Health Information Technology Oversight Council
Thursday, June 9, 2016; Portland, Oregon
12:30 – 3:45 pm

Council and Ex-officio Members Present: Erick Doolen (Chair), Bob Brown (Vice-Chair), Chuck Fischer, Bud Garrison, Brandon Gatke, Mark Hetz, Maili Boynay, Sarah Laiosa, Greg Van Pelt
Council and Ex-officio Members by Phone: Amy Henninger, Sonney Sapra
Council and Ex-officio Members Absent: Valerie Fong
Staff Present: Kristin Bork, Luke Glowasky Karen Hale, Melissa Isavoran, Kim Mounts, Marta Makarushka, Rachel Ostroy, Susan Otter, Lisa Parker

Welcome –Erick Doolen (Chair)
Refer to HITOC 7APRIL16 Minutes Final

- Erick started the meeting and welcomed the group; the council members and staff introduced themselves.
- Action: Approval of Minutes: The Chair presented the April HITOC meeting minutes; Bud Garrison moved to approve the minutes and Sarah Laiosa seconded the motion. All HITOC members present and on the phone were in favor of approving the minutes; no one opposed.
- Updates: HITOC report to the Oregon Health Policy Board (OHPB). The full draft version has been distributed for comments and the Board was asked for feedback as well. OHA will produce a legislative report that will be a summary of the full report.

Oregon's 1115 Waiver Renewal – Lori Coyner, State Medicaid Director, *refer to slides 15-17*
Presentation:

- Lori provided an update on Oregon's Medicaid waiver renewal. The waiver renewal will 1) build on health systems transformation (e.g., Patient Center Primary Care Homes and the integration of physical and oral health), 2) deeply address social determinants and health equity, 3) continue to hold costs to sustainable rate of growth, and 4) Expand the coordinated care model. The waiver will also include:
    - Coordinated Health Partnerships whereas each CCO and a Tribal partnership could be a lead entity in five year investments leveraging federal dollars. Planning could begin in mid-2017, with partnerships starting in 2018. Partnerships would include new services related to supported housing and transitions of care, with implications individuals at risk of being homeless, and transitions related to jail or state hospital settings.
- Susan presented on OHA's HIT/data sharing infrastructure concepts included in the waiver proposal, including
    - Ensuring the right infrastructure and tools for Coordinated Health Partnerships; building on Oregon's current HIE infrastructure where possible and leveraging new HIE Onboarding funding; expanding notifications of transitions of status to consider corrections, social services, state hospital stays; and supporting the data sharing policy environment.
    - Mobile and telehealth pilots proposed in waiver: building from several current telehealth pilot efforts (e.g., telepharmacy and dentistry), as well as exploring making mobile applications available for consumers and providers.

Discussion:

- The group was supportive of waiver renewal approach and concepts. One member mentioned leveraging lessons learned from existing CCO initiatives on data sharing/care coordination with housing services.
    - Question: How do we get involved in Coordinated Health Partnerships?

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        - Answer: Partnerships will be voluntary; next steps include developing the Partnership concepts further via an advisory group
    - Question: How will the funding work?
        - Answer: Funding will be separate from global budgets – prospective Partnerships will likely go through an application process. OHA anticipates the first year of the new waiver will be a planning year, then Partnerships will see a few years of paying for process, then outcomes based payments toward the end.
    - Question: Why is early childhood education not included?
        - Answer: It is included in current waiver and there are no new projects to place in the renewal. However, the metrics and scoring committee is including this and we will continue to work with our partners.

Next steps:

- OHA to submit draft to CMS summer 2016, high level agreement by fall, and finalize renewal in early 2017. The new waiver demonstration would begin July 2017. Questions, comments can be sent to Lori or Susan.

Shifting Environment, MACRA, and Federal Influences – Lisa Parker, *refer to slides 18-34*

Presentation: Lisa described the shifting environment including upcoming transformation that will include MACRA, Coordinated Health Partnerships (proposed under Oregon's Medicaid waiver), and Comprehensive Primary Care + (CPC+).

