Health Information Technology Advisory Group (HITAG)

HIE/HIT Community and Organization Panel (HCOP)

July 14, 2016

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Agenda

1:00pm	Welcome, Introductions and Agenda Review
1:15pm	Changing Environment for Health IT and HITOC's Direction on Strategic Planning
2:00pm	Clinical Quality Metrics Registry (CQMR) Year 4 and Beyond
2:30pm	Break
2:35pm	CQMR Discussion – Use Cases, Connections with HIEs and Qualified Clinical Data Registries (QCDRs)
3:20pm	Administrative Simplification Workgroup – Claims Data Request Issue
3:35pm	Health IT Portfolio Update
3:55pm	Next Steps and Conclusion

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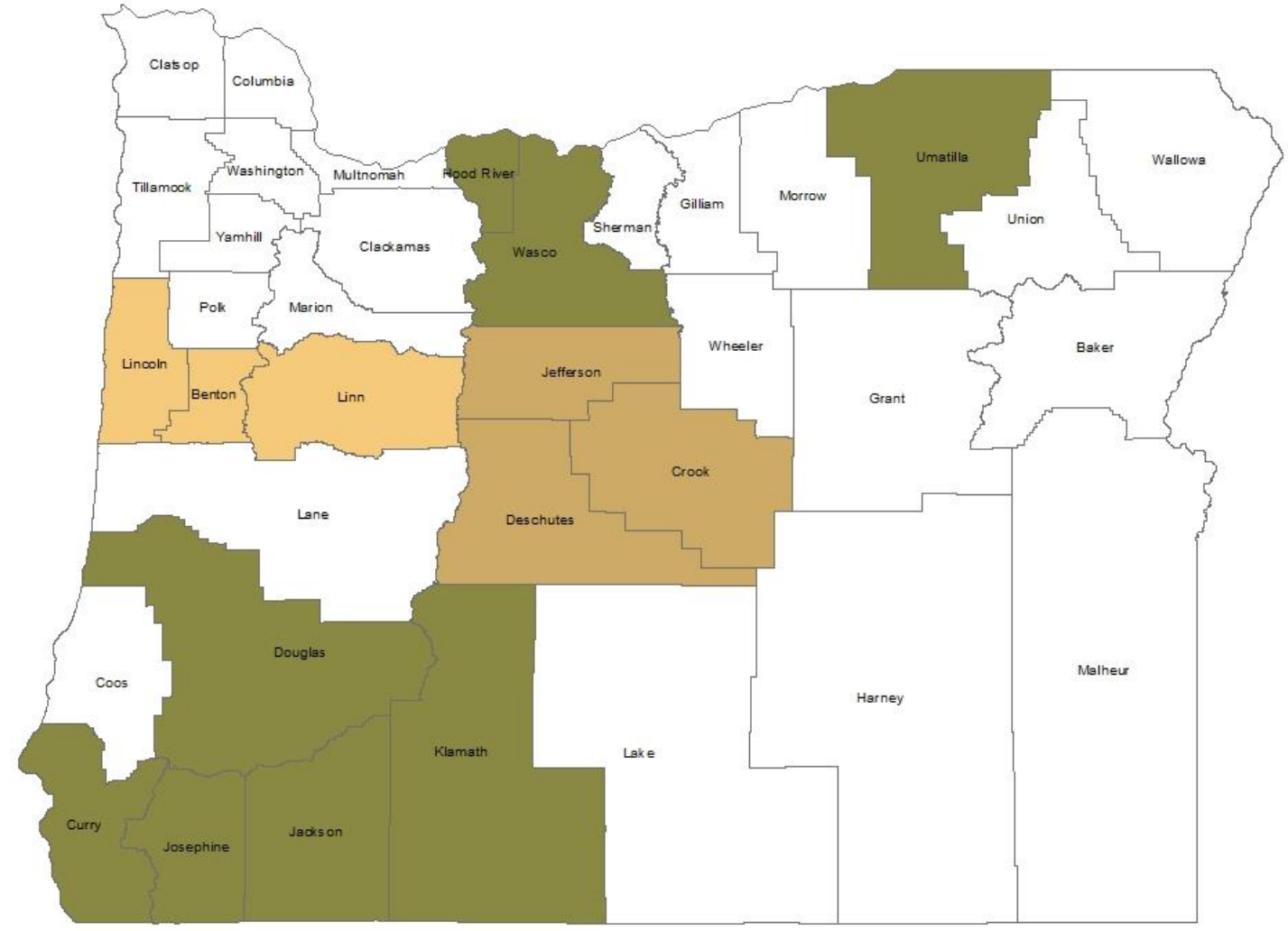
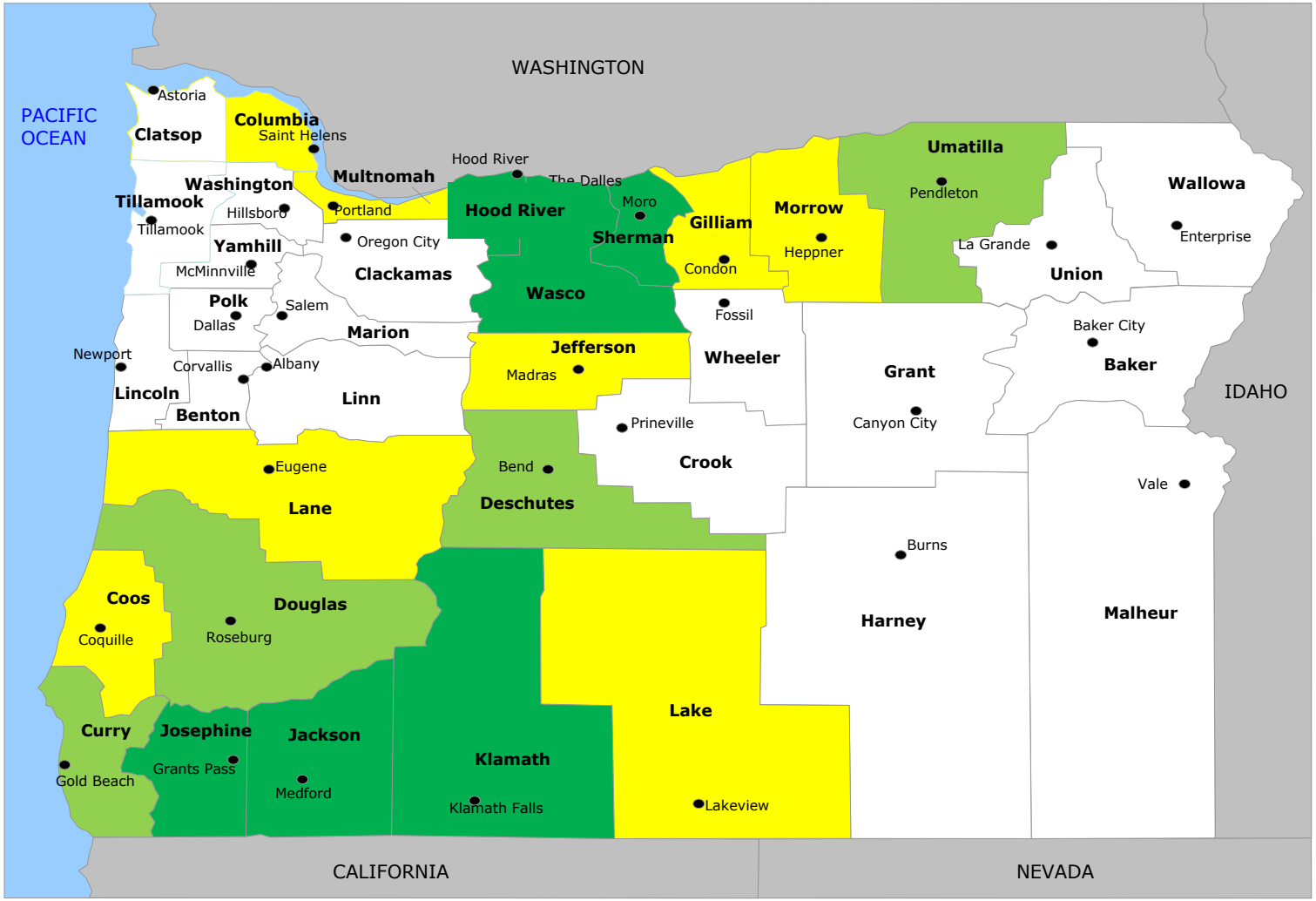
Introductions

