are in the target population
- Support OHA to finalize the State Technology plan; and coordinate governance models to make sure there is HIE across the state to cover white space
- Work with OHA to determine how to align and streamline reporting requirements for CCOs, the State and other payers. Critical data elements need to be aligned across mental health, substance abuse and physical health.
- Develop patient education materials/tools around HIE and consent to ensure informed consent, as well as consistent message among providers/staff
- Consider ability of non-traditional users to access JHIE data (P&P, court orders, child welfare, etc.) and how social determinants can be factored in to available data (e.g. housing/food security)

Behavioral Health Workgroup Discussion Highlights

Information Sharing

Under the cooperative agreement project, JHIE is facilitating discovery meetings between its technical vendor, Medicity, and 4 EHR vendors (Echo, Epic, Cocentrix and Netsmart) to discuss their technical capabilities to exchange behavioral health (BH) data and manage patient consents. Medicity will work on the system architecture and then bring back operations options for the Behavioral Health Workgroup (BHWG) to discuss.

Some of the ONC grant funds are to support EHR interfaces with JHIE. Through the grant, JHIE will also be connecting Critical Access Hospitals, and have connectivity with the VA through the federal eHealth Exchange so users will have ability to query nationwide VA data.

Most BHWG members' organizations are using EHRs, and are eager to share information. They noted that sharing Alcohol and Drug (A&D) treatment data is most challenging. The challenges center primarily on EHR implementation and how to share patient information. Small organizations lack IT resources, so progress has been slow moving. The vision for the future is standardized data and streamlined data exchange. Several members noted that mental health (MH) and substance abuse (SA) treatment data reported to CCOs and the state seems to continue to change, causing challenges for data analytics/metrics.

One (payer) BHWG member noted that the slow pace of sorting through privacy requirements in order to build architecture was necessary. Providers and payers in the state are eager to use data to demonstrate opportunities for cost savings, and for patient care coordination. He said JHIE seems poised now to have the data infrastructure to power tools to support this.

The group discussed having a way to share data consistently and collect it in the EHR. Gina noted this is the purpose for the EHR vendor discovery discussions; to determine if the data from the EHRs can also include the consent component.

Another member noted that the collaboration of BH Workgroup members creates an opportunity to increase referrals.

Suggestions for Funding Opportunities

Zoe Barber of ONC asked the group if there were additional funding available (State or Federal), which provider pain points should be supported.

One member suggested building HIE modules that assist users with basic analytics. Help for non-experienced users is needed with reports that could be used for broader population health management. Also noted was that one CCO is turning their attention to building capacity to include patients' social determinant information (e.g. food and housing insecurity, etc.), which is critical to client support. Gina noted that JHIE is negotiating with a vendor who could provide reporting on textual data (not just discreet data like lab results) which could potentially include terms related to social determinant information.

There was consensus within the group for the need to define clinical workflow around agencies that collaborate. All agreed that the cost to interface EHRs with JHIE is a huge barrier. Also, ongoing training for staff would help significantly.

The BHWG Chair suggested additional funding for patient education with regard to JHIE and informed consent to exchange their 42 CFR Part 2 covered data; such as in the form of a video could be developed. Talking points for providers to use with clients/patients could help ensure that when patients are providing consent, they understand what happens to their data, how their information is protected and might be shared, etc. The Chair requested the State provide universal guidance on this type of communication. Susan noted that the State's common consent form (in development based on JHIE's work) will help address some of the inconsistencies among how organizations are interpreting consent rules. Issues that still need to be worked out are the "on the ground" operations of getting consent and how consent will be managed.

Access to Patient Information Across the Care Team

Susan Otter asked the group what would change and what they would do differently if they had access to information across a patient's care team through JHIE.

BH organizations often have different pieces to the puzzle, so exchanging patient information across and among BH providers would have a significant impact on patient care (not just sharing information between physical and mental health providers).