- **CPC+** is a regionally based multi payer advanced primary care medical home model that provides doctors the freedom to provide care by outcomes that builds on the Comprehensive Primary Care Initiative (CPCI) launches in 2012. Oregon already participates in the CPCI and has over 600 Patient Centered Primary Care Initiatives. The Initiative's two tracks include a monthly care management fee for practices and then a larger monthly care management fee if enhanced HIT is used. Practices can apply July 15 through Sept 1, 2016. Starts in 2017. Susan mentioned that we should consider how this will impact providers and HIT and that changes in payment are needed to support investments in HIT to help providers cover costs.
- **Medicare Access and CHIP Reauthorization Act** passed in 2015 and the notice of proposed rulemaking was released in April 2016. Changes may be made later this year. MACRA repeals the sustainable growth rate and eliminates established incentives for APMs, and implements a Quality Payment Program for Medicare, which includes two pathways for provider payments. The pathways include:
    - The Merit-Based Incentive Payment System (MIPS) allows Medicare Part B clinicians payments for providing high value care in four performance categories and replaces three programs: PQRS, Value-based payment modifiers, and Medicare EHR Incentive program. MIPS is budget neutral, so while some clinicians will get enhanced payments, others will experience decreases.
    - Advanced Alternative Payment Models (APMs) - where Medicare clinicians who participate in APMs would be exempt from MIPS reporting requirements and qualify for a 5 percent Medicare Part B incentive payment.
    - Note: 2017 will be the performance year for 2019 payments. If you are using a 2014 EHR in 2017, you will not qualify for an advanced score.

Discussion:

- Question: This seems overwhelming - can we comment with push back on the rules as it is just too many requirements?
    - Answer: Yes, comments are due by June 22. OHA will be submitting comments. Many associations have relied on their national counterparts for comments.

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- Question: Is it only Medicare being released from meaningful use requirements?
    - Yes. Medicaid EHR Incentive Programs/meaningful use will continue through 2021. MACRA continues meaningful use requirements for Medicare in a somewhat different form, under the Advancing Care Information component of the MIPS composite performance score.
- Members expressed concern that these expectations will be harder to meet for independent providers and concern that some will drop out of Medicare. Also, concern that providers need to stop focusing on metrics and start focusing on the patient.
- Members were concerned that Oregon providers are not aware of MACRA and/or need more information, and recommended that OHA reach out to associations and other partners to coordinate with any work underway to educate stakeholders.

Next Steps

- OHA will send further resources to HITOC on Advancing Care Information component of MIPS and available assistance for providers, and will reach out to association partners and see what is planned for MACRA education/awareness.

Interoperability Pledge – Kim Mounts and Susan Otter, *refer to slides 35-41*

Presentation

- Interoperability pledge is a theme that came out of the HIMSS conference in March. OHA met with stakeholders and assessed moving forward with a pledge in Oregon. Pledges can be uploaded to www.healthit.gov and will be recorded online. OHA received supportive stakeholder feedback and will go back to networks again and share for awareness and promotion of the pledge.

Discussion

- Members discussed the consumer access component, including that this area needs further work beyond the pledge. While the pledge is focused on access, the real concern is whether the information being provided is useful.

Action

- Maili made a motion that HITOC endorse the Interoperability Pledge and promote to Oregon stakeholders – encouraging them to pledge, Brandon seconded the motion. There was no further discussion and no opposition.

Next Steps

- OHA will reach out to stakeholders and association partners to promote the pledge, and report back to HITOC on Oregon entities participating.

Updating Oregon's HIT Strategic Plan – Susan Otter*, refer to slides 42-54*

Presentation:

- OHA staff presented on HITOC's progress with updating Oregon's 2014-2017 HIT Strategic Plan for next year. HITOC has confirmed goals and aims/objectives; is continuing to assess the changing federal, state, and policy environment; and has begun discussions on state role.
- New federal HIE Onboarding funding, and concepts in the Medicaid waiver gives us some timing parameters to work with and reiterates that need to reevaluate the state's role – in particular, aiming to support HIE needed for the Coordinated Health Partnerships, which will likely be operational by mid-2018. Options for the state's role include a: 1) market driven approach (status-quo), 2) state-led partnership model – where OHA plays an orchestrating role in a "network of networks" model, and 3) centralization (slide 54).