Regional HIEs – by County*



*Central Oregon piloting with JHIE

JHIE Coverage Area as of Feb 2016



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

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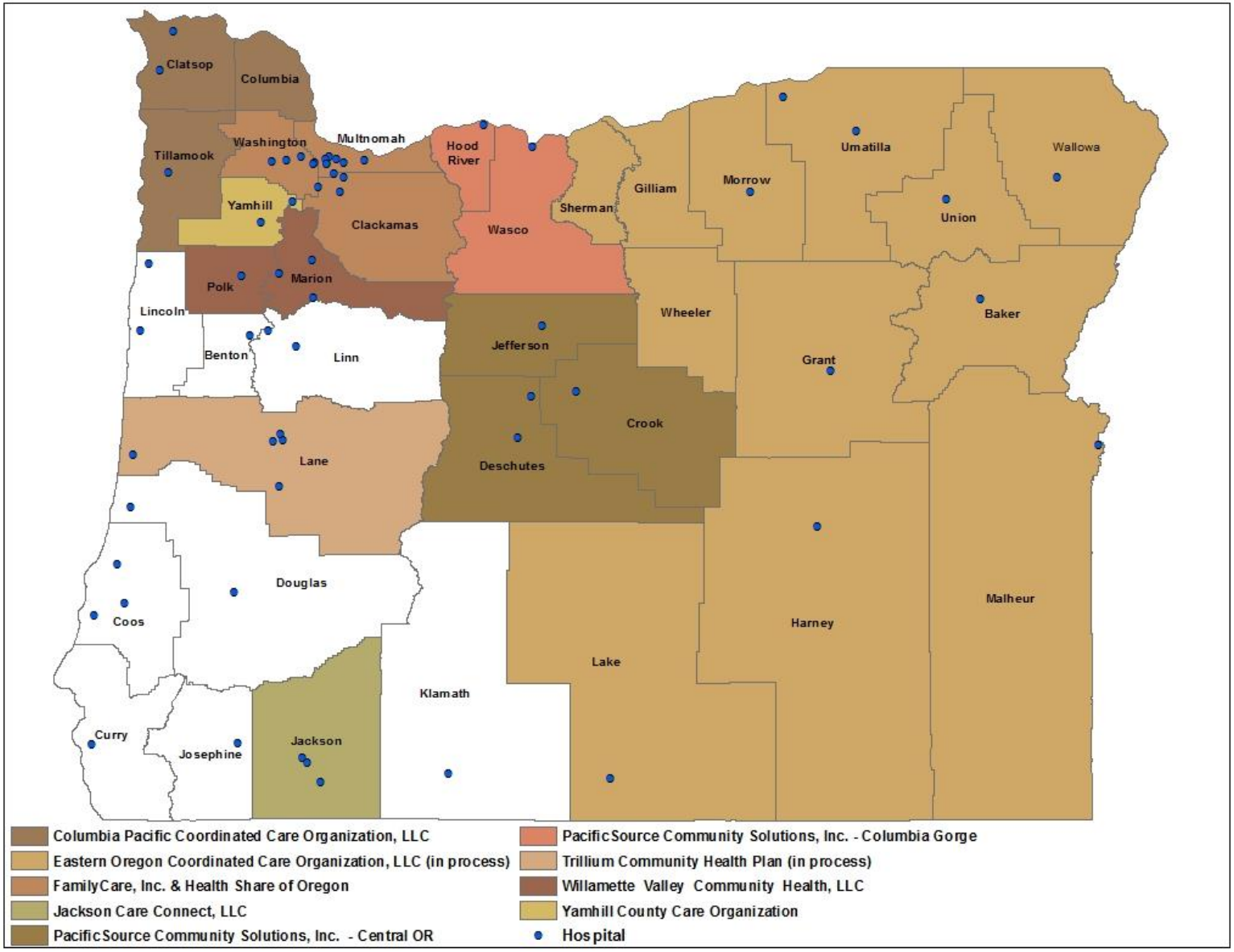
Hospital Event Data – by County

CCOs (PreManage), Hospitals (EDIE)