BHWG members explained that care teams would be better able to coordinate care and support each other. For example, using data to examine the relationship between prescribed opioid drugs and heroin addiction to identify underlying conditions, which are prompting physicians to prescribe certain types of medications to clients that might also be seeking SA/MH treatment.

BHWG members expressed their interest in more data coming into JHIE (e.g. other lab and diagnostic facilities) as not all patients use hospital labs/facilities. Having hospital/emergency department (ED) admission information is a significant benefit because if a client shows up in a hospital ED, the BH provider can be informed through JHIE and this may prompt them to intervene/assist.

Having the data readily available is likely to improve treatment completion and success rates. BH providers will no longer have to rely on patients to be the conduit for information about their health. Patient will see that providers are all "talking to each other", and providers will no longer be dealing with just pieces of the puzzle.

Medication Information

The issue of connecting pharmacies with JHIE was raised. Gina noted that pharmacies normally do not interface individually. Surescripts is an option as a source, but it is very costly. Some medication information could be obtained through transcribed reports and CCDs, which may include prescribed medications, or medication provided while the patient received inpatient care.

The Prescription Drug Monitoring Program (PDMP) is another opportunity to view data on the Schedule II, III and IV controlled substances dispensed to Oregon residents. Legislation recently passed to allow third-party connectivity for providers to query the state's PDMP. This will allow JHIE users to query and view the PDMP data through JHIE seamlessly. Susan noted that this will get underway in early 2017 as requirements and regulations still have to be built out at the State level. CCOs and health plans will not have access; but active providers treating a patient will be able to query. EDIE and JHIE will be able connect to the PDMP as will individual EHRs that meet the State requirements for privacy/security.

Behavioral Health and Other Patient Information into JHIE

The vision for BH information inclusion within JHIE involves a Qualified Service Organization Agreement (QSOA) with each contributing BH organization. JHIE would receive all data, but would only "unlock" it when a patient consent is sent/activated, including consent for past data to be accessed by an authorized provider.

A question was raised as to how other ancillary/non-traditional providers (e.g. child welfare, social services, courts, etc.) that work with BH could be involved and if they can access data through JHIE. Members reported that coordinating information (by scanning, faxing, mailing) with those organizations is currently a huge amount of work for BH providers. Gina responded that there is potential for those types of organizations to access data through JHIE once the common consent model is built into the HIE technology.

June 3, 2016

Request for Information Regarding Assessing Interoperability for MACRA

Below, please find Oregon Health Authority's comments and suggestions in response to the RFI. The Oregon Health Authority's Office of Health Information Technology (OHIT) was established in 2011 as a part of the state's health agency to support the adoption of electronic health records, the secure exchange of health information, and supporting meaningful use initiatives in the state. OHIT is a resource for both state programs and other public and private users of health information, providing planning, coordination, policy analysis and the development of public/private partnerships to further health IT in Oregon. Health IT is a key part of Oregon's efforts to create a system of better health, better care and lower cost for all Oregonians.

Thank you,
Susan Otter
Susan.OTTER@dhsoha.state.or.us
Oregon's Director of Health Information Technology

Summary of OHA Comments

The Oregon Health Authority (OHA) would like to thank the Office of the National Coordinator for Health IT (ONC) for putting forth their rationale and plan for measuring interoperability as required under section 106(b)(1)(C) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). It is very helpful to gain insights and an understanding of ONC's vision and plans. Given Oregon's commitment to healthcare transformation including care coordination, which require interoperable systems, we are in the process of addressing similar questions at the state level.

In responding to this RFI, the OHA has solicited comments from various oversight and advisory bodies and other stakeholders. We agree that ONC's plan to measure interoperability across a variety of settings, extending beyond "meaningful EHR users" to include a variety of settings and populations as described in the Interoperability Roadmap, is appropriate.