Discussion

- HITOC should consider a rolling 3-year HIT strategic plan given the pace of changes in the HIT environment, potentially including considerations for years 4-5.
- Need to understand what HIE strategies are in place both in regions and state-wide, but also private investments. Would we be asking entities to start over? Consider onboarding

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opportunities that leverage the footprint of large organizations. If transitions are needed, would need to consider what transitions would look like for those that have already invested in an HIE strategy.

- Discussion of the 3 options: centralizing HIE, considering how to coordinate/connect networks together, and market-based regional approach.
    - To focus on the individual and provider, we may have to centralize certain things and that approach may be cheaper if we do it together (e.g., EDIE). Some things are best done at the state level – registries, for example (POLST, PDMP). HIEs could feed data to registries. There is some cost complexity with multiple connections that isn't mitigated by standards.
    - There is a need to allow local markets to develop and provide support to them in doing so. However, we don't have a lot of population coverage with current regional HIEs. If we rely on locally driven approach, concern that in some regions it may not happen.
- Discussion of 2nd option – coordinating/connecting a "network of networks" with some statewide services:
    - What's happening now isn't working. Too many competing efforts with different standards. Central coordination can work to ensure that data is freely exchanged. Concerns that without a central coordinating structure there may be charging fees or other data hoarding.
- Discussion of "white spaces" or gaps in HIE in Oregon:
    - State may be able to create a model to extend current efforts into the "white spaces" where there are little or no HIE options.
    - Need to better understand and map out "white space" or gaps in HIE.
    - Even in HIE "rich" environments, like Southern Oregon, there are providers that are not participating in HIE. Some clinics don't have the financial incentives to serve rural areas but make up for it in their other locations – similarly, regional HIE may not be viable in certain areas without a larger footprint.
- Discussion of value/drivers for data sharing:
    - New business drivers such as clinically integrated networks are forming and creating competition – these forces may need to be understood better.
    - Central coordination/state role could be used as a neutral entity of trust and to ensure appropriate control of HIE strategy so that entities can use data.
- Discussion of principles for coordination of data sharing:
    - If we "democratize data" we can "raise all ships"
    - Establish that the patient has a right to have data at the point of care. Will need to break down other reasons for sharing data, and have transparency in order to move forward. There is value in sharing patient data, but organizations worry about how aggregated data is used. Organizations will want clarity on data uses and clear rules of the road to have trust and participate.
    - Consider who has rights to access data – will need a "traffic cop" to ensure data can move freely and appropriately. Will need to ensure regional HIEs and other participants are accountable if they are going to be part of a "network of networks."
    - May want to set an objective of having a core set of data available anywhere in the state to support continuity of care, safety and quality.
    - Need to develop a governance role to lead and direct with well established principles. Governance can set base expectations or objectives for data sharing and guard rails for use of data. Key element is transparency – so contributors know how their data will be used

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and how decisions will be made. Set clear options and describe what, at a minimum, organizations are expected to do – identify value.

- Additional comments:
  - Getting everyone involved first is key (e.g., Eastern Oregon, border states, etc.).
  - An HIE "light" solution may be an option for some areas, so that costs are held down.
  - Need to consider cost vs. benefit – including how best to leverage national efforts (e.g., Commonwell, Carequality).
  - Connecting may be the easy part - incorporating it into the provider workflow should be a part of the equation.
  - Will want established definition of HIEs in the network - a consumers' guide may be helpful.

Next Steps:

- OHA will flesh out HITOC ideas including exploring a central coordinating model with implications for a governance layer. OHA will also pursue further understanding of the "white spaces" for HIE in Oregon to inform priorities and strategies.