Changing Environment for Health IT and HITOC's Direction on Strategic Planning

Susan Otter, Director of Health IT

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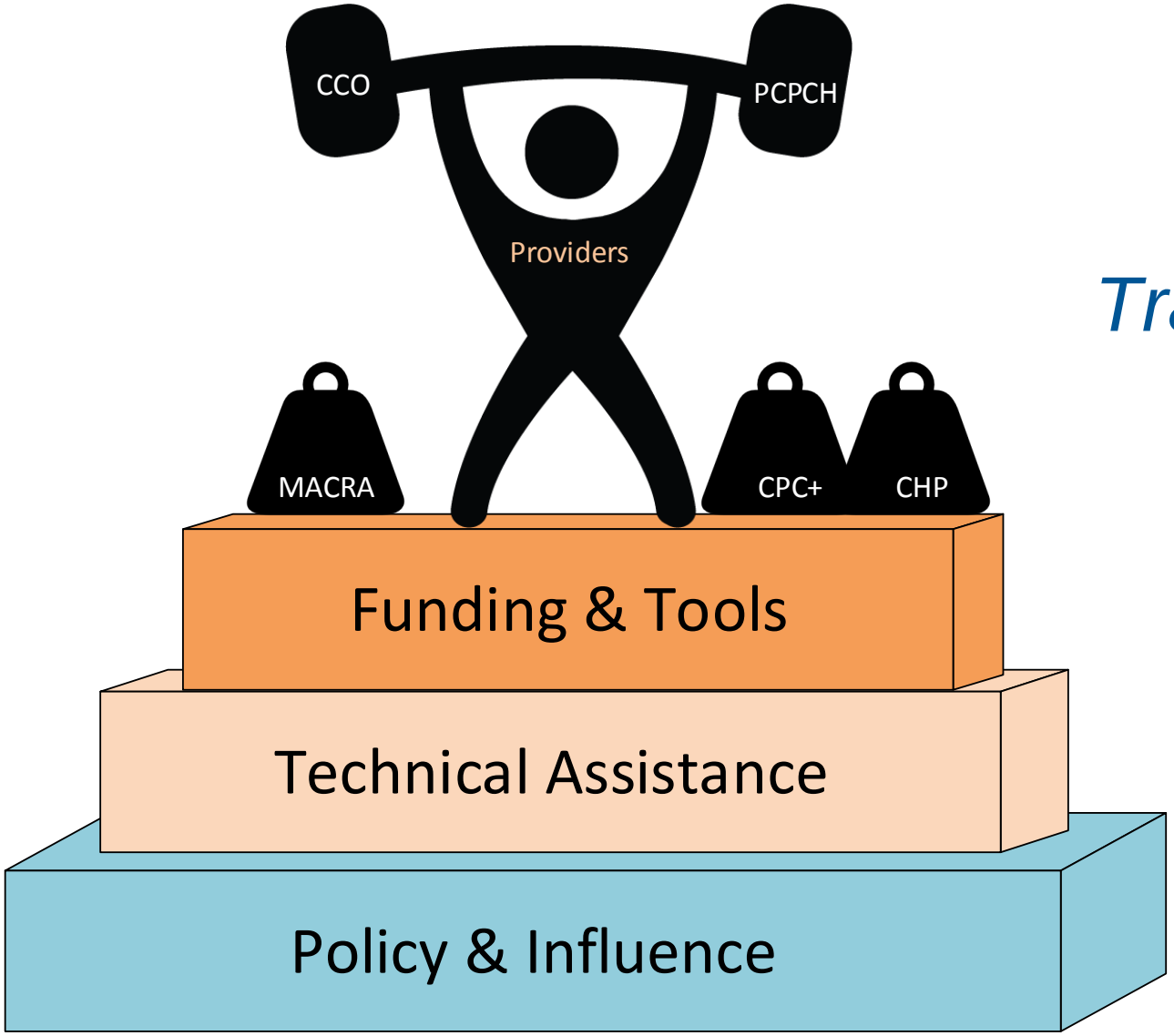
Support Needed for Upcoming Transformation



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Changing Environment

- Medicare Access and CHIP Reauthorization Act (MACRA) of 2015
  - Establishes the Merit-based Incentive Payment System (MIPS)
  - Provides incentives to participate in Advanced Alternative Payment Models (APMs)
- CPC+ is a new national advanced primary care medical home model
  - Aims to strengthen primary care through a regionally based multi-payer payment reform and care delivery transformation
  - Selected regions/states will start January 2017 and go 5 years

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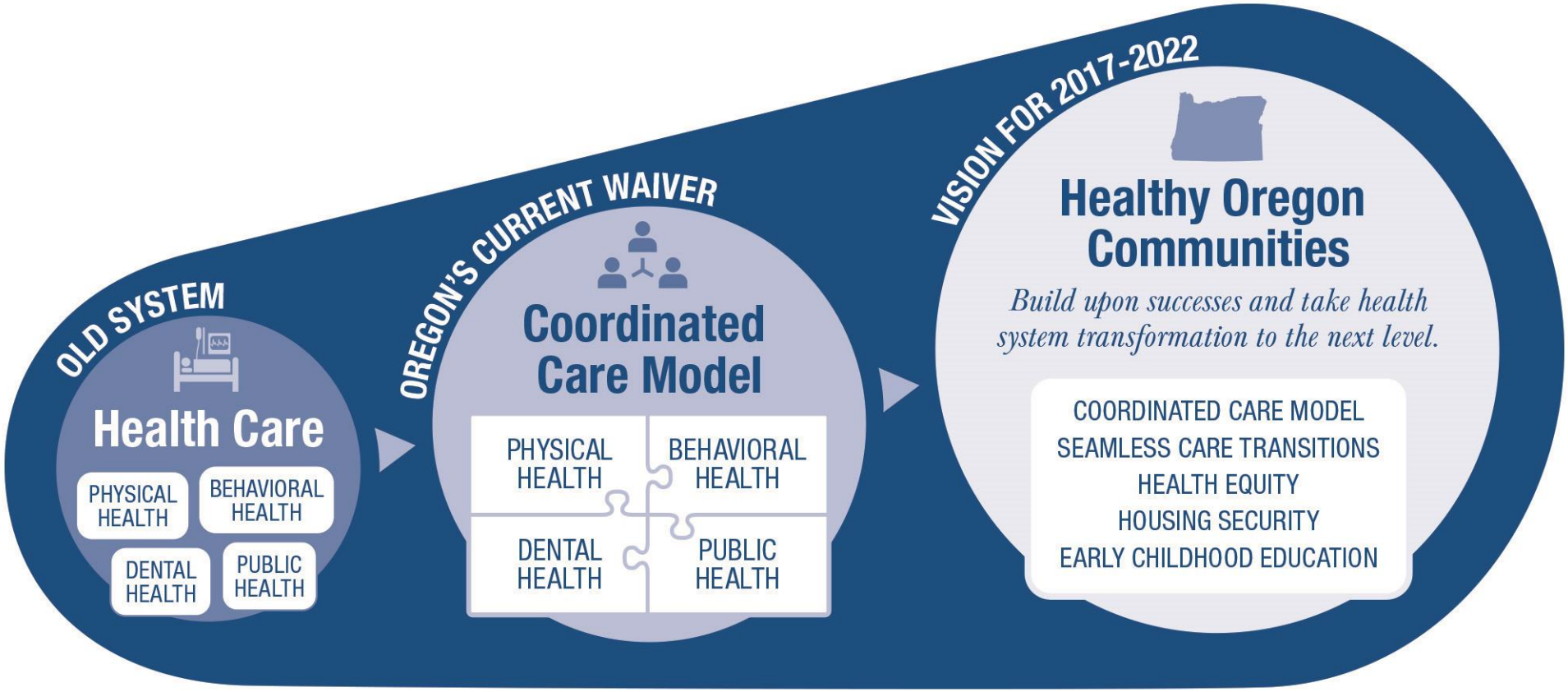
Opportunity in Oregon



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Coordinated Health Partnerships (CHPs)*

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

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

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Coordinated Health Partnerships (CHPs)

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

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

Waiver & HIT: Data Sharing Infrastructure

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

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

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New CMS HIE Funds – OHA Approach

Oregon intends to explore using new federal funds to:

1. Support care coordination across Medicaid providers, including supporting proposed housing and corrections initiatives in Oregon's proposed 1115 waiver demonstration by
   - supporting the costs of an HIE entity (e.g., regional HIEs) to onboard providers
2. Support Oregon's Medicaid providers, with or without an EHR, including:
   - behavioral health, long-term care, corrections, and other social services, to connect to HIE entities.
3. Ensure HIE entities in Oregon are able to support OHA's Medicaid objectives by setting criteria that entities would need to meet to be eligible for funding

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Waiver & HIT: Mobile/Telehealth

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

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

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

Resources

Oregon's CMS Waiver Renewal:
www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx

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

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

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Update on HIT Strategic Planning

1. Sharing Patient Information Across the Care Team

2. Using Aggregated Data for System Improvement

3. Patient Access to Their Own Health Information

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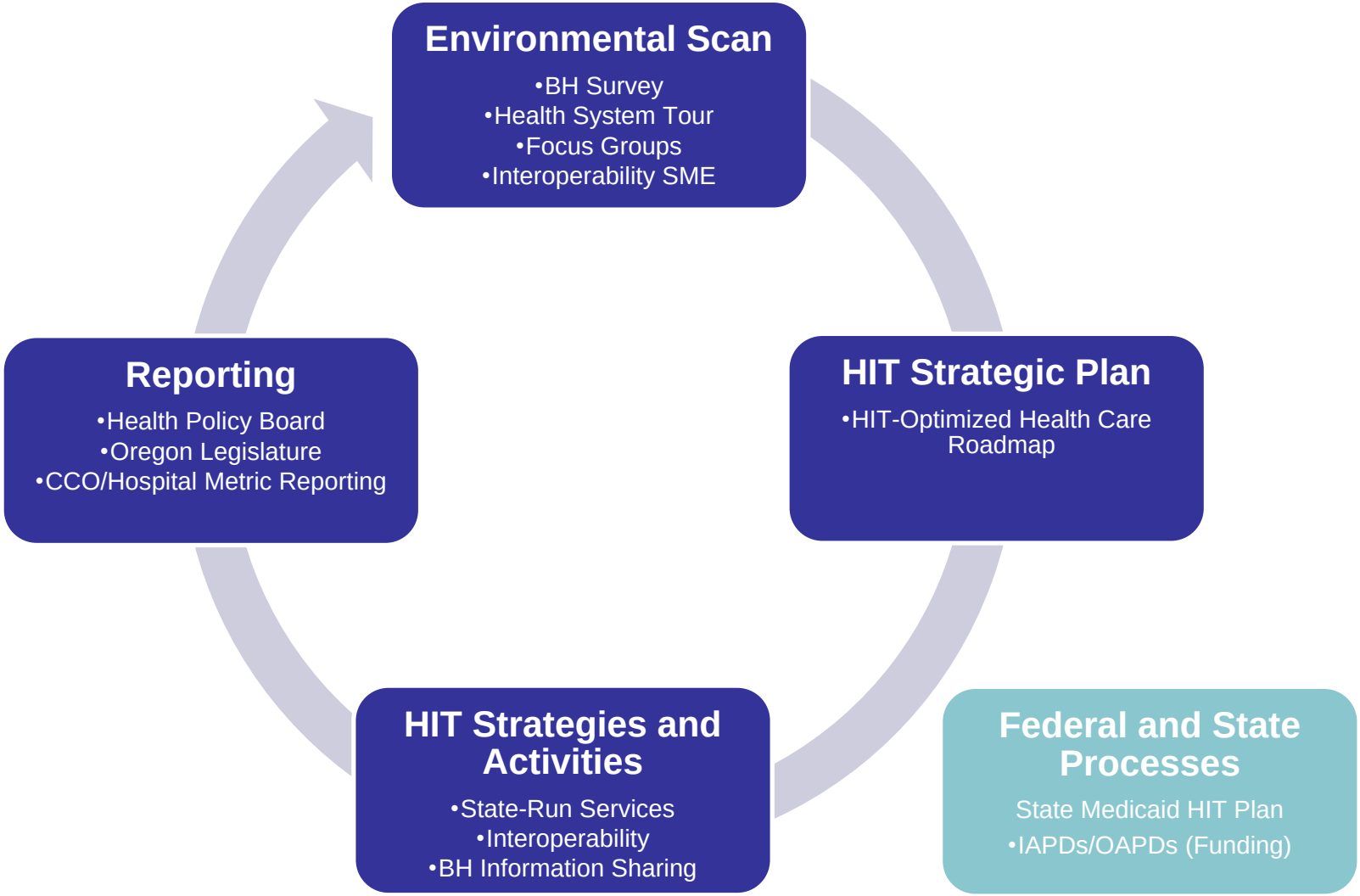

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Updating Oregon's HIT Strategic Plan

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

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Strategic planning process and progress

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

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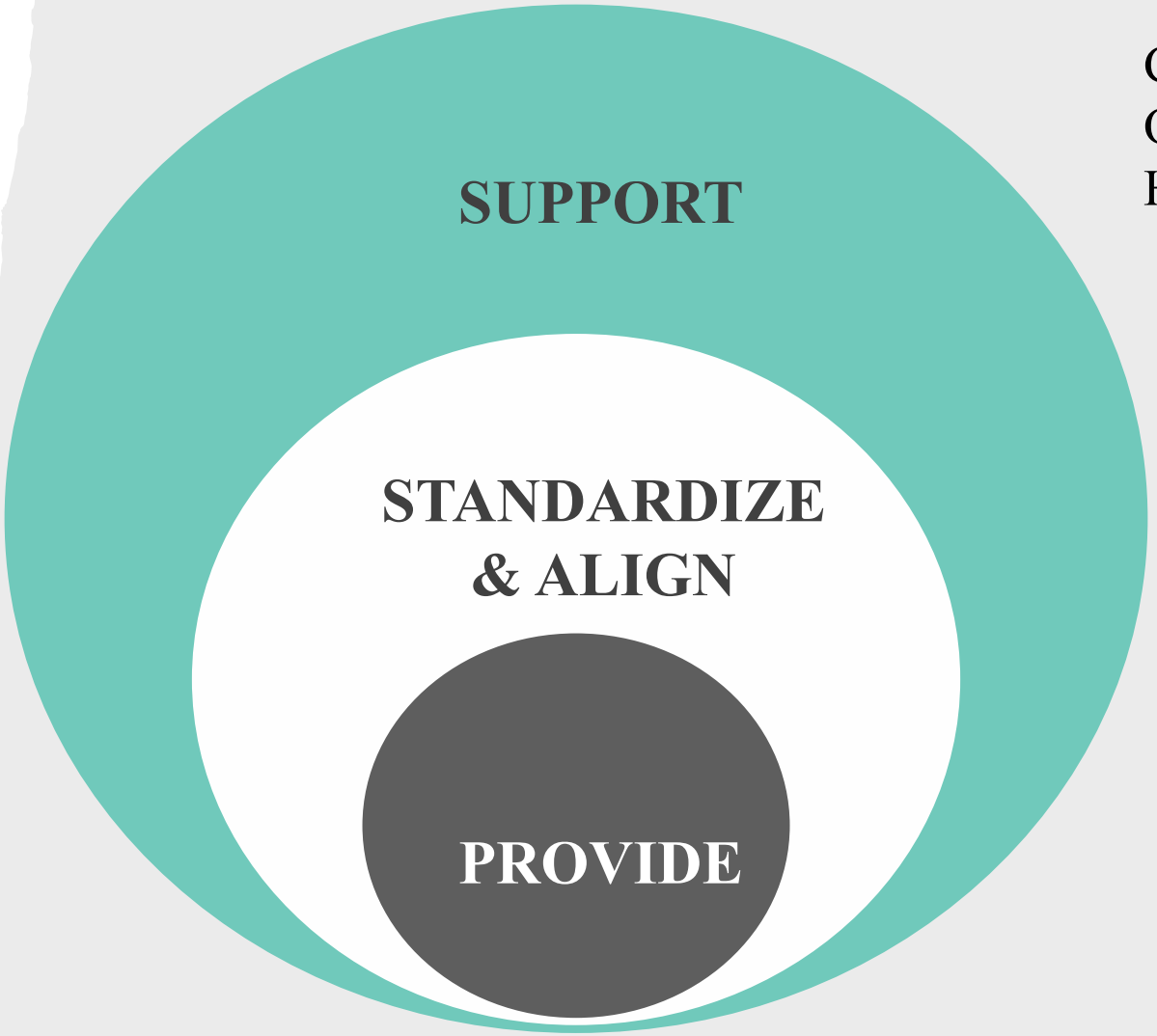
The Role of the State in Health IT