We understand and appreciate the limited sources of data available to effectively measure information exchange and its subsequent use. We agree that ONC's proposal to focus on established national surveys and CMS's Medicare and Medicaid EHR Incentive Programs data is correct. In addition, we recommend using data sources to cross-validate the findings from these sources, including primary research undertaken within state initiatives, by regional HIOs, technology developers, private HIEs, and other stakeholders. Supplemental methodological approaches to enrich and validate the data include case studies, comparative analyses, focus groups, structured interviews, transaction analyses, server log analyses, and economic structural analyses.

Within Oregon, we are addressing the specific challenges of care coordination within a context of payment innovation through a number of initiatives including our Coordinated Care Organizations. Measurement of the performance of these initiatives, including information exchange, data integration and use, and improved patient outcomes, is central to our strategies and success. As such, our activities are complementary to those of ONC under this RFI and we look forward to supporting the effort.

Answers to the specific RFI questions are below.

Populations and Key Components

1. **Should the focus of measurement be limited to "meaningful EHR users" and their exchange partners? Or, should populations and measurements be consistent with the Interoperability Roadmap and include consumers, behavioral health, long term care, and other priority populations?**

Oregon is committed to care coordination and strongly believes that this includes providers and their patient populations extending beyond those using certified technology. We concur with the vision of the Interoperability Roadmap that the measurement of progress needs to include non-eligible providers such as long-term care and behavioral health, consumers, and other identified priority populations. Oregon is actively extending the infrastructure and care coordination activities with these providers and populations and has been establishing baseline metrics to measure future performance.

We believe that a phasing of the measurement activities would be required if these additional stakeholders are included. We support the Near and Long-Term Measurement Framework developed by ONC, and think that the inclusion of these additional stakeholders fits succinctly under this framework.

2. **How should providers under MIPs and alternative payment models be addressed?**

Providers eligible under MIPs and APMs should be addressed similarly as providers meeting Meaningful Use criteria.

3. **Does the ONC approach to measuring interoperability (i.e., electronically sending, receiving, finding and integrating data from outside sources, and subsequent use of information electronically received from outside sources) adequately address the exchange and use components of MACRA?**

We agree that the ONC approach adequately addresses the exchange and use components of MACRA. However, owing to the limitations of the survey data and EHR Incentive Program Measures, we suggest the pursuit of methodologies which can cross-validate the findings from this approach including electronic reporting of transactions (including the timeliness of exchange), log audit analyses, case studies, and additional targeted qualitative research such as workflow analyses and focus groups.

4. **Should measurement be limited to certified EHR technology?**

Measurement of interoperability should extend beyond certified EHR technology to include measurement of exchange and use outside of/beyond certified EHR technology. This would

be more inclusive of the targeted providers and populations identified in the Interoperability Roadmap.

Available Data Sources and Potential Measures

1. **Do the survey data adequately address the exchange and use components of the definition of interoperability?**

We appreciate the limited sources and methodological constraints for the longitudinal measurement for data exchange and re-use. The survey approach includes issues such as responder bias (including self-report) and the reliability of shared definitions for the technology concepts. That being said, the two national survey data sources provide longitudinal data, a high response rate, designs appropriately targeted by provider segment, and substantial refinement over the course of their use.

While the sending component of exchange is relatively easy to measure, the use of the exchanged data, the facilitation of coordinated care, and the improvement of patient outcomes are the more difficult elements of the definition to measure. While the survey data address these questions and are useful, they are only one tool. We suggest the use of additional targeted methodologies to validate the survey findings. In addition, the survey findings can be correlated to those from states, such as Oregon, who are undertaking parallel primary research.

2. **Do office-based physicians serve as adequate proxies for eligible professionals who are "meaningful EHR users" under the incentive program?**

Yes, we believe that they are adequate proxies.

3. **Do national surveys provide the necessary information to determine why electronic health information may not be widely exchanged? Are there other recommended methods that ONC could use to obtain this information?**

The AHA Annual Survey IT Supplement includes questions about barriers to exchange and interoperability as well as challenges to implementing an EHR system, which would provide information as to why electronic health information is not widely exchanged. The National Electronic Health Records Survey, however, does not inquire about barriers or challenges.