HIE Onboarding Program Concept—Lisa Parker *slides 55 – 62*

Presentation:

- Lisa gave an overview of the CMS guidance (State Medicaid Director's letter) that allows states to access 90% federal match for supporting onboarding of Medicaid providers to HIEs, including providers not eligible for meaningful use incentives, where connecting the non-eligible professional to the HIE helps an eligible professional meet meaningful use.
- OHA is in the process of developing Oregon's HIE Onboarding Program, and anticipates setting criteria for HIE entities to qualify for the HIE onboarding funding. OHA has been gathering input from stakeholders and HIE entities in Oregon, and is seeking HITOC feedback, particularly in light of HITOC's strategic planning update efforts.

Discussion: HITOC generally endorsed the OHA's concept and process. Some discussion of prioritization of provider types, considering those not eligible for meaningful use incentives, behavioral health, and long term care providers.

- Question: What is the official definition of an HIE entity?
  - Answer: CMS is looking to states to define that. Funding can support multiple HIE entities.
- Question: Does this include dental providers?
  - Answer: Yes – these funds can support dentists. Dentists are eligible for meaningful use incentives and this is the last year to start the Medicaid EHR Incentive program. OHA is reaching out to ensure that Oregon dentists are aware that they may be eligible for these incentives and has had some good response.
- Question: Is the funding to help eligible professionals meet meaningful use – there might be barriers if non-eligible providers would need to be on a certified EHR.
  - Answer: Exchanging information with another provider is one component of meaningful use. So, assisting other non-eligible providers to participate in HIE (whether or not they are on a certified EHR) can help eligible providers meet meaningful use.

Next steps:

- OHA will establish process and stakeholder ad hoc group; socialize concept and gather input, report back to HITOC and others to formalize strategy before submitting a formal request to CMS for funding.

Common Credentialing—Melissa Isavoran *slides 63 – 70*

Presentation:

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- Melissa described the OHA HIT Portfolio of projects in development, which includes Common Credentialing, Provider Directory, and the Clinical Quality Metrics Registry. She then provided an overview of the efforts for the Common Credentialing activities, including the primary purpose, the advisory group, the vendor selection process, and the fee development process.

Discussion:

- Question: For a hospital or clinic to send information to the common credentialing system, will there be a fee?
  - Answer—credentialed practitioners will likely have a one-time start-up fee only. Hospitals and other credentialing organizations (e.g., health plans, CCOs, IPAs, ambulatory surgical centers) will have a one-time startup fee, and likely an annual subscription fee; fees will be tiered based on a credentialing organization's practitioner panel size.
- Question: In addition to the unknown fee structure—concern around service level standard. What will the turnaround time be? What is the baseline for expedited review? Concern that there will need to be workarounds.
  - Answer: From the completed application date, OHA's credentialing program will have 30 days to complete the verifications (standard). Expedited timeframes are being worked through with our Common Credentialing Advisory Group. Credentialing organizations are required to use the system to the extent that a practitioner's information is available in the system – if you need it more quickly than it is available, you are able to work directly with the practitioner.

Provider Directory – Karen Hale, *refer to slides 71 - 78*

Presentation:

- Karen gave an overview of key uses: efficiencies for operations; facilitate care coordination and information exchange (current work around for flat file directory); resource for data for analytics.

Discussion:

- Question: Will there be information that may be helpful for meeting MACRA expectations (e.g., Tax ID Numbers).
  - Answer: OHA is analyzing how TINs will be included in the Provider Directory. While TINs are essential from some uses (e.g., payers have expressed needing them), there are potential issues that need to be explored since some TINs are social security numbers.

Updates, *refer to slides 78-88*

Updates were skipped during the meeting due to time constraints; see meeting materials for update information

- ONC Site Visit Summary
- OHA Comments on ONC NPRM
- OHA Comments on Measuring Interoperability RFI

Public Comment – Erick Doolen, Chair

- No public comment

Closing Remarks – Erick Doolen, Chair

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