Community and Organizational HIT/HIE Efforts

Approaches to Statewide HIE Coverage

Local — Central

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

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

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

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

(HITOC-approved)

Task Force Recommended

Current Approach and Activities

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

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Options for discussion

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

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

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

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HITOC Feedback/Discussion

- Support for the state role:
  - Where state-wide efforts make the most sense (EDIE, PDMP)
  - State set rules of the road and principles, provide transparency and an open forum and encourage “democratizing data”
- Considerations for prioritizing providers
  - Providers related to integration of physical, behavioral health, and dental
  - Providers not part of Meaningful Use (e.g., behavioral health, long term care)
  - Providers essential in Oregon’s Medicaid 1115 waiver (housing, corrections, state hospital)
- Need more information about the gaps in HIE –
  - geographical, data needs, provider types
  - Identify context and value of HIE, incentives

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HIE Onboarding Program – Next steps

Health Information Technology Oversight Council endorsed concept June 9, 2016

OHA next steps:

- Establish a process and forum to determine criteria
  - Convene small stakeholder work group to help OHA staff develop the concept
  - Continue to socialize concept and gather input
  - Report back to HITOC and other stakeholders
- Formalize strategy, in partnership with stakeholders
- Submit a concept to CMS for discussion and ultimately approval

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Clinical Quality Metrics Registry (CQMR) Year 4 and Beyond

Kate Lonborg, CQMR Program Lead

Oregon Health Authority

Today's CQMR Discussion

- Overview of draft Year 4 (2016) Guidance on EHR-Based CCO Incentive Measures
- Refresher on CQMR and update on RFP/ opportunities for input
- Changing landscape – Merit-based Incentive Payment System (MIPS) and third party intermediary data submission options
- After the break, we'll transition into a discussion to
  - Validate use cases and identify any additional needs
  - Think through how CQMR and HIEs and intermediaries can best work together

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CCO Year 4 Guidance Documentation

- Guidance Documentation will outline reporting requirements for the EHR-based measures in 2016
- Guidance Documentation will be published in late July http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx
- Year 4 reporting will have two components:
  - Data Proposal – similar to 2015, but Excel format
  - Data Submission – for 2016, will include test of patient-level data submission

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Summary of Changes in 2016 – Test Submission of Patient Level Data

- Anticipate that Data Submission will have two components:
  - Data Submission Template similar to Year 3 for aggregated data
  - PLD Test Template – plan to distribute draft template in late July and finalize in August
- CCOs will be required to test submission of patient level data (PLD), **limited to CCO Medicaid beneficiaries only**
  - Test data will be submitted from a practice for each measure
  - Different practices can submit the PLD test data for different measures

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Summary of Changes in 2016 – Report Types

- Meaningful Use Attestation Reports from 2011 certified EHR technology (CEHRT) will no longer be accepted
  - In Year 3, only one clinic in one CCO used 2011 CEHRT MU attestation report
- Report types that will be accepted:
  - MU attestation reports from 2014 Edition or 2015 Edition CEHRT
  - QRDA III
  - Custom query

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Summary of Changes in 2016 – Population Threshold

- Minimum population threshold increases from 50% to 65% for three measures:
  - Screening for Clinical Depression and Follow-up Plan
  - Diabetes HbA1c Poor Control, and
  - Controlling High Blood Pressure-Hypertension
- Reporting is required for Cigarette Smoking Prevalence measure
  - Minimum population threshold of 25%
  - Payment is not tied to performance in 2016 – to earn payment, CCOs must meet cessation benefit requirements and submit EHR-based data in the Data Submission
- Anticipated population threshold glide path for new measures: 25%, 50%, current population threshold

Summary of Changes in 2016 – Minimum Population Threshold

- New guidance about hardship exceptions
  - Intended to allow for flexibility if extreme circumstances (e.g., natural disaster, EHR vendor bankruptcy) prevent a CCO from meeting population threshold requirements
  - Not intended to cover planning failures
  - In addition, OHA will continue policy to allow flexibility to report for a partial year when a practice implements a new EHR
- Clarifications on reporting zero denominators in the Data Submission so minimum population threshold can be accurately calculated

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CQMR Scope: Review

- The CQMR will be used to:
  - Collect data on EHR-based CCO incentive measures to determine CCO performance and associated payment eligibility
  - Collect data on Meaningful Use Clinical Quality Measures (CQMs)
  - Improve CCOs' access to clinical quality measure data and the ability to utilize standardized data for analytics/ quality improvement initiatives
- In later phases, the CQMR may be used to support a "report once" strategy

CQMR Solution Needs

OHA is trying to find the sweet spot where we

- Have a solution works well for end users with a wide range of technical sophistication
- Meet program needs for Medicaid EHR Incentive Program and EHR-based CCO incentive measures
- Can expand to meet future needs without incurring immediate costs for functionality we don't need
  - Focused on data collection, validation, and calculation with basic tracking; not a wide range of analytics within the CQMR itself
  - *Do the CCOs have additional immediate needs?*

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CQMR RFP Opportunities for Input

- Upcoming CQMR RFP
  - Notice posted in ORPIN (Notice # DASPS-2642-16)
  - RFP release August – September 2016
  - Vendor evaluation October – November 2016
- Please tell Kate Lonborg katrina.m.lonborg@state.or.us if you are interested in
  - Helping with review of draft RFP prior to release
  - Participating in vendor demos – anticipate 3 demos, each one a 3-hour webinar
  - Non-disclosure agreements will be required

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Environment for Reporting

As we look toward the future for quality reporting and CQMR…

- Is the Merit-based Incentive Payment System (MIPS) on your radar screen?
- Have you started thinking about qualified registries or qualified clinical data registries (QCDRs) as part of your strategies?