Amplification of the issues and insights into solutions can potentially be achieved through additional research approaches including regional case studies, focus groups, structured interviews, and economic analyses (e.g., resource constraints, market structure). Studies and data collected by states can also be used to identify barriers to exchange, lessons learned, and solutions.

CMS Medicare and Medicaid EHR Incentive Programs Measures

1. **Do the proposed Incentive Program Measures adequately address the exchange component of interoperability?**

The proposed EHR Incentive Program measures do not adequately address the receiving and use of exchanged health information. This includes the issues of technical interoperability in the context of interfaces, the ability to consume or parse exchanged data, and the larger problem of semantic interoperability once data are consumed into an EHR. In addition, the Incentive program measures do not adequately distinguish between the four elements of exchange. As such the Incentive Program does not directly measure data re-use or integration with care coordination.

2. **Do reconciliation measures serve as adequate proxies to measure subsequent use of exchanged measures? What alternative national measures (e.g., clinical quality measures) can be used to measure interoperability?**

Reconciliation measures represent a starting point for capturing the use of exchanged data by providers. It is unclear how "manual processes" are defined and their relationship to an automated workflow could vary widely. This could lead to measurement reliability issues when it is used as a proxy. Thus, consideration could be given to creating parameters as to the definition of manual processes.

Clinical quality measures have limited value in measuring exchange unless they are used as a proxy where an a priori assumption is made that outcomes are causally associated with exchange functionality. Thus, outcome measures potentially could be correlated to the presence of exchange and data re-use. However, this requires the use of control variables and careful design and would not be appropriate as a national measure.

3. **Can state Medicaid agencies share provider-level data that is similar to the Medicare data collected under the Meaningful Use Program?**

Oregon is willing to share data in a suitable format.

4. **If the data were limited to Medicare-only eligible providers, would it nevertheless be valuable to develop new measures evaluating exchange and subsequent use of 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. Given that these providers have achieved eligibility, they have the benefit of access and use of an enhanced infrastructure. If they are not engaged in exchange and the subsequent use of information, then other providers are unlikely to be so engaged. In addition, substantial lessons can be learned from these relatively early adopters.

Identifying Other Data Sources to Measure Interoperability

1. **Should ONC use a single data source for consistency or data from a variety of sources? It the latter are data from the EHR incentive program and national surveys of hospitals and physicians appropriate?**

ONC should use data from a variety of sources. While the EHR Incentive Program and National Surveys are foundational sources of data for national measurement, we believe that additional methodologies and data sources should be applied for cross-validation and additional insight. Oregon will support the ONC by providing additional relevant data and findings from the primary research undertaken for the initiatives within our state.

2. **What other measures should ONC consider from these identified data sources?**

In examining the research instruments used in the national surveys, their comprehensiveness is readily apparent. Attention should be given that the scope of information from these surveys is fully utilized.

3. **Are there Medicare claims measures that can provide unique information?**

There do not appear to be any Medicare claims measures that can provide unique information to the questions of information exchange and subsequent information re-use.

4. **What are the highest priority measures to include?**

The highest priority measures to include are those associated with semantic interoperability and data re-use in care coordination.

5. **What other national-level data sources should ONC consider? Do technology developers, HIEs, HIOs, or other entities have suggestions for national level data**?

In terms of national-data level data, Oregon believes that they are many potential sources of data including research and analyses undertaken by individual states in support of health information exchange and care coordination. Regional and state HIOs and HIEs also regularly undertake research studies including server log-audits and network analyses. Targeted-funding such as Co-Operative Agreements supporting exchange with long-term and post-acute care and behavioral health providers can provide important measures and adoption. Finally, technology developers are a potential rich-source of data and are potential partners in developing automated solutions to measure exchange.

6. **How should "widespread" be measured? For example, should the threshold be 50% of providers/hospitals be used to define "widespread" adoption.**

We believe that "widespread" should be measured using a denominator which represents the broad spectrum of shareholders identified in the Interoperability Roadmap. This extends beyond "meaningful EHR users."