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2015 Medicare Access and CHIP Reauthorization Act (MACRA)

- Establishes Merit-based Incentive Payment System (MIPS), which combines 3 existing programs:
  - Medicare EHR Incentive Program for eligible professionals
  - Physician Quality Reporting System (PQRS), and
  - Value-based Payment Modifier (VM) Programs
- Establishes incentives for participation in alternative payment models (APMs)
- CMS released the MACRA Notice of Proposed Rulemaking (NPRM) 4/27/16

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MIPS Performance Categories

1. **Quality** (50 percent of total score in year 1)
2. **Clinical Practice Improvement Activities (CPIA)** (15 percent of total score in year 1)
3. **Cost/Resource Use** (10 percent of total score in year 1) – no data submission is required for this category, which CMS will calculate based on administrative claims
4. **Advancing Care Information** (parallel to Meaningful Use) (25 percent of total score in year 1)

CMS Guidance on MIPS Scoring Methodology: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MIPS-Scoring-Methodology-slide-deck.pdf

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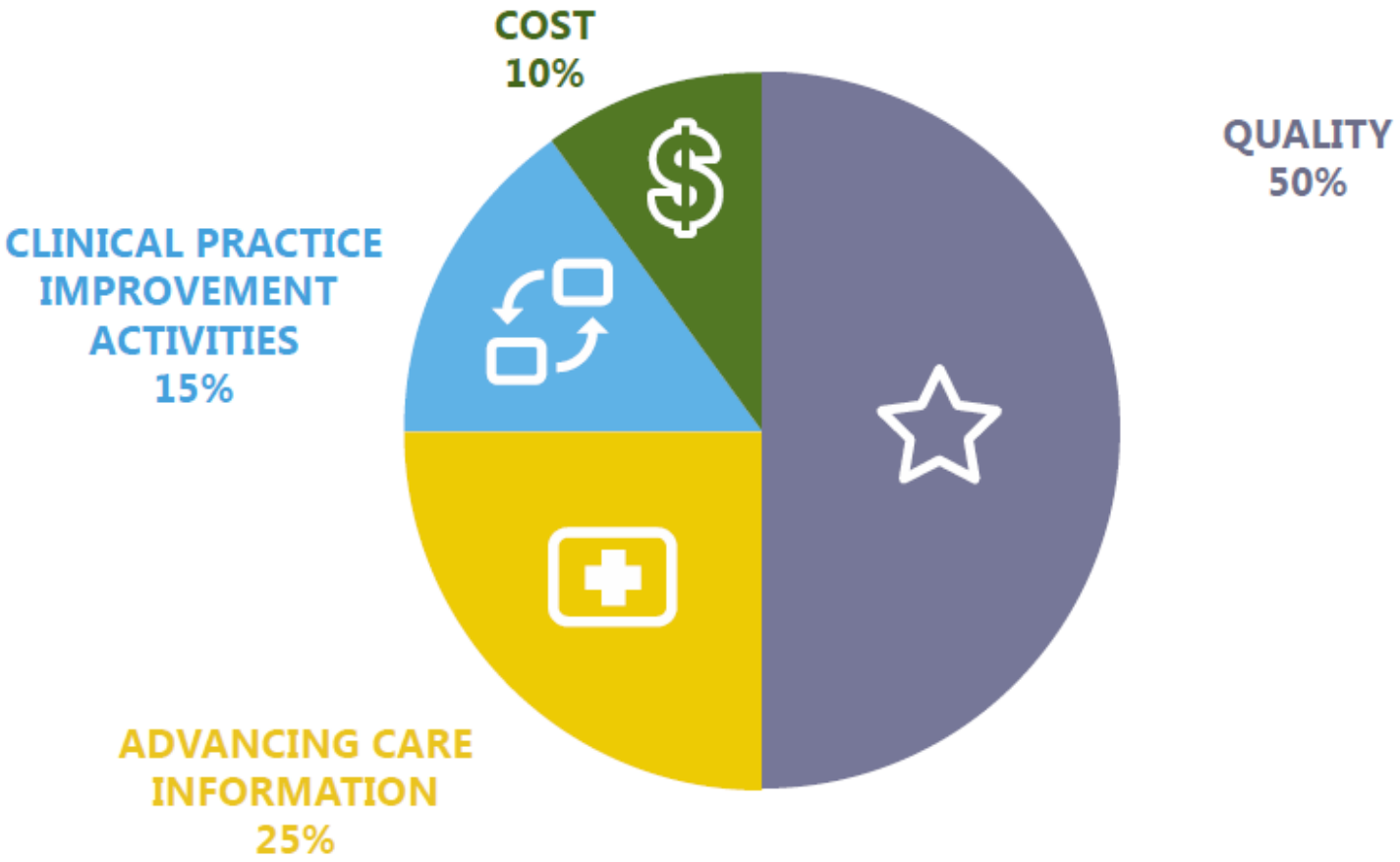
Proposed MIPS Year 1 Performance Score



https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Performance-Category-training-slide-deck.pdf

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MIPS Reporting through Intermediaries

- For all 3 reported MIPS categories, CMS proposes to allow data submission by third party intermediaries
  - Qualified Registry
  - Qualified Clinical Data Registry (QCDR)
  - Health IT vendors that obtain data from eligible clinicians' CEHRT
- For *quality* category, MIPS eligible clinicians receive a bonus point for each measure using end-to-end electronic reporting
  - Bonus points capped at 10% of denominator for quality category

PROPOSED RULE

MIPS Data Submission Options
Quality

	Individual Reporting	Group Reporting
Quality	✓ QCDR ✓ Qualified Registry ✓ EHR Vendors ✓ Administrative Claims (No submission required) ✓ Claims	✓ QCDR ✓ Qualified Registry ✓ EHR Vendors ✓ Administrative Claims (No submission required) ✓ CMS Web Interface (groups of 25 or more) ✓ CAHPS for MIPS Survey

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Performance-Category-training-slide-deck.pdf

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Definitions

Qualified Registry

- A medical registry, a maintenance of certification program operated by a specialty body of the American Board of Medical Specialties or other data intermediary that, with respect to a particular performance period, has self-nominated and successfully completed a vetting process (as specified by CMS) to demonstrate its compliance with the MIPS qualification requirements specified by CMS for that performance period

Qualified Clinical Data Registry (QCDR)

- A CMS-approved entity that has self-nominated and successfully completed a qualification process to determine whether the entity may collect medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care provided to patients

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QCDR – More Detail

- QCDRs may include regional collaboratives and specialty societies using a commercially available software platform
- Entities may collaborate to become a QCDR – must have written agreement that specifically details relationship and responsibilities
- QCDR option allows a specialty society to propose measures that are pertinent to that specialty
  - Examples for 2016 PQRS reporting: American Academy of Allergy, Asthma, and Immunology Quality Clinical Data Registry in collaboration with CECity; ABG Anesthesia Data Safety Group; American Academy of Neurology
  - https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016QCDRPosting.pdf

Establishing a QCDR or Qualified Registry

- By January 1 of the performance period, the entity must
  - Be in existence
  - Have at least 25 participants

    Participants do not need to be using the entity to report MIPS data to CMS on January 1, but need to be submitting data to the entity for quality improvement
- CMS will post a list of approved QCDRs and registries

Similarities: QCDR and Qualified Registry

- Both are required to have appropriate Business Associate Agreements (BAAs) and documentation of authorization to submit MIPS data
- Similar data quality requirements apply
  - Information on data collection methods, methodology for calculating performance rates, randomized audit process, data validation processes, etc.
  - Data errors can lead to probation, notation on CMS posting site, and disqualification

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Differences: QCDR and Qualified Registry

- QCDR may seek approval to submit up to 30 quality measures that are non-MIPS quality measures
  - Not on the annual MIPS list
  - On the MIPS list but with substantive differences in manner of submission (e.g., submitting through QCDR where a MIPS measure is reportable only through CMS Web Interface)
- Frequency of feedback to clinicians on MIPS categories that the entity will report to CMS
  - QCDR: at least 6 times/year
  - Qualified registry: at least 4 times/year

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Break

CQMR Discussion – Use Cases, Connections with HIEs and Qualified Clinical Data Registries (QCDRs)

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Third Party Intermediary Options – Initial Thoughts

- General thoughts about MIPS reporting options and how that affects your quality reporting strategies?
- What are the CCOs' needs related to reporting?
  - What are the CCOs' plans to leverage intermediary reporting options being used by networked providers?
  - Any plans on the part of CCOs' networked providers to use QCDRs or qualified registries, either now for PQRS or later for MIPS?
- How are the HIEs working with CCOs or providers on reporting and what can you provide/ are you providing to the CCOs or providers?
  - Any plans on the part of the HIEs to pursue qualification as a QCDR or qualified registry?
- Thoughts on CQMR planning to accept data from intermediaries?
  - Thoughts on whether CQMR should move toward becoming a QCDR or qualified registry?

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CQMR Use Cases - Refresher

Use cases previously identified and refined with HITAG:

- CCO users (within CCO, at organizations/ practices, individual practitioners/ delegates) submit incentive measure data
- CCO monitors data submissions (and indicates when submissions are complete for the performance period)
- CCO users can run reports

The requirements for these use cases also support potential future uses by other payers and users

OHA users also will be able to run reports and export data for analytics.

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CQMR Use Cases – New

- CCO submits Data Proposal
  - Previous Data Proposal will display for editing
  - Data Proposal will identify who will submit the data and trigger notification if account creation needed
- Medicaid eligible professional or delegate submits Meaningful Use clinical quality measures
- Third party intermediary submits data on behalf of CCO or provider
- Users test data submissions prior to formal submission (optional)

Other use cases?

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CQMR Standardized Interface Option

- Anticipated access option for an interface via an API or web services
  - Single standardized interface option with an implementation guide
  - Avoid customization / one-offs
- Other access options such as web portal and Direct secure messaging to accommodate range of users
- Thoughts on that approach?

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Next Steps

- Further feedback and thoughts about qualified registries, QCDRs, MIPS planning
- Volunteer if interested in review of materials for RFP
  - Roles-based access chart
  - Requirements
  - NDA needed

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Administrative Simplification Workgroup – Claims Data Request Issue

Susan Otter

The Data Request Issue

- Providers need and request patient claims encounter data for reasons such as population management and risk based contracting.
- Coordinated Care Organizations (CCOs) are committed to providing this data to providers, but struggle to provide it in a streamlined way across all payers.
- OHA is beginning to work with payers and the Oregon Health Leadership Council to find ways to minimize the complexities for both providers and payers.

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Data Request Challenges

CCOs have shared challenges in furnishing data requests:

- Lack of standardization in data requests (e.g., file formats, system capabilities, data definitions)
- Challenging contract and system management (e.g., data masking, protected information)
- Patient and provider attribution complexities
- Delays related to claims processing affecting the value of the data
- Multiple payer online tools/data sources add complexity for providers

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Type of Data Requested

Typical data requests include:

- Eligibility files,
- Medical claims files,
- Prescription claims files,
- Provider files, and
- Supplemental lab files

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Type of Entities Requesting Data?

CCOs have shared challenges in furnishing data requests:

- Health systems and provider groups
- Quality organizations (e.g., The Oregon Quality Corporation)
- Population health partners with provider groups, systems, regions or state:
  - Third party pop health vendors
  - Insurance brokers who maintain advanced analytics
  - Independent Practice Associations offering analytic services
  - Health Information Exchanges

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Discussion

OHA is beginning to work with payers and the Oregon Health Leadership Council to find ways to minimize the complexities for both providers and payers.

Seeking additional information:

- If OHLC and/or OHA were to seek to address these types of issues – what would be your top 1-2 priorities to tackle?
  - Which are the most pressing or problematic?
  - Which would you be willing to discuss or work on?
- What are your thoughts on how to have an impact on these problem areas?

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Health IT Portfolio Update

Susan Otter

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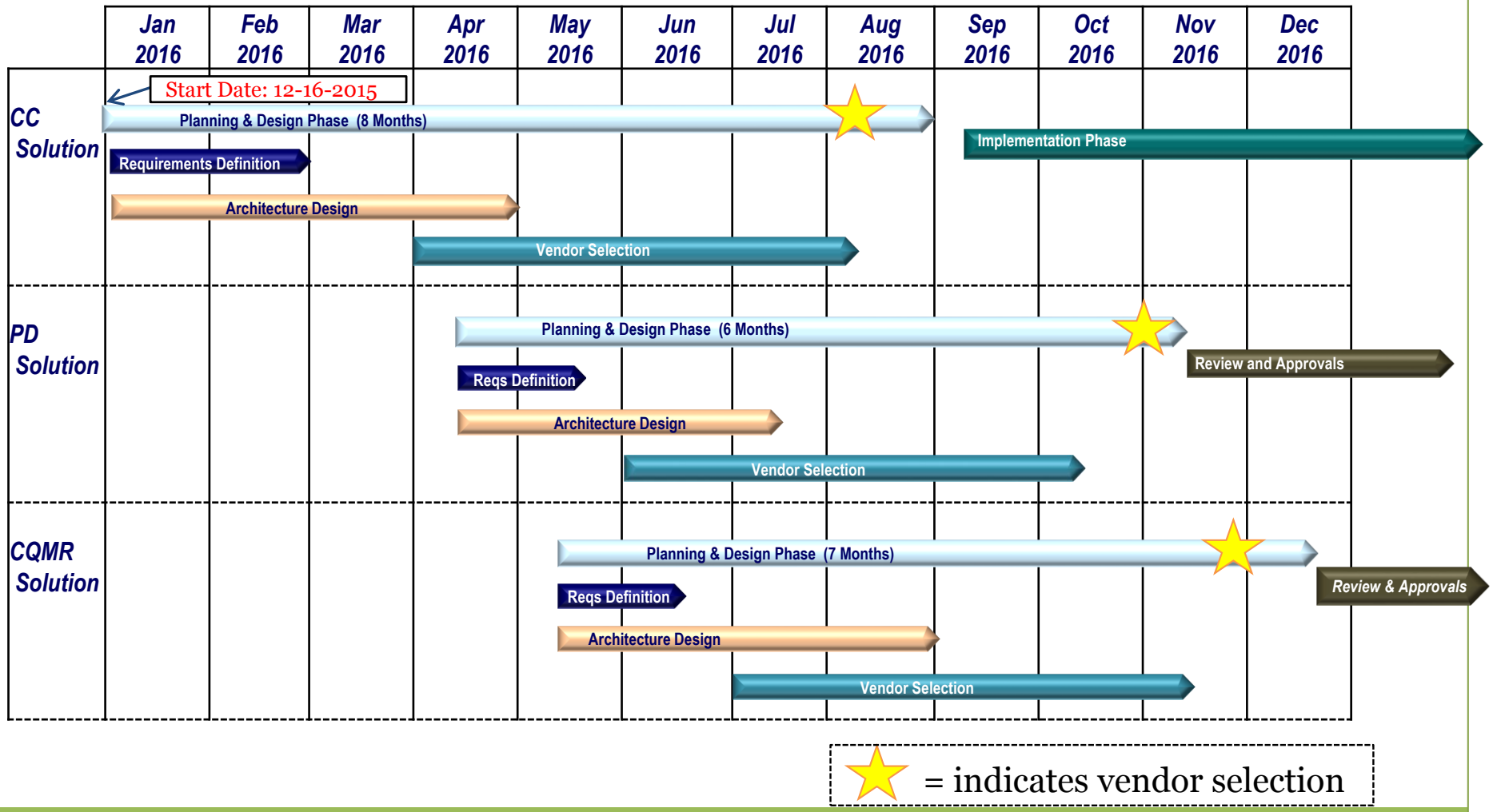
Overall HIT Project Summary



Vendor Product Selection Process

Del-10 (Interface Req Spec)	Del-6 (CC Market Analysis)	Del-7 (RFP)	Del-8 (Final Recommendations)		
Refine the Need	**Conduct Market Analysis**	**Release RFP (Full & Open)**	**Evaluate Proposal Responses**	**Hold Demonstrations**	**Deliver Final Assessment & Recommendation**
1. Finalize product requirements 2. Define Integration and Interface requirements 3. Create minimum qualification list for viable vendors 4. Prepare announcement for upcoming RFP posting	1. Research based on OHA RFI responses, CCAG, and other sources 2. Compile contact information for interested vendors and viable candidates 3. Issue NDAs to viable vendors 4. Develop Evaluation Matrix	1. Develop, Review, and Post RFP 2. Manage Q&A period 3. Receive responses from vendors	1. Evaluate products against detailed requirements & evaluation criteria 2. Engage vendors with necessary questions/ clarifications 3. Recommend top 3-5 products	1. Host scripted demonstration sessions for top 3-5 products 2. Arrange for Site Visits of production Systems 3. Request best and final offer	1. Present Recommendation: a) Summarize responses b) Analysis a) Evaluation criteria b) Demonstration c) Benefits/risks d) Cost e) Implementation Timelines 2. Finalize selection a) Recommendation b) Identified Risks

OHA Review and Acceptance

CC	✓	✓	✓	✓	**Status**: Scheduling vendor demonstration and site visits
PD	✓	✓	**Status**: RFP package submitted to OHA for review		
CQMR	✓	**Status**: Key deliverables in work in preparation for RFP package			

Common Credentialing Procurement Update

- ✓ RFP was released on April 29, 2016
- ✓ Responses were Due May 20, 2016
- ✓ Down Select to 3 Vendors: June 17
- ✓ Demonstrations complete July 6
- Site Visits week of July 11
- Vendor selection in July/August 2016

Upcoming Procurement Timeline

Provider Directory ORPIN Announcement

- RFP Release Date: August 2016
- Q & A Period: 1 week after RFP Release
- RFP Response Due Date: 4 weeks after RFP Release
- Demonstrations and Site Visits: September - October 2016
- Vendor Selection: November 2016

- Interested vendors can contact the Harris team at: OregonProcurement@harris.com

CQMR Projected Schedule

- RFP Release Date: Aug - Sept 2016
- Q & A Period: 1 week after RFP Release
- RFP Response Due Date: 4 weeks after RFP Release
- Demonstrations and Site Visits: November 2016
- Vendor Selection: November 2016

Oregon's Medicaid Meaningful Use Technical Assistance Program

(OMMUTAP)

Kristin Bork, Lead

Oregon Health Authority

OMMUTAP Update

- Regional Work Plans for 7 (out of 10) Regions have been completed
- Planning meetings have started with clinics and providers whose CCOs have completed Regional Work Plans
- Participation Agreements have been signed with 24 clinics and a total of 91 providers
  - Slightly over half of providers signed up for Interoperability Consulting and Technical Assistance
  - Risk and Security Training is at roughly 20 percent of providers
  - Meaningful Use has been selected by roughly 20 pecent
  - Certified EHR Assessment has been selected by less than 10 percent of providers
- Next Step: Subject Matter Experts will work with clinics to plan out the TA delivery

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Statewide Medicaid PreManage Subscription

Kristin Bork, Lead Policy Analyst

Oregon Health Authority

PreManage Subscription

- PreManage Subscription expected to be EXECUTED and LAUNCHED this week!
- Emails will be sent to CCOs to discuss next steps for those who currently have subscriptions and those moving toward onboarding and those still deciding
- Kristin Bork (kristin.m.bork@state.or.us) is POC at OHA for any questions regarding the PreManage Subscription.
- Justin Keller (justin.keller@collectivemedicaltech.com) is POC at CMT
- Discussion point: For CCOs with a subscription, what questions did you have when you first signed up?

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Next Steps and Conclusion

- Scheduling for 2017
  - Same time slot for HITAG (2nd Thurs of odd-numbered months)?
  - Same time slot for HCOP (2nd Thurs quarterly – Jan, April, July, Oct)?
  - Periodic joint meetings of HITAG and HCOP?
- OHIT staff will follow up by email on scheduling

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Conclusion